No.

In the Supreme Court of the United States

XAVIER BECERRA, SECRETARY
OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

EMPIRE HEALTH FOUNDATION,
FOR VALLEY HOSPITAL MEDICAL CENTER

*ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT*

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

The Medicare statute provides that a hospital that serves a "significantly disproportionate number of low-income patients" may receive an additional payment for treating Medicare patients, known as the disproportionate-share-hospital adjustment. 42 U.S.C. 1395ww(d)(5)(F)(i)(I) and (ii). The statute directs the Secretary of Health and Human Services to calculate a hospital's disproportionate-share-hospital adjustment (if any) using a formula that is based principally on the sum of two separate proxy measures of the proportion of low-income patients the hospital serves. The first proxy measure, known as the Medicare fraction, is the percentage of all patient days of individuals who were "entitled to benefits under [Medicare] part A" and who were also entitled to supplemental-security-income benefits. 42 U.S.C. 1395ww(d)(5)(f)(vi)(I). The second proxy measure, known as the Medicaid fraction, is the percentage of all of a hospital's patient days that are attributable to individuals who were eligible for Medicaid coverage but who were not entitled to Medicare Part A benefits. 42 U.S.C. 1395ww(d)(5)(f)(vi)(II). The question presented is as follows:

Whether the Secretary has permissibly included in a hospital's Medicare fraction all of the hospital's patient days of individuals who satisfy the requirements to be entitled to Medicare Part A benefits, regardless of whether Medicare paid the hospital for those particular days.

RELATED PROCEEDINGS

United States District Court (E.D. Wash.):

Empire Health Found., for Valley Hosp. Med. Ctr. v. *Price*, No. 16-cv-209 (Aug. 13, 2018)

United States Court of Appeals (9th Cir.):

Empire Health Found., for Valley Hosp. Med. Ctr. v. *Azar*, Nos. 18-35845 and 18-35872 (May 5, 2020)

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PETITION FOR A WRIT OF CERTIORARI

The Acting Solicitor General, on behalf of the Secretary of Health and Human Services, respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Ninth Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-23a) is reported at 958 F.3d 873. The order of the district court (App., *infra*, 23a-75a) is reported at 334 F. Supp. 3d 1134. The decision of the Provider Reimbursement Review Board (App., *infra*, 76a-83a) is unreported.

[1] Secretary Becerra is automatically substituted as a party for his predecessor in office pursuant to Rule 35.3 of the Rules of this Court.

JURISDICTION

The judgment of the court of appeals was entered on May 5, 2020. A petition for rehearing was denied on October 20, 2020 (App., *infra*, 84a-85a). On March 19, 2020, the Court extended the time within which to file any petition for a writ of certiorari due on or after that date to 150 days from the date of the lower-court judgment, order denying discretionary review, or order denying a timely petition for rehearing. The effect of that order was to extend the deadline for filing a petition for a writ of certiorari in this case to March 19, 2021. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

Pertinent statutory and regulatory provisions are reproduced in the appendix to this petition. App., *infra*, 86a-105a.

STATEMENT

A. Legal Background

1. The Medicare program, established in 1965 by Title XVIII of the Social Security Act (Medicare Act), 42 U.S.C. 1395 *et seq.*, provides health-insurance coverage to individuals who are at least 65 years old and are entitled to monthly Social Security benefits, and to disabled individuals who meet certain requirements. 42 U.S.C. 426(a) and (b). Such individuals are automatically "entitled to * * * benefits" under Medicare Part A, *ibid.*, which authorizes payments to providers for certain hospital and related services that they furnish to Medicare beneficiaries, see 42 U.S.C. 1395c *et seq.* The Centers for Medicare & Medicaid Services (CMS) within the Department of Health and Human Services (HHS) administers the Medicare program on behalf of the Secretary. See *Maine Med. Ctr.* v. *Burwell*, 841 F.3d 10, 13-14 (1st Cir. 2016).

Prior to 1983, "the federal government reimbursed hospitals for the 'reasonable cost' of treating Medicare patients." *Maine Med. Ctr.*, 841 F.3d at 14. In 1983, Congress replaced that reasonable-cost approach with "a prospective payment system through which hospitals are reimbursed predetermined amounts for certain services." *Ibid.* Under that prospective payment system, the government pays "a hospital a fixed dollar amount for each Medicare patient it discharges on the basis of the patient's diagnosis, regardless of the actual cost of the treatment provided." *Metropolitan Hosp.* v. *United States Dep't of Health & Human Servs.*, 712 F.3d 248, 250 (6th Cir. 2013) (citing *Good Samaritan Hosp.* v. *Shalala*, 508 U.S. 402, 406 n.3 (1993)); see 42 U.S.C. 1395ww(d)(1)-(4). Those fixed per-patient amounts are subject, however, to certain "adjustments" that Congress prescribed "based on various hospital-specific factors." *Northeast Hosp. Corp.* v. *Sebelius*, 657 F.3d 1, 3 (D.C. Cir. 2011); see *Edgewater Med. Ctr.* v. *Blue Cross & Blue Shield Ass'n*, HCFA Adm'r Dec. (PRRB Dec. Nos. 2000-D44 & 2000-D45), 2000 WL 1146601, at *2-*3 (June 19, 2000).

At issue here is one such adjustment that increases Medicare payments to "hospitals that serve a disproportionate share of low-income patients," *Sebelius* v. *Auburn Reg'l Med. Ctr.*, 568 U.S. 145, 150 (2013), known as the "disproportionate share hospital" (or colloquially "DSH") adjustment, App., *infra*, 3a; see 42 U.S.C. 1395ww(d)(5)(F). Congress recognized that "low-income patients are often in poorer health, and therefore costlier for hospitals to treat." *Catholic Health Initiatives Iowa Corp.* v. *Sebelius*, 718 F.3d 914, 916 (D.C. Cir. 2013). And "because hospitals with an unusually high percentage of low-income patients generally have higher per-

patient costs," Congress determined that "such hospitals * * * should receive higher reimbursement rates." *Auburn Reg'l Med. Ctr.*, 568 U.S. at 150.

Congress initially directed the Secretary to develop adjustments to account for those higher costs. But in 1985, after those efforts had not come to fruition, Congress "established its own measure for assessing whether a hospital 'serves a significantly disproportionate number of low income patients.'" *Metropolitan Hosp.*, 712 F.3d at 250 (quoting 42 U.S.C. 1395ww(d)(5)(F)(v)). The centerpiece of the measure that Congress enacted is the "disproportionate patient percentage," 42 U.S.C. 1395ww(d)(5)(F)(v) and (vi), which is a "'proxy measure' for the number of low-income patients a hospital serves." *Northeast Hosp. Corp.*, 657 F.3d at 3 (quoting H.R. Rep. No. 241, 99th Cong., 1st Sess. Pt. 1, at 17 (1985)). That percentage is used to determine whether a hospital will receive any disproportionate-share-hospital adjustment and, if so, to calculate the amount of that upward adjustment. See 42 U.S.C. 1395ww(d)(5)(F)(i)-(v), (vii)-(xiv); *Metropolitan Hosp.*, 712 F.3d at 250-251. In general, a "higher [disproportionate-patient percentage] means greater reimbursements" for a hospital, reflecting that "the hospital is serving more low-income patients." *Catholic Health Initiatives*, 718 F.3d at 916.

The disproportionate-patient percentage "is not the *actual* percentage of low-income patients served"; it is instead merely "an indirect, proxy measure for low income." *Catholic Health Initiatives*, 718 F.3d at 916. The disproportionate-patient percentage "is statutorily defined as the sum of two fractions, often called the 'Medicare fraction' and the 'Medicaid fraction,'" which "represent two distinct and separate measures of low income" that are focused on two different populations: low-income

patients who are insured by Medicare Part A, and low-income patients who are not insured by Medicare Part A, respectively. *Ibid;* see 42 U.S.C. 1395ww(d)(5)(F)(vi).

The first component of the disproportionate-patient percentage—the Medicare fraction, also "commonly called the SSI fraction," *Auburn Reg'l Med. Ctr.*, 568 U.S. at 150—focuses on low-income patients treated by a hospital in a reporting period who were Medicare beneficiaries, *i.e.*, who "were entitled to benefits under [Medicare] part A." 42 U.S.C. 1395ww(d)(5)(F)(vi)(I). It uses a patient's entitlement to supplemental-security-income (SSI) benefits under Title XVI of the Social Security Act, 42 U.S.C. 1381 *et seq.*—which provides financial assistance to certain "financially needy individuals," *Bowen* v. *Galbreath*, 485 U.S. 74, 75 (1988)—to identify patients in that pool who also have low incomes. Specifically, the Medicare fraction is defined as a

> fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter [*i.e.*, Medicare Part A] and were entitled to supplementary security income benefits (excluding any State supplementation) under [Title XVI], and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under [Medicare] part A.

42 U.S.C. 1395ww(d)(5)(F)(vi)(I). The Medicare fraction thus "effectively asks, out of all patient days *from Medicare beneficiaries*, what percentage of those days came from Medicare beneficiaries who *also*" were entitled to SSI benefits. *Catholic Health Initiatives*, 718 F.3d at 917; see *Auburn Reg'l Med. Ctr.*, 568 U.S. at 150.

The second component of the disproportionate-patient percentage—the Medicaid fraction—focuses on low-income patients a hospital treated who were *not* Medicare beneficiaries, *i.e.*, "who were not entitled to benefits under [Medicare] part A." 42 U.S.C. 1395ww(d)(5)(F)(vi)(I). The Medicaid fraction uses a patient's eligibility for medical assistance under the Medicaid program, 42 U.S.C. 1396 *et seq.*, rather than entitlement to SSI benefits, to estimate the low-income non-Medicare patients a hospital serves relative to its total patient population. Specifically, the Medicaid fraction is defined as a

> fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under [Title XIX], but who were not entitled to benefits under part A of this subchapter [*i.e.*, Medicare Part A], and the denominator of which is the total number of the hospital's patient days for such period.

42 U.S.C. 1395ww(d)(5)(F)(vi)(II). The Medicaid fraction thus calculates, as a percentage of a hospital's total patient days in a reporting period, how many days were attributable to patients who were *not* entitled to Medicare benefits but who *were* eligible for Medicaid benefits. See *Catholic Health Initiatives*, 718 F.3d at 917.

The Medicare and Medicaid fractions thus provide separate but complementary proxies for the percentage of low-income patients a hospital serves, each focused on a different subset of its patient pool: Medicare Part A patients, and all other patients, respectively. "[W]hen summed together," those two measures "provide a proxy for the [hospital's] total low-income patient percentage." *Catholic Health Initiatives*, 718 F.3d at 916.

2. This case concerns the calculation of the Medicare fraction, and in particular the meaning of the phrase "entitled to benefits under [Medicare] part A" in the Medicare fraction's numerator and denominator. 42 U.S.C. 1395ww(d)(5)(F)(vi)(I). The central dispute is whether that phrase encompasses individuals who satisfied the statutory criteria to be "entitled" to Medicare Part A benefits, 42 U.S.C. 426(a) and (b), at the time they received services from a hospital, but for which services Medicare ultimately did not (and was not required to) pay the hospital. In the 2004 notice-and-comment regulation at issue in this case, the Secretary determined that such individuals are to be counted in the Medicare fraction. See 69 Fed. Reg. 48,916, 49,098-49,099, 49,246 (Aug. 11, 2004).

a. The Secretary has long interpreted the term "entitled" in the Medicare context to refer to an individual's status as a Medicare beneficiary, *i.e.*, that the individual satisfies the statutory requirements for entitlement to benefits under the program. For example, a regulation first promulgated in 1983, and still in force today, provides that, "[a]s used in connection with the Medicare program, unless the context indicates otherwise," the term "*[e]ntitled* means that an individual meets all the requirements for Medicare benefits." 48 Fed. Reg. 12,526, 12,535 (Mar. 25, 1983) (42 C.F.R. 400.202).

Prior to 2004, however, when HHS calculated a hospital's disproportionate-share-hospital adjustment, it nevertheless included in the Medicare fraction only "covered" Medicare patient days, 42 C.F.R. 412.106(b)(2) (2003)—*i.e.*, days for which payment from the Medicare program was available to the hospital, cf. 42 C.F.R. 409.3 (2003) (providing that the term "*[c]overed*" in regulations addressing inpatient hospital services "refers to services for which

the law and the regulations authorize Medicare payment"). HHS had interpreted the parenthetical phrase "(for such days)"—which appears in both the Medicare fraction (referring to "patients who *(for such days)* were entitled to benefits under [Medicare] part A") and the Medicaid fraction (referring to "patients who *(for such days)* were eligible for [Medicaid]"), 42 U.S.C. 1395ww(d)(5)(F)(vi) (emphases added)—as directing it to focus on patient days for which a hospital was actually paid by Medicare or Medicaid, respectively. See 51 Fed. Reg. 31,454, 31,460 (Sept. 3, 1986) (discussing Medicaid fraction); *id.* at 31,460-31,461 (discussing Medicare fraction).[2]

b. HHS subsequently revisited that approach following a series of judicial decisions rejecting its interpretation of the "(for such days)" qualifier in the context of the Medicaid fraction. See *Monmouth Med. Ctr.* v. *Thompson*, 257 F.3d 807, 810 (D.C. Cir. 2001) (citation omitted). By 1997, four courts of appeals had rejected HHS's position that only patient days actually paid by the Medicaid program should be counted in the numerator of the Medicaid fraction. See *ibid.* (citing *Cabell Huntington Hosp., Inc.* v. *Shalala*, 101 F.3d 984 (4th Cir. 1996); *Legacy Emanuel Hosp. & Health Ctr.* v. *Shalala*, 97 F.3d 1261 (9th Cir. 1996); *Deaconess*

[2] HHS has also excluded from the Medicaid fraction's numerator *all* patient days of Medicare Part A beneficiaries, regardless of whether Medicare had paid the hospital for those days. See *Edgewater Med. Ctr.*, 2000 WL 1146601, at *4-*5; see *Catholic Health Initiatives*, 718 F.3d at 918, 921. In the definition of the Medicaid fraction's numerator in subclause (II), unlike in the definition of the Medicare fraction in subclause (I), the phrase "(for such days)" does not modify the phrase "entitled to benefits under [Medicare] part A"; it modifies only the phrase "eligible for medical assistance under [Medicaid]." 42 U.S.C. 1395ww(d)(5)(F)(vi)(II).

Health Servs. Corp. v. *Shalala*, 83 F.3d 1041 (8th Cir. 1996) (per curiam); and *Jewish Hosp., Inc.* v. *Secretary of HHS*, 19 F.3d 270 (6th Cir. 1994)). In 1997, CMS's predecessor issued a ruling that acquiesced nationwide in those courts' interpretation and "established a new interpretation" of the Medicaid fraction, under which "Medicaid eligible days *would* be counted 'whether or not the hospital received payment for those inpatient hospital services.'" *Ibid.* (quoting Health Care Fin. Admin., HHS, *HFCA Rulings: No. 97-2* (Feb. 27, 1997), https://go.usa.gov/xsn8W) (emphasis added).

In 2004, following notice and comment, the Secretary promulgated the regulation at issue here, which carried over that same approach to the Medicare fraction. See 69 Fed. Reg. at 49,098-49,099. The 2004 regulation implemented that interpretation by replacing the direction to "[d]etermine[] the number of *covered* patient days" of Medicare Part A beneficiaries in the prior regulation with a direction to "[d]etermine[] the number of patient days" of such patients simpliciter. *Id.* at 49,246 (emphasis added) (amending 42 C.F.R. 412.106(b)(2)(i) (2003)); see App., *infra*, 77a. As a result, under the 2004 regulation, all patient days of Medicare Part A beneficiaries are included in the Medicare fraction, regardless of whether Medicare paid for those particular days. All patient days attributable to Medicare Part A beneficiaries are counted in the Medicare fraction's denominator, and all patient days of such individuals who were entitled to SSI benefits are counted in the Medicare fraction's numerator. See App., *infra*, 77a; 42 C.F.R. 412.106(b)(2)(i) and (iii).[3]

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[3] The 2004 rule also continued to exclude all patient days of Medicare Part A beneficiaries from the numerator of the Medicaid fraction, regardless of whether those days were paid for by Medicare. See 69 Fed. Reg. at 49,098-49,099; see also p. 8 n.2, *supra*.

In adopting the 2004 regulation, the Secretary specifically addressed its application to patients who were Medicare Part A beneficiaries at the time they were treated at a hospital, but who had exhausted their Medicare Part A coverage for hospital inpatient days for the relevant benefit period—such that the Medicare program was not required to pay the hospital for those particular days. 69 Fed. Reg. at 49,098-49,099. In general, Medicare Part A will pay only for a limited number of successive hospital inpatient days (typically 90) in a single "spell of illness." 42 U.S.C. 1395d(b); see 42 U.S.C. 1395x(a) ("spell of illness" ends after a patient is discharged and has 60 consecutive days without inpatient care); 42 C.F.R. 409.61(a)(1). With certain exceptions, if a patient's stay exceeds that limit, his or her Medicare coverage of hospital inpatient days for that period is "exhausted," and Medicare does not pay for the days in excess of the limit. App., *infra*, 7a n.8; see 42 C.F.R. 409.61(a)(1) and (2).

The Secretary determined that patient days attributable to an individual who satisfied the requirements to be entitled to Medicare Part A benefits at the time she received care should be counted in the Medicare fraction even if the individual had exhausted her Part A inpatient coverage. See 69 Fed. Reg. at 49,098-49,099. The Secretary observed that a Medicare Part A beneficiary who exhausts her covered inpatient days for a benefit period does not thereby lose her entitlement to Medicare Part A benefits altogether. See *id.* at 49,098. To the contrary, the Secretary noted that Medicare "beneficiaries who have exhausted their Medicare Part A inpatient coverage may still be entitled to other Part A benefits." *Ibid.* For example, although a

beneficiary's entitlement to inpatient care may be exhausted, "other items and services * * * still might be covered under Part A," such as "certain physician services and skilled nursing services." CMS, HHS, *CMS Rulings: No. CMS-1498-R*, at 10 (Apr. 28, 2010) (*Ruling No. CMS-1498-R*), https://go.usa.gov/xsnnz. The Secretary accordingly endorsed a commenter's observations "that a patient who exhausts coverage for inpatient hospital services still remains entitled to other Medicare Part A benefits," and that it is "difficult to reconcile" that fact with an interpretation of the statute that deems Medicare beneficiaries who have exhausted inpatient days to be "not entitled to Medicare Part A benefits" at all. 69 Fed. Reg. at 49,098. The Secretary recognized that including Medicare beneficiaries' patient days in the Medicare fraction rather than in the Medicaid fraction could increase some hospitals' payments while decreasing those of others, depending on the makeup of their patient populations. See *ibid.*

B. The Present Controversy

1. Valley Hospital Medical Center operated a short-term acute-care hospital that participated as a provider in the Medicare program. Compl. ¶ 5. Respondent acquired Valley Hospital's right to payment from the Medicare program for (as relevant here) fiscal year 2008. App., *infra*, 10a.

"Dissatisfied with its total reimbursement amount" for 2008 as determined by the Medicare contractor that calculated Valley Hospital's payment, respondent appealed to the Provider Reimbursement Review Board within HHS. App., *infra*, 10a-11a. Respondent contended (as relevant) that the 2004 regulation's treatment of patient days of Medicare beneficiaries for days

which were not covered was inconsistent with the Medicare Act's text. *Id.* at 77a-78a. Respondent requested, and the Board granted, expedited judicial review under 42 U.S.C. 1395*oo*(f)(1), which allows a provider to seek review of a Medicare contractor's action directly in district court over matters the Board determines it lacks authority to resolve. App., *infra*, 11a n.13; see *id.* at 83a.

2. Respondent commenced this action in the district court challenging the 2004 rule as substantively and procedurally invalid. App., *infra*, 25a. Respondent contended that "the Secretary's interpretation of the phrase 'entitled to benefits under [Medicare Part A]'" in Section 1395ww(d)(5)(F)(vi)(I) conflicts with the statutory language and Ninth Circuit precedent. *Ibid.* (citation omitted; brackets in original). Respondent additionally contended that the Secretary had failed to comply with notice-and-comment procedures prescribed in the Administrative Procedure Act, 5 U.S.C. 551 *et seq.*, 701 *et seq.*, in promulgating the final rule. App., *infra*, 51a.

The district court granted partial summary judgment to respondent. App., *infra*, 23a-75a. The court rejected respondent's substantive challenge to the relevant portion of the 2004 rule. *Id.* at 31a-51a. It found the Secretary's interpretation of "entitled to benefits under [Medicare] part A" in the Medicare fraction—as encompassing all individuals who have met the statutory requirements for entitlement to Medicare, regardless of whether Medicare made any payment—to be a permissible interpretation of ambiguous statutory language. *Id.* at 39a-51a. The court concluded, however, that the rule was procedurally invalid because it was "not a logical outgrowth" of the agency's notice of proposed rulemaking. *Id.* at 70a; see *id.* at 51a-72a. The

court enjoined HHS from applying the challenged portion of the 2004 rule to respondent and directed the agency to recalculate respondent's disproportionate-share-hospital adjustment for fiscal year 2008 in accordance with the court's order. *Id*. at 74a-75a.

3. The court of appeals affirmed, but on different grounds. App., *infra*, 1a-22a.

The court of appeals first determined that the final rule was a logical outgrowth of the agency's proposed rule and that the district court thus erred in vacating the rule on procedural grounds. App., *infra*, 12a-16a.

The court of appeals further concluded, however, that the 2004 regulation is "substantively invalid." App., *infra*, 21a. The court reasoned that the regulation's interpretation was foreclosed by the Ninth Circuit's prior decision in *Legacy Emanuel*, *supra*, which addressed the Medicaid fraction. App., *infra*, 18a-21a.

In *Legacy Emanuel*, the Ninth Circuit had rejected HHS's previous approach of excluding from the Medicaid fraction's numerator those patient days of an individual who satisfied the criteria for Medicaid eligibility under the relevant State's Medicaid plan but for which the Medicaid program did not ultimately pay—including because the individual had exhausted the number of days of inpatient care the State's Medicaid plan would cover. 97 F.3d at 1263-1266; see *id.* at 1265 (concluding that "the Medicaid proxy includes all patient days for which a person was eligible for Medicaid benefits, whether or not Medicaid actually paid for those days of service"). In reaching that conclusion—which HHS subsequently embraced in the context of the Medicaid fraction, and which it extended to the Medicare fraction in the 2004 rule, pp. 8-11, *supra*—the court in *Legacy Emanuel* relied in part on "Congress's use of the word

'eligible' rather than 'entitled'" when referring to Medicaid. 97 F.3d at 1265. The court "presum[ed]" that Congress, in using both the terms "'eligible'" when referring to Medicaid and "'entitled'" when referring to Medicare, "intended [them] to have different meanings." *Ibid.* (citation omitted). It interpreted "entitled" to "'mean[] that one possesses the right or title to [a] benefit'" for the particular service, and it construed "eligible" to be "broader" and not to be limited to "only those days actually paid for by Medicaid." *Id.* at 1264-1265 (citation omitted).

In the decision below, the court of appeals held that its decision in *Legacy Emanuel* had resolved the meaning of "entitled" when referring to Medicare at "step one" of the inquiry under *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council*, 467 U.S. 837 (1984), and therefore had left no room for further or contrary interpretation by the agency. App., *infra*, 18a. The decision below interpreted *Legacy Emanuel* as having definitively "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" under the relevant federal program, not that the "patient simply meets the [program's] statutory criteria." *Ibid.* (citation omitted). The court noted *Legacy Emanuel*'s observation that, "'if Congress had wanted to limit the Medicaid proxy to days for which Medicaid actually paid, Congress could have used "entitled" or expressly specified that it was to include only those days actually paid for by Medicaid.'" *Ibid.* (quoting *Legacy Emanuel*, 97 F.3d at 1265). The court thus viewed its decision in *Legacy Emanuel* as foreclosing the 2004 regulation's interpretation of the Medicare fraction as "embracing even those patient days for which Medicare coverage is exhausted (i.e., for which there is no absolute right to payment)." *Ibid.*

The court of appeals acknowledged that its decision invalidating the 2004 regulation's interpretation of the Medicare fraction conflicts with decisions of the D.C. and Sixth Circuits that have upheld the agency's interpretation as a reasonable reading of the statutory language. App., *infra*, 19a-21a (citing *Catholic Health Initiatives*, 718 F.3d at 920, and *Metropolitan Hosp.*, 712 F.3d at 270). The court declined to follow those decisions, stating that neither of those courts had been confronted with "binding circuit precedent holding that the statutory language was unambiguous." *Id.* at 19a; see *id.* at 19a-21a.

The court of appeals accordingly "affirm[ed], on different grounds, the district court's order * * * vacating the [2004] Rule." App., *infra*, 22a (capitalization and emphasis omitted). The court stated that it was "reinstat[ing] the prior version of 42 C.F.R. § 412.106(b)(2)(i), which embraced only 'covered' patient days" in calculating the Medicare fraction. *Ibid.*

4. The court of appeals denied the government's petition for rehearing en banc. App., *infra*, 84a-85a.

REASONS FOR GRANTING THE PETITION

In the decision below, the Ninth Circuit erroneously held invalid the Secretary's longstanding interpretation, codified in a notice-and-comment regulation in force since 2004, of a provision of the Medicare Act that governs payments to Medicare-participating hospitals nationwide. That conclusion rests on a misreading of the statutory text and context. And as the court recognized, its ruling directly conflicts with decisions of two other courts of appeals that have upheld the Secretary's interpretation. This Court's review is warranted to resolve that conflict and to correct the court of appeals' error.

Recognizing that "hospitals with an unusually high percentage of low-income patients generally have higher per-patient costs," Congress determined that "such hospitals * * * should receive higher reimbursement rates," and it prescribed in the statute a formula for determining whether a hospital is entitled to such an increase in payment and, if so, how much. *Sebelius* v. *Auburn Reg'l Med. Ctr.*, 568 U.S. 145, 150 (2013); see 42 U.S.C. 1395ww(d)(5)(F). The central components of that formula are two proxy measures Congress established to reflect a hospital's proportion of low-income Medicare and non-Medicare patients, respectively. In the first of those proxies—the Medicare fraction—Congress directed the Secretary to include patient days attributable to "patients who (for such days) were *entitled* to benefits under [Medicare] part A." 42 U.S.C. 1395ww(d)(5)(F)(vi)(I) (emphasis added). The Secretary has properly included in that calculation patient days of all individuals who satisfy the basic statutory requirements for entitlement to Medicare Part A benefits, without regard to whether Medicare ultimately paid the hospital for those particular patient days.

That interpretation embodied in the Secretary's 2004 regulation represents the best reading of the statutory text, context, structure, and purpose. At a minimum, it embodies a reasonable construction that warrants judicial respect. The Medicare Act and the Secretary's regulations make clear that an individual is "entitled" to Medicare Part A benefits so long as he or she satisfies certain applicable requirements. 42 U.S.C. 426(a) and (b); see 42 C.F.R. 400.202. Other provisions of the statute confirm, as HHS has long recognized, that a Medicare beneficiary's "entitlement[]" to Part A benefits does not depend on whether he or she has exhausted the maximum

allotment of one particular benefit (hospital inpatient days) for a specific benefit period. The Secretary's interpretation also accords with the statutory structure, history, and purpose, which reflect Congress's deliberate design of the proportions of low-income patients in the Medicare and non-Medicare populations a hospital serves.

The court of appeals based its contrary conclusion solely on its own precedent addressing a distinct issue: its prior decision in *Legacy Emanuel Hosp. & Health Ctr.* v. *Shalala*, 97 F.3d 1261 (9th Cir. 1996), holding that the number of patient days of individuals "eligible for [Medicaid] benefits" in the Medicaid fraction, 42 U.S.C. 1395ww(d)(5)(F)(vi)(II), is *not* limited to patient days for which the Medicaid program actually paid. Relying on a distinction *Legacy Emanuel* had mistakenly drawn between being "eligible" for benefits—rather than "entitled" to benefits—the court below, again mistakenly, believed itself bound to construe the Medicare fraction to operate in a fundamentally different manner than the Medicaid fraction. That conclusion lacks any sound basis in the text or purpose of the statute and overlooks that Congress's linguistic choices are fully explained by the distinct usage of the terms "eligible" and "entitled" in the Medicaid and Medicare programs.

The court of appeals' erroneous decision warrants this Court's review. As the court of appeals acknowledged, the decision below creates a direct conflict, now entrenched by its denial of rehearing en banc, with decisions of the D.C. and Sixth Circuits. Both of those courts have expressly upheld the Secretary's interpretation as reflecting at least a permissible construction of the statute. And because the Ninth Circuit concluded that the statutory text unambiguously precludes that interpreta-

tion, the agency cannot resolve the conflict through further rulemaking to reconfirm the Secretary's construction.

If allowed to stand, the decision below thus will require the agency either to abandon altogether its longstanding interpretation of the Medicare Act that two circuits have upheld, or to interpret the same statutory provision governing a complex nationwide benefits program differently in different circuits. The latter, patchwork approach is especially fraught because any provider that would receive a larger payment under HHS's approach—including those in the Ninth Circuit—may seek review in the D.C. Circuit, which has upheld the agency's position. The petition for a writ of certiorari should be granted.

I. THE DECISION BELOW IS INCORRECT

The Medicare Act directs HHS to include in calculating a hospital's Medicare fraction the patient days of individuals "who (for such days) were entitled to benefits under [Medicare] part A." 42 U.S.C. 1395ww(d)(5)(F)(vi)(I). The Secretary properly determined to include all patient days of individuals who satisfy the statutory criteria to be "entitled" to Medicare Part A benefits, 42 U.S.C. 426(a) and (b), regardless of whether the Medicare program ultimately pays the hospital for those days.

The court of appeals erred in reading in an unstated limitation requiring the agency to exclude patient days of a Medicare Part A beneficiary for which Medicare did not pay, including because the beneficiary exhausted his inpatient benefits for that particular benefit period. At a minimum, the court erred in failing to recognize that the Secretary's interpretation reflects a reasonable construction of the statute's text and context that is accordingly entitled to judicial respect.

A. The Secretary Properly Interpreted The Medicare Fraction To Include All Individuals Who Meet The Requirements To Be Entitled To Medicare Part A Benefits

1. Cognizant that "hospitals that serve a disproportionate share of low-income patients * * * generally have higher per-patient costs," Congress directed in the Medicare Act that "such hospitals * * * should receive higher reimbursement rates." *Auburn Reg'l Med. Ctr.*, 568 U.S. at 149. Congress prescribed a formula for identifying such a "disproportionate share hospital" and for determining its additional payment. 42 U.S.C. 1395ww(r)(1); see 42 U.S.C. 1395ww(d)(5)(F).

At the heart of the statutory formula are two separate but related proxy measures of a hospital's low-income patients that are added together. The first proxy, the Medicare (or SSI) fraction, addresses patients treated by the hospital who were Medicare beneficiaries—*i.e.*, who were "entitled to benefits under [Medicare] part A." 42 U.S.C. 1395ww(d)(5)(F)(vi)(I). The Medicare fraction uses a patient's entitlement to SSI benefits to gauge his or her low-income status, by asking what percentage of all of a hospital's patient days attributable to Medicare-beneficiary patients was for treatment of such patients who also were entitled to SSI benefits. *Ibid.*

The second proxy, the Medicaid fraction, estimates the hospital's proportion of low-income patients who were *not* Medicare beneficiaries—*i.e.*, who were not "entitled to benefits under [Medicare] part A." 42 U.S.C. 1395ww(d)(5)(F)(vi)(II). As a stand-in for low-income status, the Medicaid fraction uses a patient's eligibility for medical assistance under Medicaid, instead of entitlement to SSI benefits. The Medicaid fraction thus determines what percentage of all of a hospital's patient days was attributable to patients who

"were eligible for medical assistance under a State [Medicaid] plan, * * * but who were not entitled to benefits under [Medicare] part A." *Ibid.*; see *Catholic Health Initiatives Iowa Corp.* v. *Sebelius*, 718 F.3d 914, 917 (D.C. Cir. 2013).

Individually, each proxy offers only a partial picture, providing separate estimates of two different, complementary subsets of a hospital's population of low-income patients: low-income patients who were entitled to Medicare, and low-income patients who were not. But the statute directs that those two separate proxies be "summed together," providing one aggregate "proxy for the [hospital's] total low-income patient percentage." *Catholic Health Initiatives*, 718 F.3d at 916.

2. The central question in this case concerns the meaning of the phrase "entitled to benefits under [Medicare] part A" in the Medicare fraction. 42 U.S.C. 1395ww(d)(5)(F)(vi)(I). The precise question is whether an individual's patient days should be excluded in counting the total patient days that a hospital provided to patients "entitled to benefits under [Medicaid] part A," *ibid.*, if the Medicare program did not pay the hospital for those particular days—for example, because the patient had exhausted the allotted number of days of inpatient treatment for that particular benefit period. The Secretary properly answered that question in the negative.

a. The Secretary's longstanding interpretation, codified in the 2004 regulation at issue here, is that the phrase "entitled to benefits under [Medicare] part A" in the Medicare fraction, 42 U.S.C. 1395ww(d)(5)(F)(vi)(I), means what it says: a person is entitled to Part A benefits if he or she meets the requirements that Congress

has established in the statute for a person to be "entitled" to participate in the Part A program. 69 Fed. Reg. at 49,098-49,099.

Section 426, captioned "[e]ntitlement to hospital insurance benefits," provides that certain categories of individuals who satisfy certain specified criteria are "entitled to hospital insurance benefits under part A of subchapter XVIII," *i.e.*, Medicare Part A. 42 U.S.C. 426(a) and (b) (emphasis omitted). For example, "[e]very individual who * * * has attained age 65" and who is "entitled" to traditional Social Security benefits under 42 U.S.C. 402 is automatically "entitled" to Medicare Part A benefits. 42 U.S.C. 426(a); see *Hall* v. *Sebelius*, 667 F.3d 1293, 1295 (D.C. Cir. 2012) ("Since Congress created Medicare in 1965, entitlement to Social Security benefits has led automatically to entitlement to Medicare Part A benefits for those who are 65 or older."), cert. denied, 568 U.S. 1085 (2013). Similarly, "[e]very individual" under age 65 who has been entitled for 24 months (and remains entitled) to certain federal disability benefits is entitled to Medicare Part A benefits as well. 42 U.S.C. 426(b). Although "entitlement" to Part A benefits "consist[s] of" a right to have payment made for Part A services, that right is "subject to the limitations" set forth in Part A, 42 U.S.C. 426(c)(1), and accordingly the statute does not make the individual's basic "entitlement" under Medicare Part A contingent on whether the Medicare program pays for a particular hospital stay or specific days.

For decades, the Secretary has interpreted "entitled" in the context of Medicare benefits in that manner. In a regulation promulgated in 1983 and still in force, HHS defined the term "[e]ntitled," when "used in connection with the Medicare program," to "mean[] that an individual meets all the requirements for Medicare benefits"—referring to the individual's insured status as a Medicare

beneficiary. 48 Fed. Reg. at 12,535 (42 C.F.R. 400.202). Given that settled, straightforward meaning of "entitled" in the context of Medicare benefits, the Secretary properly determined in the 2004 regulation that "entitled to benefits under [Medicare] part A" in the Medicare fraction, 42 U.S.C. 1395ww(d)(5)(F)(vi)(I), refers to patients who satisfied the statutory criteria for "entitle[ment]" to Part A benefits at the time of treatment, 42 U.S.C. 426(a) and (b). 69 Fed. Reg. at 49,099.

The Secretary specifically considered, but rejected, reading into the Medicare fraction an additional, unstated limitation that would have excluded those patient days attributable to patients "entitled to benefits under [Medicare] part A" for which Medicare did not ultimately pay because the beneficiary had exhausted her allocated inpatient days for the benefit period. See 69 Fed. Reg. at 49,099. The 2004 regulation stated that HHS was "adopting a policy to include the days associated with" patients entitled to Medicare "in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage." *Ibid.* Thus, the Secretary explained, "[i]f the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction," whether or not the Medicare program ultimately paid for those patient days. *Ibid.*

That approach, which the agency has repeatedly reaffirmed since, accords with the statutory language. See, *e.g.*, 75 Fed. Reg. 50,042, 50,280-50,281 (Aug. 16, 2010); *Ruling No. CMS-1498-R*, at 10. Nothing in the text of the statutory provision prescribing who is "entitled" to Part A benefits, 42 U.S.C. 426(a) and (b), ties a beneficiary's basic entitlement under the Medicare Part

A program to the program's payment for particular services. Nor does it deem a Medicare beneficiary disentitled to Part A benefits generally merely because the beneficiary has exhausted the full allotment of one specific type of service (hospital inpatient days) in a particular benefit period. *Ibid.* Section 426 classifies a set of individuals who meet specified requirements as automatically "entitled to [Part A] benefits." *Ibid.* The Secretary appropriately interpreted the corresponding text of the Medicare fraction to carry the same meaning.

b. The statutory context reinforces the Secretary's determination in the 2004 rule that a Medicare Part A beneficiary remains entitled to Part A benefits, including for purposes of the Medicare fraction, regardless of whether that beneficiary has exhausted his or her hospital inpatient days for the particular benefit period.

Various provisions of the Medicare statute specifically contemplate that a person may be entitled to Medicare Part A benefits even though his or her Part A benefits for a particular service have been exhausted. For example, in 1997, Congress specified that covered outpatient services include certain hospital inpatient services that are furnished to an individual who "(I) *is entitled* to benefits under part A *but has exhausted* benefits for inpatient hospital services during a spell of illness, *or* (II) is not so entitled." 42 U.S.C. 1395*l*(t)(1)(B)(ii) (emphases added). Similarly, in prescribing the amount that Medicare will pay for outpatient physical-therapy services, Congress specified that the amount prescribed applies to an outpatient or to a hospital inpatient "who *is entitled* to benefits under part A *but has exhausted* benefits for inpatient hospital services during a spell of illness *or* is not so entitled to benefits under part A." 42 U.S.C. 1395*l*(a)(8)(B)(i) (emphases added). By making clear that entitlement to and

exhaustion of benefits can coexist, and by distinguishing between beneficiaries who are entitled to but have exhausted Part A benefits from those not entitled to Part A benefits at all, those provisions make clear that exhaustion of some or all types of Part A benefits does not nullify a beneficiary's basic entitlement under Part A.

By the same token, a view that equated a beneficiary's entitlement to Medicare Part A benefits with payment by Medicare for particular hospital inpatient days would produce incongruous results under other statutory provisions that Congress is unlikely to have intended. For example, an individual's ability to enroll in Medicare Part B (which covers outpatient and other services not covered by Part A), Medicare Part C (which provides for coverage through privately administered Medicare Advantage plans), and Medicare Part D (which provides prescription-drug benefits) is generally predicated upon the individual's being "entitled to" Part A benefits. 42 U.S.C. 1395*o*(1), 1395w-21(a)(3), 1395w-101(a)(3)(A). Nothing in the statute suggests that Congress intended an individual's eligibility to enroll in Parts B, C, or D to depend on whether Medicare paid for particular past inpatient days under Part A or on whether the individual has exhausted particular Part A benefits. Similarly, another provision requires HHS to notify "individuals entitled to benefits under part A" of their benefit information, including information about the "limitations on payment * * * that are imposed under [Medicare Part A]." 42 U.S.C. 1395b-2(a)(2). No sound basis exists to suppose that Congress designed that statutory obligation to provide such notices to all Medicare beneficiaries to phase in and out merely because a beneficiary either exhausts Part A benefits or obtains other health-care coverage that becomes the primary payer for services Part A also covers, see 42 U.S.C. 1395y(b)(2).

Moreover, describing a Medicare Part A beneficiary who has completely exhausted one particular type of Part A benefit in a benefit period as no longer entitled to Medicare Part A benefits would disregard important attributes of entitlement under Part A. As the Secretary explained in the 2004 rule, "beneficiaries who have exhausted their Medicare Part A inpatient coverage may still be entitled to other Part A benefits." 69 Fed. Reg. at 49,098. In addition to hospital inpatient care, Part A also provides, "for example, certain physician services and skilled nursing services." *Ruling No. CMS-1498-R*, at 10; see 42 U.S.C. 1395d(a). A Part A beneficiary whose inpatient "hospital benefits have been exhausted * * * still might be covered" for such "other items and services." *Ruling No. CMS-1498-R*, at 10. As a comment endorsed by the Secretary in adopting the 2004 rule observed, it is "difficult to reconcile" deeming individuals who have exhausted inpatient coverage to be "not entitled to Medicare Part A benefits" with the fact that "they can receive other covered Part A services." 69 Fed. Reg. at 49,098. Even as to inpatient care, a patient who exhausts the allotted inpatient days in one benefit period will receive a new allotment of days in future periods. See *Ruling No. CMS-1498-R*, at 10 (such a patient "would even qualify for an additional 90 days of Part A hospital benefits if at least 60 days elapsed between the individual's first and second hospital stay").

c. Finally, the structure, history, and purpose of the disproportionate-share-hospital adjustment itself support the Secretary's interpretation. The two-part proxy measure Congress established as an estimate of a hospital's proportion of low-income patients considers two separate patient populations: low-income patients who are Medicare beneficiaries, and those who are not. Congress adopted distinct approaches for addressing those two

groups. It directed HHS to evaluate a hospital's Medicare beneficiaries by calculating the percentage of all such patients who were entitled to SSI benefits. 42 U.S.C. 1395ww(d)(5)(F)(vi)(I). In contrast, Congress directed HHS to assess non-Medicare patients using a different gauge of low-income status—*i.e.*, eligibility for medical assistance under a State Medicaid plan—and in comparison to the hospital's entire patient pool. 42 U.S.C. 1395ww(d)(5)(F)(vi)(II). That hybrid approach to approximating low-income patients was no accident; it was adopted following a compromise in Congress between competing House and Senate proposals that combined aspects of both. See H.R. Conf. Rep. No. 453, 99th Cong., 1st Sess. 459-461 (1985); see also *Jewish Hosp., Inc.* v. *Secretary of HHS*, 19 F.3d 270, 280-283 (6th Cir. 1994) (Batchelder, J., dissenting); cf. *Obduskey* v. *McCarthy & Holthus LLP*, 139 S. Ct. 1029, 1038 (2019) (giving effect to statutory language that "ha[d] all the earmarks of a compromise" between competing proposals in Congress).

The bifurcated framework that separately estimates Medicare and non-Medicare patients with low incomes fits well with HHS's interpretation of "entitled to benefits under [Medicare] part A," 42 U.S.C. 1395ww(d)(5)(F)(vi)(I), as marking a boundary between two categories of individuals whose status as a Medicare beneficiary vel non is mostly static during a given computation period. That status is binary and fairly easy to determine; once each patient's status is ascertained, the separate calculations Congress called for can proceed straightforwardly. Congress might have perceived potential differences between Medicare and non-Medicare patients' typical costs, which might warrant approximating the percentages of low-income patients in each group separately.

That divided framework crafted by Congress, which applies different metrics to estimating different subsets of a hospital's low-income patient pool, would be an unusual choice had Congress intended each unit of treatment—each patient day—to be classified individually and incorporated into one fraction or the other based on whether it was paid for by Medicare. And it is unclear why Congress, in creating a mechanism to adjust hospitals' Medicare payments to account for the generally higher cost of treating low-income patients, see *Auburn Reg'l Med. Ctr.*, 568 U.S. at 150, would view patient days of Medicare beneficiaries for which the Medicare program did not happen to pay as shedding less or different light on a hospital's relative costs of care than those for which the program did pay.

* * * * *

For all of those reasons, the Secretary's interpretation of the Medicare fraction 2004 regulation embodies the best construction of the statutory text in light of its context, structure, history, and purpose. At a minimum, it represents a reasonable reading that the court of appeals was obligated to uphold. See *Entergy Corp.* v. *Riverkeeper, Inc.*, 556 U.S. 208, 218 & n.4 (2009).

B. The Court Of Appeals Erred In Concluding, Based On Its Own Precedent, That The Statute Unambiguously Forecloses The Secretary's Interpretation

The Ninth Circuit rejected the Secretary's reasonable interpretation of the Medicare fraction for a single reason: in the court's view, that interpretation was barred by the court's own decision addressing a different question a quarter century ago in *Legacy Emanuel*, *supra*. App., *infra*, 16a-21a. That is incorrect.

1. The court of appeals in *Legacy Emanuel* rejected an interpretation of the Medicaid fraction, 42 U.S.C. 1395ww(d)(5)(F)(vi)(II), previously espoused by HHS, as counting in its numerator only patient days "for which Medicaid actually paid." 97 F.3d at 1265. The court disagreed with HHS's contention that "the parenthetical '(for such days)'"—in the phrase "patients who (for such days) were eligible for medical assistance under a State [Medicaid] plan"—"limit[ed] the Medicaid proxy to patient days paid for by Medicaid, even though the patient met the status requirements for Medicaid eligibility during his full stay." *Id.* at 1266 (citation omitted). The court held instead that HHS must include patient days of (non-Medicare) individuals who were "eligible for Medicaid benefits, whether or not Medicaid actually paid for those days of service." *Id.* at 1265.

The court of appeals' holding in *Legacy Emanuel* did not encompass the proper calculation of the Medicare fraction—which was not at issue in the case, and which the parties did not dispute. 97 F.3d at 1265. And the bottom-line result the *Legacy Emanuel* court reached —that a patient's status under the pertinent federal program is the statutory touchstone, rather than whether that program ultimately paid for particular services—is the same basic position the Secretary has since adopted and extended here to the Medicare fraction.

2. In the decision below, the Ninth Circuit concluded that a portion of the *Legacy Emanuel* panel's reasoning nevertheless controlled the outcome of this case and categorically precluded the Secretary's interpretation of the Medicare fraction. App., *infra*, 18a-19a. The court in *Legacy Emanuel* had underscored Congress's use of different terms in the Medicare and Medicaid fraction—"entitled" to benefits under Medicare Part A

in the former, versus "eligible" for medical assistance under Medicaid in the latter—from which the court inferred that Congress meant the two provisions to be interpreted differently. 97 F.3d at 1265. The court construed "entitlement" narrowly to "mean[] 'the absolute right to ... payment'" for particular services, while construing "'eligible'" to have a "broader" scope. *Ibid.* (quoting *Jewish Hosp.*, 19 F.3d at 275). In this case, the Ninth Circuit deemed that passage of the *Legacy Emanuel* opinion as having definitively determined the "clear" meaning of the word "'entitled'" in this context. App., *infra*, 18a. Because the court viewed its prior decision as having identified the "unambiguous" meaning of that statutory term, it found "'no room for agency discretion'" and "no need to proceed" further. *Id.* at 17a (citation omitted). That analysis was erroneous.

It is debatable at best whether the panel below was bound by the Ninth Circuit's earlier discussion of "'entitled'" in the Medicare fraction in *Legacy Emanuel*, where neither the term nor even that provision was "directly at issue." *Northeast Hosp. Corp.* v. *Sebelius*, 657 F.3d 1, 13 n.7 (D.C. Cir. 2011) (declining to follow *Legacy Emanuel* because that portion of its discussion was "dicta"); see Gov't C.A. Resp. & Reply Br. 27-28; see also *Metropolitan Hosp.* v. *United States Dep't of Health & Human Servs.*, 712 F.3d 248, 257-258 (6th Cir. 2013) (declining to follow parallel discussion in prior Sixth Circuit decision as dictum for the same reasons). In any event, that question is academic because the Ninth Circuit's previous conclusion undoubtedly does not constrain this Court, which should reject that conclusion because it is incorrect.

To be sure, this Court "ha[s] recognized, as a general rule, that Congress' use of 'certain language in one part

of the statute and different language in another' can indicate that 'different meanings were intended.'" *Auburn Reg'l Med. Ctr.*, 568 U.S. at 156 (citation omitted). "But th[at] interpretive guide * * * is 'no more than a rule of thumb' that can tip the scales" in close cases. *Ibid.* (brackets and citation omitted). And in this particular context, that interpretive guide "has little weight" because it merely reflects Congress's usage of different terminology in the Medicare and Medicaid contexts. *Northeast Hosp. Corp.*, 657 F.3d at 12. "'Congress has, throughout the various Medicare and Medicaid statutory provisions, consistently used the words "eligible" to refer to potential Medicaid beneficiaries and "entitled" to refer to potential Medicare beneficiaries.'" *Ibid.* (quoting *Cabell Huntington Hosp., Inc.* v. *Shalala,* 101 F.3d 984, 992 (4th Cir. 1996) (Luttig, J., dissenting)). "To the extent Congress was merely borrowing these terms from elsewhere in the statute, it would be a mistake to read too much into the difference in nomenclature." *Id.* at 13.

At a minimum, Congress's selection of different adjectives does not amount to an unambiguous pronouncement by which it "has directly spoken to [the] issue" whether the Medicare fraction includes patient days of Medicare beneficiaries who have exhausted their inpatient days for a benefit period. *Entergy*, 556 U.S. at 218 n.4. Absent any such pellucid prescription from Congress, the agency's reasonable interpretation of the statute should control. See *ibid.*

II. THE DECISION BELOW CREATES A DIRECT AND ACKNOWLEDGED CONFLICT WITH TWO CIRCUITS

A. The decision below warrants review because, as the court of appeals recognized, its ruling directly conflicts with decisions of the D.C. and Sixth Circuits—each

of which has upheld the Secretary's interpretation of the statute codified in the 2004 regulation. See App., *infra*, 19a-21a (discussing *Catholic Health Initiatives*, *supra*, and *Metropolitan Hosp.*, *supra*).

In *Catholic Health Initiatives*, the D.C. Circuit confronted the same statutory question presented here: whether "an individual is 'entitled to benefits' under Medicare" for purposes of calculating the disproportionate-patient percentage so long as "he meets the basic statutory criteria." 718 F.3d at 919. The court sustained the Secretary's position that such an individual is entitled to benefits and that an individual who "has exhausted" Medicare Part A benefits should not be excluded as being "no longer entitled to Medicare benefits." *Id.* at 920. Writing for the panel, Judge Silberman explained that, although "not quite inevitable," the agency's "interpretation is the better one," and at least "permissible." *Ibid.*

The Sixth Circuit reached the same conclusion in *Metropolitan Hospital*. 712 F.3d at 255-269. Like the Ninth Circuit in *Legacy Emanuel*, the Sixth Circuit had previously rejected the Secretary's prior interpretation of the Medicaid fraction (as encompassing only patient days actually paid by Medicaid) in *Jewish Hospital*, 19 F.3d at 274-276, on which *Legacy Emanuel* had relied, 97 F.3d at 1265. But unlike the Ninth Circuit here, the Sixth Circuit recognized that neither its holding nor its reasoning regarding the Medicaid fraction in that earlier decision dictated the answer to the question presented here. See *Metropolitan Hosp.*, 712 F.3d at 257-261. The Sixth Circuit in *Metropolitan Hospital* ultimately sustained the Secretary's interpretation in the 2004 regulation as a permissible construction of the statute. See *id.* at 261-269.

The court of appeals in this case acknowledged the conflict between its conclusion and those of the D.C. and Sixth Circuits in *Catholic Health Initiatives* and *Metropolitan Hospital*, respectively. App., *infra*, 19a-21a. The court stated that neither of those decisions had "dealt with binding circuit precedent holding that the statutory language was unambiguous." *Id.* at 19a. In fact, however, the Sixth Circuit in *Metropolitan Hospital* had confronted substantially the same scenario as the Ninth Circuit here, in light of its earlier decision in *Jewish Hospital*. In any event, the controlling interpretation of the Medicare fraction today in the Sixth and Ninth Circuits differs.

B. The conflict created by the decision below, and cemented by the court of appeals' denial of rehearing en banc, is highly problematic in the context of a massive federal program that operates in cooperation with front-line providers, as well as administrative contractors that adjudicate on CMS's behalf payment disputes that arise throughout the Nation. If allowed to stand, the decision below presents the agency overseeing a federal benefits program of great size and complexity with the stark choice between abandoning what it has long understood to be the better interpretation of Congress's directions, on the one hand, and accepting a balkanized approach to Medicare payment rules, on the other.

The inter-circuit divergence presents especially acute practical difficulties because it places both HHS and its contractors that apply the payment standards to providers in an untenable position. Any provider, including those in the Ninth Circuit, may seek judicial review not only within the circuit in which it is located, but also in the District Court for the District of Columbia, see 42 U.S.C. 1395*oo*(f)(1), where the decision in *Catholic Health Initiatives* sustaining the Secretary's interpretation is controlling. Although

some providers (like respondent) may prefer the Ninth Circuit's approach because it results in greater payments to those providers based on the makeup of their patient populations, other providers whose patient pools differ may receive greater payments under the Secretary's approach. See 69 Fed. Reg. at 49,098. The path forward for HHS with respect to providers located in the Ninth Circuit is, at the risk of understatement, unclear. If such providers can select whichever forum for judicial review will maximize the provider's payment amount, HHS and its contractors would face the challenging prospect of having their payment determinations challenged on an ongoing basis regardless of which approach to the Medicare fraction HHS applies. This Court's review is warranted to restore certainty and clarity on this important and recurring question.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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MARCH 2021

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Nos. 18-35845 and 18-35872
D.C. No. 2:16-cv-00209-RMP

EMPIRE HEALTH FOUNDATION, FOR VALLEY HOSPITAL MEDICAL CENTER,
PLAINTIFF-APPELLEE/CROSS-APPELLANT

v.

ALEX M. AZAR II, SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,
DEFENDANT-APPELLANT/CROSS-APPELLEE

Argued and Submitted: Feb. 6, 2020
Seattle, Washington
Filed: May 5, 2020

Appeal from the United States District Court
for the Eastern District of Washington
Rosanna Malouf Peterseon, District Judge, Presiding

OPINION

Before: MILAN D. SMITH, JR. and N. RANDY SMITH, Circuit Judges, and JOHN R. TUNHEIM,* District Judge.

* The Honorable John R. Tunheim, United States Chief District Judge for the District of Minnesota, sitting by designation.

M. SMITH, Circuit Judge:

This appeal, made pursuant to the Medicare Act's expedited judicial review provision, 42 U.S.C. § 1395*oo*(f)(1), requires us to determine whether a rule promulgated by the Secretary of the Department of Health and Human Services (HHS) (the 2005 Rule[1]) is procedurally and substantively valid pursuant to the Administrative Procedure Act (APA), 5 U.S.C. § 551 *et seq.*[2] The 2005 Rule removed the word "covered" from 42 C.F.R. § 412.106(b)(2)(i), effectively amending HHS's interpretation of "entitled to [Medicare]" in 42 U.S.C. § 1395ww(d)(5)(F)(vi), a subsection of the Medicare Act, 42 U.S.C. § 1395 *et seq.*[3] At stake is HHS's annual cal-

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[1] At issue in this case is one portion of a final rule that amended a wide range of Medicare regulations. 69 Fed. Reg. 48916, 49098-99 (Aug. 11, 2004). For the purposes of this opinion, "2005 Rule" refers only to the portion of the final rule, discussed in greater detail below, which removed the word "covered" from 42 C.F.R. § 412.106(b)(2)(i).

[2] The Medicare Act's expedited judicial review provision incorporates the judicial review provisions of the APA. *See* 42 U.S.C. § 1395*oo*(f); *see also Los Angeles Haven Hospice, Inc. v. Sebelius*, 638 F.3d 644, 652 (9th Cir. 2011) ("In a civil action under § 1395*oo*(f)(1), the validity of the fiscal intermediary's action is subject to judicial review using the familiar standards of the Administrative Procedure Act ('APA')—i.e., whether the action was 'arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.'" (citing 5 U.S.C. § 706(2)(A))).

[3] 42 U.S.C. § 1395ww(d)(5)(F)(vi) refers to "benefits under part A" instead of "Medicare," "supplementary social security income benefits (excluding any State supplementation) under subchapter XVI of this chapter," instead of "SSI benefits," and "medical assistance un-

culation of the disproportionate share hospital adjustment (DSH Adjustment), which increases a hospital's annual Medicare inpatient services reimbursement based on the approximate number of low-income patients the hospital serves. *See Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914, 916 (D.C. Cir. 2013).

Plaintiff Empire Health Foundation (Empire) challenged the 2005 Rule as part of its appeal of HHS's calculation of its 2008 reimbursement. The district court granted partial summary judgment for Empire, ruling that, while the 2005 Rule was substantively valid, it should be vacated because the rulemaking process leading to its adoption failed to meet the APA's procedural requirements.

We affirm the district court's summary judgment in favor of Empire, and its order vacating the 2005 Rule, but on different grounds. *See McSherry v. City of Long Beach*, 584 F.3d 1129, 1135 (9th Cir. 2009) ("We may affirm on the basis of any ground supported by the record."). We hold that the 2005 Rule's rulemaking process, while not perfect, satisfied the APA's notice-and-comment requirements. However, we also hold that the 2005 Rule is substantively invalid, and must be vacated, because it directly conflicts with our interpretation of 42 U.S.C. § 1395ww(d)(5)(F)(vi) in *Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F.3d 1261, 1265-66 (9th Cir. 1996). Because *Legacy Emanuel* interpreted the meaning of "entitled to [Medicare]" in 42 U.S.C. § 1395ww(d)(5)(F)(vi) to be unambiguous,

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der a State plan approved under subchapter XIX," instead of "Medicaid." Herein, when quoting the statute, we use "[Medicare]," "[SSI benefits]," and "[Medicaid]" for simplicity.

the 2005 Rule's conflicting construction cannot stand. *See Nat'l Cable & Telecomms. Ass'n v. Brand X Internet Servs.* (*Brand X*), 545 U.S. 967, 982-83 (2005).

FACTUAL AND PROCEDURAL BACKGROUND

I. Relevant Statutory and Regulatory Background

As part of the Medicare program, a hospital that "serves a significantly disproportionate number of low-income patients," 42 U.S.C. § 1395ww(d)(5)(F)(i)(I), receives a DSH Adjustment, which approximately reimburses it for higher costs associated with providing that service, *Catholic Health*, 718 F.3d at 916. HHS administers DSH Adjustments through the Centers for Medicare and Medicaid Services (CMS).[4]

Qualification for the DSH Adjustment and the amount of any DSH Adjustment are determined by a hospital's "disproportionate patient percentage" (DPP). 42 U.S.C. § 1395ww(d)(5)(F)(v). The DPP is calculated by adding the two fractions set forth in § 1395ww(d)(5)(F)(vi),[5]

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[4] For simplicity, we include CMS in our references to "HHS" herein.

[5] In pertinent part, 42 U.S.C. § 1395ww(d)(5)(F)(vi) provides:

> **(vi)** In this subparagraph, the term "disproportionate patient percentage" means, with respect to a cost reporting period of a hospital, the sum of—
>
> > **(I)** the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter and were entitled to supplementary security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days

commonly referred to as the "Medicare fraction" and the "Medicaid fraction." *See, e.g.*, *Catholic Health*, 718 F.3d at 916. The two fractions are intended to capture a hospital's number of patient days attributable two different groups of low-income patients. *Id.* at 916-17. SSI entitlement is used as the low-income proxy for the Medicare population, and Medicaid eligibility is used as the low-income proxy for the non-Medicare population. *Id.*; *Legacy Emanuel*, 97 F.3d at 1265-66.

The following chart illustrates the two fractions:

	Medicare fraction	**Medicaid fraction**
Numerator	Patient days for patients entitled to Medicare and entitled to SSI Benefits	Patient days for patients eligible for Medicaid but not entitled to Medicare
Denominator	Patient days for patients entitled to Medicare	Total number of patient days

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for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter, and

(II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX, but who were not entitled to benefits under part A of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.

See Catholic Health, 718 F.3d at 917 (providing the chart as a visual representation of the two fractions).

Empire's challenge concerns the 2005 Rule's interpretation of the statutory phrase "entitled to [Medicare]" in its implementing regulation, 42 C.F.R. § 412.106(b)(2)(i),[6] and that interpretation's effect on the treatment of "dual eligible exhausted coverage patient days."[7] These are patient days attributable to patients

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[6] In pertinent part, 42 C.F.R. § 412.106(b), as amended by the 2005 Rule, provides:

> (b) Determination of a hospital's disproportionate patient percentage—
>
> > (1) General rule. A hospital's disproportionate patient percentage is determined by adding the results of two computations and expressing that sum as a percentage.
> >
> > (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
> >
> > > (i) Determines the number of patient days that—
> > >
> > > > (A) Are associated with discharges occurring during each month; and
> > > >
> > > > (B) Are furnished to patients who during that month were entitled to both Medicare Part A (including Medicare Advantage (Part C)) and SSI, excluding those patients who received only State supplementation;. . . .

[7] As part of its argument that the 2005 Rule's rulemaking process failed to meet the APA's procedural requirements, Empire's briefing alludes to the impact of the 2005 Rule on "Medicare Secondary Payer" days, which are patient days for which Medicare is not the primary payer pursuant to 42 U.S.C. § 1395y(b)(2)(A). Empire of-

eligible for both Medicare and Medicaid and whose hospital stays have exceeded the 90-day limit applicable to Medicare coverage (after which Medicare ceases to cover the patient's inpatient hospital services costs).[8] 42 U.S.C. § 1395d; 42 C.F.R. § 409.61(a)(1).

Pursuant to the version of 42 C.F.R. § 412.106(b)(2)(i) in place before the 2005 Rule was promulgated, HHS included only "covered" patient days in the Medicare fraction when calculating a hospital's DSH Adjustment. 42 C.F.R. § 412.106(b)(2)(i) (2003); 69 Fed. Reg. at 49098. This had the effect of excluding dual eligible exhausted coverage patient days from the numerator and denominator of the Medicare fraction. Meanwhile, HHS also excluded dual eligible exhausted coverage patient days from the Medicaid fraction. *Edgewater Med. Ctr. v. Blue Cross & Blue Shield Ass'n*, HCFA Adm'r Dec., 2000 WL 1146601, at *4-5 (June 19, 2000).[9] Because HHS did not include dual eligible exhausted coverage patient days in either the Medicare fraction or the Medicaid fraction before the 2005 Rule, HHS did not count

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fered little explanation as to what the 2005 Rule's impact on Medicare Secondary Payer days was, and did not refer to Medicare Secondary Payer days in its reply brief. Because Empire insufficiently explained this argument in its briefing, we rule that it was waived. *See Ghahremani v. Gonzales*, 498 F.3d 993, 997-98 (9th Cir. 2007); *Acosta-Huerta v. Estelle*, 7 F.3d 139, 144 (9th Cir. 1992). In any case, it is immaterial to our holding today, which invalidates the 2005 Rule on substantive grounds.

[8] Medicare will pay for a limited number of days for each hospitalization. If a patient's stay exceeds that number, coverage is exhausted, and Medicare will not pay for the additional days. 42 U.S.C. § 1395d.

[9] The Health Care Financing Administration is the predecessor of CMS. *See Catholic Health*, 718 F.3d at 918 n.2.

those days at all for the purpose of calculating a given hospital's DSH Adjustment. *See Catholic Health*, 718 F.3d at 921, 921 n.5.

In contrast, in the 2005 Rule, HHS removed the word "covered" from 42 C.F.R. § 412.106(b)(2)(i). As a result, HHS now includes dual eligible exhausted coverage patient days in the numerator and denominator of the Medicare fraction when calculating a given hospital's DSH Adjustment.[10]

A. The 2005 Rule's Rulemaking Process

To arrive at the interpretation reflected in the 2005 Rule, HHS took a circuitous route. Initially, HHS proposed in 2003 to include dual eligible exhausted coverage patient days in the Medicaid fraction commencing with Fiscal Year (FY) 2004 (the 2003 Notice). 68 Fed. Reg. 27154, 27207-208 (May 19, 2003). In the 2003 Notice, HHS misstated its then-applicable rule with respect to dual eligible exhausted coverage patient days, asserting that HHS counted them in the Medicare fraction. Several comments responding to the 2003 Notice noted the misstatement and pointed out that the then-applicable regulation did *not* include dual eligible exhausted coverage patient days in the Medicare fraction. In its FY 2004 final rule, HHS deferred deciding whether to promulgate the proposed change, noting that it was

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[10] Empire contends that the 2005 Rule "serves to systematically reduce payments hospitals receive for treating" low-income patients. Empire's Brief at 5. The record, however, is unclear as to whether the 2005 Rule's interpretation has increased or decreased hospital reimbursements in general. It appears that its effect on hospitals is highly fact-specific, depending on a given hospital's patient demographics. *See* 69 Fed. Reg. at 49098-99.

still reviewing comments on dual eligible exhausted coverage patient days and would respond in a different document. 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).

In 2004, as part of its rulemaking proposal for the 2005 Rule, the agency explained that it would make sure to address any comments received in response to the 2003 Notice. 69 Fed. Reg. 28196, 28286 (May 18, 2004). The new comment period ran until July 12, 2004. Days before the comment period for the 2005 Rule closed, HHS posted a webpage acknowledging the 2003 Notice's misstatement of the then-applicable rule.[11] HHS stated that "[o]ur policy has been that only covered patient days are included in the Medicare fraction." A few commenters acknowledged HHS's correction. Without acknowledging HHS's initial mistake, however, many other commenters voiced support for the erroneously stated status quo.

In the August 11, 2004 Federal Register entry describing the final version of the 2005 Rule, HHS noted that:

> We received numerous comments that commenters were disturbed and confused by our recent Web site posting regarding our policy on dual-eligible patient days. The commenters believe that this posting was a modification or change in our current policy to include patient days of dual-eligible Medicare beneficiaries whose Medicare Part A coverage has expired in the Medicaid fraction of the DSH calculation. In

[11] We note that there appears to be some dispute in the record over whether the webpage was published three or five days before the close of the comment period. For the purposes of our analysis, this difference of two days is immaterial.

> addition, the commenters believed that the information in this notice appeared with no formal notification by CMS and without the opportunity for providers to comment.

69 Fed. Reg. at 49098. In response, HHS explained that the webpage posting "was not a change in our current policy," but a "correction of an inadvertent misstatement" made in the 2003 Notice. *Id.*

The 2005 Rule included dual eligible exhausted coverage patient days in the Medicare fraction. 69 Fed. Reg. at 49098-99. In effect, the new rule enacted what HHS had mistakenly stated was the status quo in the 2003 Notice. Pursuant to the 2005 Rule, HHS now counts dual eligible exhausted coverage patient days as Medicare days even if Medicare did not pay for them. 69 Fed. Reg. at 49099 ("[W]e are adopting a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, *whether or not the beneficiary has exhausted Medicare Part A hospital coverage.*" (emphasis added)).

II. The Proceedings in this Case

Empire acquired the outstanding Medicare reimbursement owed to Valley Hospital Medical Center for periods prior to October 1, 2008, including the 2008 fiscal year at issue here.[12] Dissatisfied with its total reimbursement amount for FY 2008, Empire timely appealed

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[12] Due to HHS's delay in amending the language of its regulations after the promulgation of the 2005 Rule, FY 2008 was the first year in which the 2005 Rule was implemented, removing the word "covered" from 42 C.F.R. § 412.106(b)(2)(i). *See Allina Health Services v. Sebelius*, 746 F.3d 1102, 1106 n.3 (D.C. Cir. 2014); 72 Fed. Reg.

HHS's calculation of Empire's FY 2008 reimbursement and requested a hearing before the Provider Reimbursement Review Board (PRRB). The PRRB granted Empire's request for expedited judicial review pursuant to 42 U.S.C. § 1395*oo*(f)(1), allowing Empire to challenge the 2005 Rule in the district court.[13] Empire timely filed this action in the district court, challenging the 2005 Rule's interpretation of "entitled to [Medicare]" as both procedurally and substantively invalid pursuant to the APA.[14]

The parties cross-moved for summary judgment. The district court granted Empire's summary judgment motion in part, denied HHS's summary judgment motion, and vacated the 2005 Rule, ruling that the 2005 Rule's rulemaking process violated the APA because HHS did not give more time for comment after correcting its misstatement in the 2003 Notice. However, the district court sided with HHS on the substantive propriety of HHS's interpretation of "entitled." First, it held that our ruling in *Legacy Emanuel*, 97 F.3d at 1265, did not foreclose HHS's interpretation of the statute pursuant to *Brand X*. It next held at *Chevron* step one, *see Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 842 (1984), that Congress's intent was unclear

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47130, 47384 (Aug. 22, 2007) (describing "technical correction" implementing changes to 42 C.F.R. § 412.106(b)(2)(i)).

[13] Expedited judicial review is triggered when the PRRB, on its own or at the request of a provider, determines it does not have the authority to resolve a provider's challenge. 42 U.S.C. § 1395*oo*(f)(1).

[14] Empire also argued that, if HHS's 2005 Rule were upheld, HHS should broaden its interpretation of "entitled to [SSI benefits]" in the Medicare fraction to include patient days that reflect SSI eligibility, not just payment. Because we vacate the 2005 Rule, we do not address this argument.

from the plain language and statutory purpose of 42 U.S.C. § 1395ww(d)(5)(F)(vi). Finally, it held at *Chevron* step two, *see* 467 U.S. at 843, that HHS's interpretation of the statute was a permissible construction of the statute. Empire and HHS each timely appealed.

JURISDICTION AND STANDARD OF REVIEW

The district court had jurisdiction over this appeal pursuant to 42 U.S.C. § 1395*oo*(f)(1), the Medicare Act's expedited judicial review provision, and 28 U.S.C. § 1331, as a dispute arising under federal law. We have jurisdiction over these cross-appeals pursuant to 28 U.S.C. § 1291. We review de novo a district court's decision on cross motions for summary judgment. *Guatay Christian Fellowship v. County of San Diego*, 670 F.3d 957, 970 (9th Cir. 2011).

ANALYSIS

I. The Procedural Validity of the 2005 Rule

Empire asserts that the 2005 Rule violated the APA's procedural requirements because HHS did not provide the public with an additional comment period after admitting that it misrepresented the status quo in the 2003 Notice. We disagree.

The APA requires an agency to comply with notice-and-comment procedures when the agency amends its regulations. 5 U.S.C. § 553.[15] The agency must pub-

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[15] The Medicare Act has its own notice-and-comment procedure. 42 U.S.C. § 1395hh(b). Because of the similarity of the two procedures, we will use the more robust APA caselaw in order to analyze this claim of procedural error. *See Monmouth Med. Center v.*

lish a notice of proposed rulemaking, which shall include, in relevant part, "either the terms or substance of the proposed rule or a description of the subjects and issues involved." *Id.* § 553(b)(3). After notice, interested parties must have the opportunity to comment on the proposal, "participat[ing] in the rule making through submission of written data, views, or arguments." *Id.* § 553(c).

We will set aside an agency action that we find to be "without observance of procedure required by law." 5 U.S.C. § 706(2)(D). We have also concluded that "[a] decision made without adequate notice and comment is arbitrary or an abuse of discretion." *Nat. Res. Def. Council v. EPA* (*NRDC II*), 279 F.3d 1180, 1186 (9th Cir. 2002) (citing 5 U.S.C. § 706(2)(A)). Pursuant to the APA, whether notice is adequate is "whether interested parties reasonably could have anticipated the final rulemaking" from the proposed rule. *Id.* at 1187 (quoting *Nat. Res. Def. Council v. EPA* (*NRDC I*), 863 F.2d 1420, 1429 (9th Cir. 1988)). The key inquiry is whether the changes in the final rule are a "logical outgrowth of the notice and comments received." *Rybachek v. United States EPA*, 904 F.2d 1276, 1288 (9th Cir. 1990). The Medicare statute echoes this standard, providing that if a final regulation "is not a logical outgrowth of a previously published notice of proposed rulemaking," the final regulation "shall be treated as a proposed regulation" requiring further public comment. 42 U.S.C. § 1395hh(a)(4).

Thompson, 257 F.3d 807, 814 (D.C. Cir. 2001). Moreover, the parties briefed this issue pursuant to the APA. *See also Stringfellow Mem. Hosp. v. Azar*, 317 F. Supp. 3d 168, 184 n.6 (D.D.C. 2018).

Other considerations to determine the adequacy of notice include "whether a new round of notice and comment would provide the first opportunity for interested parties to offer comments that could persuade the agency to modify its rule," *NRDC II*, 279 F.3d at 1186 (quoting *Am. Water Works Ass'n v. EPA*, 40 F.3d 1266, 1274 (D.C. Cir. 1994), and whether "the notice 'fairly apprise[s] interested persons of the subjects and issues before the [a]gency,'" *Louis v. U.S. Dep't of Labor*, 419 F.3d 970, 975 (9th Cir. 2005) (quoting *NRDC II*, 279 F.2d at 1186.

Here, HHS undoubtedly misstated the then-applicable rule in the 2003 Notice. Nevertheless, the 2003 Notice did describe the content of the 2005 Rule, even if it incorrectly characterized it as the then-applicable rule. 68 Fed. Reg. 27154, 27207. HHS corrected its misstatement of the then-applicable rule before the end of the second comment period. Moreover, many sophisticated commenters, including several large hospital associations, supported placing dual eligible exhausted coverage patient days in the Medicare fraction, as the 2005 Rule finally did. The rulemaking process was certainly not perfect, and some commenters expressed confusion with HHS's correction notice. 69 Fed. Reg. 48916, 49098. However, the 2005 Rule was a logical outgrowth of the proposed rule change, and HHS's 2003 Notice provided adequate notice to commenters of what the agency was considering. As another district court observed in upholding the 2005 Rule's notice-and-comment process: "Numerous commenters during both the initial and the second comment periods wrote in support of the misstated status quo—that is, the policy that was ultimately adopted—to 'urge that CMS not change the

rules for counting dual-eligible days.'" *Stringfellow*, 317 F. Supp. 3d at 187 (quoting record).

We conclude that the procedural error alleged by Empire here is similar to the one the Supreme Court addressed in *Long Island Care at Home, Ltd. v. Coke*, 551 U.S. 158, 174-75 (2007). There, the Court rejected a procedural challenge to a final rule that was the opposite of what was contained in a rulemaking proposal. *Id.* The final rule exempted certain domestic workers from the Fair Labor Standards Act (FLSA), when the proposal had contemplated including them within the FLSA's ambit. *Id.* Nevertheless, the court held that the final rule was "reasonably foreseeable" and the proposal had provided fair notice to commenters. *Id.* at 175. The Court observed that commenters could reasonably foresee that "after . . . consideration [of the proposal] the Department might choose to adopt the proposal or to withdraw it." *Id.* Commenters on the 2005 Rule were similarly apprised of a binary choice—under the new rule, dual eligible exhausted coverage patient days would be included in either the Medicare or the Medicaid fraction. In the end, they were included in the Medicare fraction.

Allina Health Services v. Sebelius, 746 F.3d 1102 (D.C. Cir. 2014), on which Empire relies, is inapposite. *Allina* involved a challenge to a different portion of the final rule that also contained the 2005 Rule. *Id.* at 1106-07. In the applicable notice of proposed rulemaking, the agency proposed to "clarify" an existing practice and stated that it did not expect the clarification to have a major financial impact. *Id.* at 1106. But the final rule in *Allina* was an entirely new policy with enormous financial consequences. *Id.* at 1107. The D.C. Circuit

held that the rule was not a "logical outgrowth" of its proposal, because it could not have been anticipated by the parties based on the purported clarification described in the notice of proposed rulemaking. *Id.* at 1108-09 (asking whether "even a good lawyer" could "anticipate . . . such a volte-face with enormous financial implications would follow [HHS's] proposed rule."); *see also Stringfellow*, 317 F. Supp. 3d at 188-89 (distinguishing *Allina* while upholding the 2005 Rule's notice-and-comment procedure). Here, however, the 2005 Rule was a "logical outgrowth" of the 2003 Notice because, as we have explained, the parties could anticipate that HHS intended to change the way it treated dual eligible exhausted coverage patient days in the DSH Adjustment. The rulemaking procedure at issue here did not involve the unexpected "volte-face" that the D.C. Circuit confronted in *Allina*. 746 F.3d at 1109.

Because we conclude that the 2005 Rule was a logical outgrowth of the notice and the comments received, we reverse the district court's contrary conclusion. Nevertheless, we ultimately affirm the district court's summary judgment in favor of Empire and order vacating the 2005 Rule, because we hold that the 2005 Rule is substantively invalid.

II. The Substantive Validity of the 2005 Rule

Having determined that the 2005 Rule met the APA's procedural requirements, we next consider its substantive validity pursuant to the APA. Empire argues that our decision in *Legacy Emanuel* forecloses HHS's interpretation of "entitled to [Medicare]" in the 2005 Rule. HHS, citing Sixth and D.C. Circuit decisions, maintains that we are not bound by *Legacy Emanuel*'s analysis of

"entitled to," because there, according to HHS's argument, we decided only the meaning of the phrase "eligible for medical assistance under . . . [Medicaid]." According to HHS, our analysis of the phrase "entitled to [Medicare]" is nothing more than "non-binding dicta." Government's Reply Brief at 28. We agree with Empire that *Legacy Emanuel* is directly at odds with the 2005 Rule, and thus conclude that the rule is substantively invalid.

In a substantive APA challenge to a notice-and-comment rule, we apply the *Chevron* two-step framework. *See United States v. Mead Corp.*, 533 U.S. 218, 230-31 (2001). At *Chevron* step one, we ask whether Congress "has directly spoken to the precise question at issue" in the statutory text. *Chevron*, 467 U.S. at 842. We employ "traditional tools of statutory construction" to determine whether "Congress had an intention on the precise question at issue[.]" *Id.* at 843 n.9. If the statute is silent or ambiguous, however, we proceed to *Chevron* step two and ask "whether the agency's answer is based on a permissible construction of the statute." *Id.* at 843.

Judicial precedent affects how we apply the *Chevron* framework. "[A] judicial precedent holding that the statute unambiguously forecloses the agency's interpretation, and therefore contains no gap for the agency to fill, displaces a conflicting agency construction." *Brand X*, 545 U.S. at 982-83. This occurs "if the prior court decision holds that its construction follows from the unambiguous terms of the statute and thus leaves no room for agency discretion." *Id.* at 982. In other words, if the prior court decision was decided at *Chevron* step one, there is no need to proceed to *Chevron* step two.

Our ruling in *Legacy Emanuel* was clearly a *Chevron* step one decision. 97 F.3d at 1265 ("We believe the language of the Medicare reimbursement provision is clear[.]"). In *Legacy Emanuel*, we considered the meaning of the words "entitled" and "eligible" in tandem. We interpreted the word "entitled" to mean that a patient has an "absolute right . . . to payment." *Id.* In contrast, we interpreted the word "eligible" to mean that a patient simply meets the Medicaid statutory criteria: "if Congress had wanted to limit the Medicaid proxy to days for which Medicaid actually paid, Congress could have used 'entitled' or expressly specified that it was to include only those days actually paid for by Medicaid." *Id.* We held that Congress used a "broader word" than entitled in the Medicaid fraction to fulfill its intent of compensating hospitals for treating low-income patients. *Id.* And we noted that the use of "entitled" in the Medicare fraction did not frustrate that purpose, because the low-income proxy in the Medicare fraction is ultimately determined by entitlement to SSI, not Medicare. *Id.* at 1265-66. The 2005 Rule's interpretation of "entitled," in contrast, resembles our understanding of the term "eligible" in *Legacy Emanuel* by embracing even those patient days for which Medicare coverage is exhausted (i.e., for which there is no absolute right to payment). 69 Fed. Reg. at 49099. Thus, the 2005 Rule mistakenly treats as ambiguous statutory language that we deemed clear, and rewrites that language in contravention of our interpretation.

Rejecting Empire's challenge to the 2005 Rule's substantive validity, the district court determined that *Legacy Emanuel* does not control the meaning of the statutory text at issue here and thus proceeded to *Chevron*

step two. HHS adopts that position here and argues that that *Legacy Emanuel* did not actually decide the meaning of the term "entitled" in the Medicare fraction. We reject this reading of *Legacy Emanuel*. *Legacy Emanuel*'s analysis of "eligible for [Medicaid]" is inextricable from its analysis of "entitled to [Medicare]." Consequently, we are bound by *Legacy Emanuel*'s interpretation of "entitled to [Medicare]" unless and until change comes from our court sitting en banc or the Supreme Court. *Miller v. Gammie*, 335 F.3d 889, 899 (9th Cir. 2003) (en banc). Pursuant to *Brand X*, *Legacy Emanuel*'s unambiguous interpretation of "entitled to [Medicare]" in 42 U.S.C. § 1395ww(d)(5)(F)(vi) requires us to invalidate the 2005 Rule, which adopts a conflicting interpretation of the statute.

We recognize, as HHS argues on appeal, that the Sixth and D.C. Circuits have affirmed the 2005 Rule's interpretation of the phrase "entitled to [Medicare]" in 42 U.S.C. § 1395ww(d)(5)(F)(vi) at *Chevron* step two. *See Catholic Health*, 718 F.3d at 920 (affirming 2005 Rule at *Chevron* step two); *Metro. Hosp. v. HHS*, 712 F.3d 248, 270 (6th Cir. 2013) (same). Those decisions, however, do not control our analysis here because neither court dealt with binding circuit precedent holding that the statutory language was unambiguous, as *Legacy Emanuel* did.

For example, in *Catholic Health*, the D.C. Circuit relied on circuit precedent determining that the statutory language in question was ambiguous. 718 F.3d at 920 (citing *Northeast Hosp. v. Sebelius*, 657 F.3d 1, at 13

(D.C. Cir. 2011).[16] So *Brand X* could not have warranted a different result in *Catholic Health*.

The Sixth Circuit's binding precedent construing 42 U.S.C. § 1395ww(d)(5)(F)(vi) also did not trigger *Brand X*'s "stare decisis effect to a prior judicial construction" of a statute. *Metro. Hosp.*, 712 F.3d at 256. In *Metropolitan Hospital*, the Sixth Circuit held that its precedent construing "eligible for [Medicaid]" in the Medicaid fraction, *Jewish Hospital, Inc. v. Secretary of Health & Human Services*, 19 F.3d 270 (6th Cir. 1994), did not foreclose the 2005 Rule's interpretation of "entitled to [Medicare]" in the Medicare fraction. 712 F.3d at 257-58. The Sixth Circuit held that *Brand X* did not apply because *Jewish Hospital* was not decided at *Chevron* step one. *Metro. Hosp.*, 712 F.3d at 256. Nevertheless, the court also noted that, even if *Jewish Hospital* were decided at *Chevron* step one, the decision did not precisely decide the statutory meaning of "entitled to [Medicare]," and its discussion of that statutory phrase was secondary to other arguments supporting its holding. *Id.* at 256-57 (describing *Jewish Hospital*'s contrast of "entitled" and "eligible" as a "'back-up' analysis").

HHS argues that the Sixth Circuit's reading of *Jewish Hospital*, as set forth in *Metropolitan Hospital*, should somehow control our analysis here because we cited *Jewish Hospital* as part of our statutory interpretation in *Legacy Emanuel*. But *Legacy Emanuel*'s

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[16] We note that then-Judge Kavanaugh's concurring opinion in *Northeast Hospital* agreed with the interpretation of "entitled to [Medicare]" we announced in *Legacy Emanuel*. *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 20 (D.C. Cir. 2011).

holding, construing the unambiguous language of 42 U.S.C. § 1395ww(d)(5)(F)(vi), is fundamentally different than *Jewish Hospital*'s, which held that the statute was ambiguous and deferred to the agency's permissible interpretation. Moreover, *Jewish Hospital*'s analysis of "entitled to [Medicare]" is comparatively shorter than our analysis in *Legacy Emanuel* and was just one of several analyses informing court's decision interpreting "eligible for [Medicaid]." *Compare Jewish Hospital*, 19 F.3d at 274-76 *with Legacy Emanuel*, 97 F.3d at 1265-66. Even the Sixth Circuit recognized that our interpretation of "entitled to [Medicare]" in *Legacy Emanuel* played a central role in our analysis. *Metro. Hosp.*, 712 F.3d at 259 (noting that *Legacy Emanuel* "bas[ed] its conclusion" on the distinction between "eligible to [Medicaid]" and "entitled to [Medicare]"). Because we have already construed the unambiguous meaning of "entitled to [Medicare]" in 42 U.S.C. § 1395ww(d)(5)(F)(vi), we hold that the 2005 Rule's contrary interpretation of that phrase is substantively invalid pursuant to the APA. Thus, we affirm, on different grounds, the district court's summary judgment in favor of Empire.

III. Vacatur of 2005 Rule

Having affirmed, on different grounds, the district court's summary judgment in favor of Empire, we also affirm its order vacating the 2005 Rule. *See Nat. Res. Def. Council v. EPA* (*NRDC III*), 526 F.3d 591, 608 (9th Cir. 2008) (vacating rule held to be unlawful under *Chevron* analysis). We have observed that "when 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." *Univ. of Cal. v. U.S. Dep't Homeland Sec.*, 908 F.3d 476, 511 (9th Cir. 2018) (quoting *Nat'l Mining Ass'n v. U.S. Army Corps. of Eng'rs*, 145 F.3d 1399, 1409 (D.C. Cir. 1998)). Accordingly, we reinstate the prior version of 42 C.F.R. § 412.106(b)(2)(i), which embraced only "covered" patient days, *see Paulsen v. Daniels*, 413 F.3d 999, 1008 (9th Cir. 2005) ("The effect of invalidating an agency rule is to reinstate the rule previously in force.").

CONCLUSION

While HHS's notice-and-comment procedure for the 2005 Rule was not without flaws, it met the APA's requirements. However, the 2005 Rule violated the unambiguous text of 42 U.S.C. § 1395ww(d)(5)(F)(vi) and our court's ruling in *Legacy Emanuel* by removing the word "covered" from 42 C.F.R. § 412.106(b)(2)(i). As a result, we **AFFIRM**, on different grounds, the district court's order granting partial summary judgment for Empire and vacating the 2005 Rule. We **REMAND** to the district court with instructions to further remand to the PRRB to decide the remaining issue in this case.[17]

AFFIRMED AND REMANDED.

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[17] Both parties agreed to, and the district court ordered, a remand to the PRRB to decide whether, in light of *Allina*, 746 F.3d at 1102, Medicare Part C days should have been included in the Medicare fraction for the Empire's 2008 DSH calculation.

APPENDIX B

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF WASHINGTON

No. 2:16-CV-209-RMP

EMPIRE HEALTH FOUNDATION, FOR VALLEY HOSPITAL MEDICAL CENTER, PLAINTIFF

v.

THOMAS E. PRICE, M.D., SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, DEFENDANT

[Filed: Aug. 13, 2018]

ORDER GRANTING IN PART AND DENYING IN PART PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT, AND DENYING DEFENDANT'S MOTION FOR SUMMARY JUDGMENT

Plaintiff Empire Health Foundation ("Empire"), for Valley Hospital Medical Center (the "Hospital"), brings this action against the Secretary of the United States Department of Health and Human Services (the "Secretary"). Before the Court is Empire's Motion for Summary Judgment, ECF No. 34, and the Secretary's Cross-Motion for Summary Judgment, ECF No. 46. Theresa Sherman and Daniel Hettich appeared on behalf of Empire. James Bickford appeared on behalf of the Secretary. Having considered the parties' filings

and oral argument, the remaining record, and the relevant law, the Court is fully informed.

This case concerns the validity of the Secretary's 2005 Final Rule promulgation with regard to the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A]" in 42 U.S.C. § 1395ww. Both parties have moved for summary judgment. For the reasons set forth below, Empire's motion is granted in part and denied in part, and the Secretary's motion is denied.

PROCEDURAL HISTORY

Effective October 1, 2004, the Secretary's 2005 Final Rule relating to Medicare Part A hospital coverage amended 42 C.F.R. § 412.106(b)(2) to reflect the Secretary's newly adopted policy regarding the assessment of Medicare Part A patient-days. ECF No. 11-2. The actual language of the 2004 amendment, which removed the word "covered" from 42 C.F.R. § 412.106(b)(2), appeared for the first time in the 2008 publication of the regulation. *Id.* Pursuant to the Medicare disproportionate share hospital ("DSH") reimbursement process, Wisconsin Physicians Services, the fiscal intermediary that was auditing the Hospital's cost reporting, applied the amended policy from the 2005 Final Rule to the Hospital's cost reporting period for the 2008 fiscal year. ECF No. 34 at 14. The Hospital timely filed an appeal with the Provider Reimbursement Review Board ("Board"). *Id.*

After filing its appeal, the Hospital sought expedited judicial review pursuant to 42 U.S.C. § 1395oo(f)(1), which states that providers "shall also have the right to obtain judicial review of any action of the fiscal interme-

diary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines . . . that it is without authority to decide the question." *See* ECF No. 11-1. Finding that it was without authority to decide the legal issue in this case, the Board granted the Hospital's request for expedited judicial review regarding whether the regulation, 42 C.F.R. § 412.106(b)(2), is valid. ECF No. 11-2.

Empire, on behalf of the Hospital, filed the complaint in this matter alleging that the 2005 Final Rule amending 42 C.F.R. § 412.106(b)(2) is substantively and procedurally invalid and that the agency should be enjoined from applying the 2005 Final Rule against the Hospital. *See* ECF No. 1. Empire moves for summary judgment, challenging the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A]" as inconsistent with the plain language of the statute, inconsistent with circuit precedent, and arbitrary and capricious. ECF No. 34 at 20-30. Empire also challenges the adequacy of the notice that the Secretary provided prior to the promulgation of the 2005 Final Rule. *Id.* at 17-20. Alternatively, if the Court agrees with the Secretary regarding the treatment of unpaid Medicare Part A days, Empire asks that the Court direct the Secretary "to include unpaid [supplemental security income ('SSI')] eligible patient days in the numerator of the [Medicare fraction] utilizing SSI payment status codes that reflect the individuals' eligibility for SSI—even if the individuals did not receive SSI payments," as a matter of consistency. *Id.* at 23.

Empire also challenges the validity of the inclusion of Part C coverage days in the Hospital's 2008 fiscal year DSH calculation. *Id.* at 11. In a 2014 case, the D.C.

Circuit Court of Appeals vacated the Medicare Part C regulatory revision on procedural grounds. *See Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1109 (D.C. Cir. 2014). Accordingly, both Empire and the Secretary have agreed that this Court should remand the Part C issue back to the Board.

The Secretary also moves for summary judgment, arguing that the Court should find the Secretary's 2005 Final Rule substantively and procedurally valid.

JURISDICTION

This case comes to the Court from the Provider Reimbursement Review Board, which hears appeals concerning DSH reimbursement payments to hospitals and other Medicare providers. The Board concluded that this case "involves a question of law or regulations" that it "is without authority to decide." *See* ECF No. 11-2 (citing 42 C.F.R. § 405.1842(f)(1), (g)(2)). Pursuant to 42 U.S.C. § 1395oo(f)(1), the Board granted expedited judicial review of the legal questions raised by the Hospital in its appeal, now being prosecuted by Empire. The Board found that it "lacks the authority to decide whether regulation, 42 C.F.R. § 412.106(b)(2) is valid." ECF No. 11-2.

The Secretary disputes the Court's jurisdiction to hear Empire's challenge to the Secretary's assessment of SSI-entitlement. ECF No. 46 at 32. As the Court makes clear below, it finds that the Secretary's assessment of SSI-entitlement in the Medicare fraction of the disproportionate patient percentage provision is outside the scope of the Board's grant of expedited judicial review in this matter. *See infra* Part III. However, the Court has subject matter jurisdiction over the other

questions of law presented in this matter pursuant to the Board's grant of expedited judicial review under 42 U.S.C. § 1395oo(f)(1), and pursuant to 28 U.S.C. § 1331, as a civil action arising under the laws of the United States, because Empire challenges the interpretation of a provision in the Medicare Act, 42 U.S.C. § 1395ww(d)(5)(F). *See* ECF No. 1.

LEGAL STANDARD FOR SUMMARY JUDGMENT

When parties file cross-motions for summary judgment, the Court considers each motion on its own merits. *See Fair Housing Council of Riverside County, Inc. v. Riverside Two*, 249 F.3d 1132, 1136 (9th Cir. 2001). A court may grant summary judgment where "there is no genuine dispute as to any material fact" of a party's prima facie case, and the moving party is entitled to judgment as a matter of law. *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-33 (1986); *see also* Fed. R. Civ. P. 56(c). Because Empire's claims arise under the Administrative Procedure Act ("APA"), 5 U.S.C. §§ 701-706, resolution of its claims "does not require fact finding on behalf of [the] court." *Nw. Motorcycle Ass'n v. USDA*, 18 F.3d 1468, 1471-72 (9th Cir. 1994).

Here, there are no disputed facts, and the Court's grant of jurisdiction is limited to the legal question of the validity of 42 C.F.R. § 412.106(b)(2).

STATUTORY AND REGULATORY FRAMEWORK

Under Part A of the Medicare Act, the Medicare program reimburses providers for inpatient services based on the Prospective Payment System ("PPS"), which derives reimbursements from standardized reimbursable expenditure rates that are subject to adjustments based on certain hospital-specific factors. *See* 42 U.S.C.

§§ 1395c to 1395i-5, 1395ww(d). The Hospital's challenge concerns the DSH adjustment, created to "compensate hospitals for the additional expense per patient associated with serving high numbers of low-income patients." *Phoenix Mem. Hosp. v. Sebelius*, 622 F.3d 1219, 1221 (9th Cir. 2010). As alleged in the complaint, the Hospital provided short-term acute care to patients insured under the federal health insurance program Medicare in the 2008 fiscal year. ECF No. 1 at 3.

Whether a hospital receives a DSH adjustment, and the amount of the adjustment received, is determined by a calculation of the hospital's disproportionate patient percentage ("DPP"). 42 U.S.C. § 1395ww(d)(5)(F)(v), (vii). The DPP is the sum of two fractions, commonly referred to as the Medicare fraction and Medicaid fraction. The relevant statutory language for determining the DPP is as follows:

> **(vi)** In this subparagraph, the term "disproportionate patient percentage" means, with respect to a cost reporting period of a hospital, the sum of—
>
> > **(I)** the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A of this subchapter* and were entitled to supplementary security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A of this subchapter*, and

> **(II)** the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX, but who were not entitled to benefits under part A of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.

42 U.S.C. § 1395ww(d)(5)(F)(vi) (emphasis added).

The regulation implementing the DPP provision, 42 C.F.R. § 412.106(b), as amended by the 2005 Final Rule, states the formula for determining the DPP, which serves "as a proxy for all low-income patients." *Legacy Emanuel Hosp. & Health Ctr. v. Shalala*, 97 F.3d 1261, 1265 (9th Cir. 1996). The formula is as follows, represented visually:

Medicare Fraction   ***Medicaid Fraction***

$$\frac{\textit{Days Entitled to Medicare Part A and to SSI}}{\textit{Days Entitled to Medicare Part A}} + \frac{\textit{Days Eligible for Medicaid (but not entitled to Medicare)}}{\textit{Total Patient Days}} = \textit{DPP}$$

See 42 C.F.R. § 412.106(b). "A higher DPP produces a higher adjustment percentage, which in turn produces a larger adjustment payment." *Metro. Hosp. v. United States HHS*, 712 F.3d 248, 251 (6th Cir. 2013) ("In sum, the DPP is the key figure in determining whether a hospital will receive additional Medicare dollars for serving low-income patients and, if so, in what amount.").

As referenced in the above equation, the numerator of the Medicare fraction consists of the number of patient-days in the relevant period for patients who were both "entitled to benefits under [Medicare] part A" and "entitled to [SSI] benefits." 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The relevant portion of the implementing regulation closely tracks the statute. It states that the Secretary calculates the DPP by determining the number of patient days that "[a]re associated with discharges occurring during each month" and "[a]re furnished to patients who during that month were *entitled to both Medicare Part A (including Medicare Advantage (Part C)) and SSI*, excluding those patients who received only State supplementation." 42 C.F.R. § 412.106(b)(2) (emphasis added). The Secretary then divides this number by the number of patient days that "[a]re associated with discharges that occur during that period" and "[a]re furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C))". *Id.* § 412.106(b)(2).

EMPIRE'S CHALLENGE TO THE VALIDITY OF 42 C.F.R. § 412.106(B)(2)

As previously stated, the issue under expedited judicial review in this matter is the validity of 42 C.F.R. § 412.106(b)(2). *See* ECF No. 11-2. "[R]egulations, in order to be valid, must be consistent with the statute under which they are promulgated." *United States v. Larionoff*, 431 U.S. 864, 873 (1977). In addition, "[a] substantive rule is invalid if the agency has failed to comply with APA requirements." *Southern California Aerial Advertisers' Ass'n v. Fed. Aviation Admin.*, 881 F.2d 672, 677 (9th Cir. 1989); *see also Buschmann v.*

Schweiker, 676 F.2d 352, 355-56 (9th Cir. 1982) ("A regulation is invalid if the agency fails to follow procedures required by the Administrative Procedures Act, 5 U.S.C. § 553."). Thus, a regulation may be substantively valid but fail because it is procedurally invalid.

Empire argues that the Secretary's 2005 Final Rule is both substantively and procedurally invalid. ECF No. 34 at 17-30. The Secretary contends that the 2005 Final Rule was properly adopted and that the Secretary's interpretation of the phrase "entitled to benefits under [Medicare] part A" is reasonable. *See* ECF No. 46 at 22-32. The Court first considers the substantive validity of 42 U.S.C. § 412.106(b)(2), then its procedural validity.

I. Interpretation of the Phrase "Entitled to Benefits Under [Medicare] Part A"

Empire challenges the Secretary's application of 42 C.F.R. § 412.106(b)(2), which is the Medicare fraction in the DPP provision, and contends that the agency's interpretation of 42 U.S.C. § 1395ww(d)(5)(F) is arbitrary and capricious. *See* ECF No. 1 at 14. Under the 2005 Final Rule, the patient-days of patients who exhausted their Medicare Part A coverage are included in the Medicare fraction. *See* 69 Fed. Reg. 49,098-99 (Aug. 11, 2004). Prior to the Secretary's promulgation of the 2005 Final Rule, exhausted Medicare Part A patient-days were not included in the Medicare fraction, and when a patient was eligible for Medicaid, exhausted Medicare Part A patient-days were included in the Medicaid fraction. *See id.* The Secretary argues that it correctly and reasonably interpreted § 1395ww(d)(5)(F) in the 2005 Final Rule amending 42 C.F.R. § 412.106(b)(2), and

in the agency's subsequent application of the regulation. *See* ECF No. 46 at 2.

The standard of review for an agency's interpretation of a statute that is reflected in a regulation adopted through notice-and-comment rulemaking is the two-step framework outlined in *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). *See United States v. Mead Corp.*, 533 U.S. 218, 226-27 (2001) (requiring analysis under the Chevron framework for regulations adopted through notice-and-comment rulemaking). The first question for the reviewing court is "whether Congress has directly spoken to the precise question at issue." *Chevron,* 467 U.S. at 842. "If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." *Id.* at 842-43. The reviewing court employs "traditional tools of statutory construction" to ascertain whether "Congress had an intention on the precise question." *Id*. at 843 n.9. The precise substantive question before the Court is whether Congress intended the phrase "entitled to benefits under [Medicare] Part A" in the Medicare fraction of the DPP provision to mean "qualified to receive benefits" or "legally due payment."

The Supreme Court has held that "if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute." *Id.* at 843. In this second step of *Chevron*, the court "must reject administrative constructions of [a] statute . . . that are inconsistent with the statutory mandate or that frustrate the policy that Congress

sought to implement." *Fed. Election Comm'n v. Democratic Senatorial Campaign Committee*, 454 U.S. 27, 32 (1981). The agency's construction need not be the only possible permissible interpretation of the statute, nor must it be "even the reading the court would have reached if the question initially had arisen in a judicial proceeding." *Chevron,* 467 U.S. at 843 n.11. Rather, the agency's construction need only be a "permissible" construction of the statute. *Id.* at 843.

A. Stare Decisis for **Chevron** ***Decisions***

"A court's prior judicial construction of a statute overrides an agency construction otherwise entitled to *Chevron* deference only if the prior court decision holds that its construction follows from the unambiguous terms of the statute and thus leaves no room for discretion." *Nat'l Cable & Telecomms. Ass'n v. Brand X Internet Servs.*, 545 U.S. 967, 983 (2005). In other words, the doctrine of stare decisis applies if a prior court has reached a *Chevron* Step One decision finding that "Congress has directly spoken to the precise question at issue." *See Chevron,* 467 U.S. at 842.

Empire argues that in *Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F.3d 1261, 1265 (9th Cir. 1996), the Ninth Circuit Court of Appeals reached a *Chevron* Step One decision regarding the interpretation of "entitled" in the DPP provision, and that interpretation is binding on this Court. *See* ECF No. 34 at 21-22. The Secretary contends that the *Legacy* court's *Chevron* Step One determination is "limited to the precise question at issue" in *Legacy*, which was the interpretation of the word "eligible" in the Medicaid fraction. *See* ECF No. 46 at 25-27 (citing *Legacy Emanuel*, 97 F.3d at 1265-66). The Secretary argues that the *Legacy* court did

not answer the precise question presently before this Court regarding the interpretation of the phrase "entitled to benefits under [Medicare] part A" in the Medicare fraction of the DPP provision. *Id.* The Secretary argues that the *Legacy* decision is not binding on this Court, and that the Court should proceed with a full *Chevron* analysis. *Id.*

The Court first considers whether the Ninth Circuit's statements in *Legacy* constitute a *Chevron* Step One holding regarding the statutory meaning of "entitled" in the context of the Medicare fraction when the *Legacy* court's statements related to the statutory meaning of "entitled" in the context of the Medicaid fraction. If so, then the *Legacy* holding would be binding on this Court under the doctrine of stare decisis.

In *Legacy*, the Ninth Circuit Court of Appeals considered the validity of the Secretary's interpretation of the word "eligible" in the Medicaid fraction of the DPP provision. *See Legacy Emanuel*, 97 F.3d at 1261-62. The *Legacy* court held that "the language of the Medicare reimbursement provision is clear: the Medicaid proxy includes all patient days for which a person was eligible for Medicaid benefits, whether or not Medicaid actually paid for those days of service." *Id.* at 1265. The court based its conclusion on "Congress's use of the word 'eligible' rather than 'entitled,' as well as Congress's use of the Medicaid proxy to define non-Medicare low-income patients for purposes of determining a hospital's share of low-income patients." *Id.* The words "eligible" and "entitled" both appear in the Medicaid fraction.

In reaching its conclusion, the *Legacy* court cited and discussed *Jewish Hospital, Inc. v. Secretary of Health and Human Services*, a Sixth Circuit Court of Appeals

decision that considered the same question regarding the interpretation of "eligible" in the Medicaid fraction. *See Legacy Emanuel*, 97 F.3d at 1264-65 (citing *Jewish Hosp., Inc. v. Sec'y of Health & Human Servs.*, 19 F.3d 270 (6th Cir. 1994)). In *Jewish Hospital*, the Secretary argued that Congress intended "eligible" in the Medicaid fraction to include "only those days actually paid by Medicaid." *Jewish Hosp.*, 19 F.3d at 272. The Sixth Circuit concluded that, "by using the different terms 'entitled' and 'eligible' in adjacent provisions, Congress intended different meanings for the terms." *Legacy Emanuel*, 97 F.3d at 1264 (citing *Jewish Hosp.*, 19 F.3d at 275). Although the court found Congress's intent clear, it continued its analysis. *See Jewish Hosp.*, 19 F.3d at 275. The Sixth Circuit went on to hold that, "even if the language of the statute can be deemed silent or ambiguous, the Secretary's construction is *not* permissible" because "[t]he legislative history of the Medicaid proxy clearly shows that the Secretary's construction is contrary to that intent expressed by Congress." *Id.* at 275-76 (emphasis in original). The *Jewish Hospital* court held that according to the plain language of the DSH adjustment statute, "the word 'eligible' refers to whether a patient is capable of receiving . . . Medicaid." *Id.* at 274.

In 2013, after the Secretary issued the 2005 Final Rule amending the agency's policy regarding the interpretation of "entitled to benefits under [Medicare] part A" in the Medicare fraction, the parties in *Metropolitan Hospital v. United States HHS*, 712 F.3d 248 (6th Cir. 2013), challenged whether the patient-days of individuals "entitled to benefits under [Medicare] part A" in the

Medicare fraction include "the patient days of all Medicare [Part A] beneficiaries, regardless of whether a beneficiary has exhausted coverage for any particular patient day." *Id.* at 253. In the case presently before the Court, Empire similarly challenges whether the statutory interpretation of "entitled to benefits under [Medicare] part A" in the 2005 Final Rule applies to patient-days for which no payment was received under Medicare Part A. *See* ECF No. 1 at 1, 14.

After opining that "courts often describe statutory language as 'clear' or 'unambiguous' without making a *Chevron* step-one holding," the *Metropolitan Hospital* court determined that the *Jewish Hospital* decision was "unclear regarding whether the court's *Chevron* step-one discussion is a holding," because "the only explicit statements of a holding that appear in *Jewish Hospital* are expressed in terms of *Chevron* step two." *Metro. Hosp.*, 712 F.3d at 256. The *Metropolitan Hospital* court stated that the *Jewish Hospital* opinion "proceeds in the *Chevron* analysis to conclude that the Secretary's interpretation was impermissible," a holding in line with *Chevron* step two. *Id.* at 256 (citing *Jewish Hosp.*, 19 F.3d at 275-76).

The *Metropolitan Hospital* court stated that, even if it read the *Jewish Hospital* decision as a *Chevron* Step One holding, the *Metropolitan Hospital* court "decline[d] to hold that *Jewish Hospital*'s 'back-up' analysis contrasting the phrase 'entitled to benefits under [Medicare] part A' with the phrase 'eligible for [Medicaid]'" resolved the "precise question at issue" in *Metropolitan Hospital*, which was the interpretation of "entitled to benefits under [Medicare] part A" in the Medicare fraction. *Id.* at 257. Therefore, the court in *Metropolitan*

Hospital concluded it was not bound by the *Jewish Hospital* decision, and proceeded with a full *Chevron* analysis of the statutory interpretation of the phrase "entitled to benefits under [Medicare] part A." *Id.* at 255-66.

In this case, Empire argues that the *Legacy* court's conclusion is controlling as a *Chevron* Step One decision that "the statutory language is clear because of Congress's use of 'eligible' rather than 'entitled,' and because Congress's overarching goal was to reimburse hospitals for the added expense of serving low-income patients." ECF No. 34 at 22 (citing *Legacy*, 97 F.3d at 1266). Empire argues that, when the *Legacy* court distinguished "eligible" and "entitled" in the Medicaid fraction, the *Legacy* court found that Congress's intent was clear and unambiguous and that Congress intended "entitled" to mean "entitled to payment," foreclosing this Court's need to repeat a *Chevron* Step One analysis of the interpretation of the phrase "entitled to benefits under [Medicare] part A" in the Medicare fraction of the DPP provision. *Id.* (citing *Legacy*, 97 F.3d at 1266).

The Secretary contends that *Legacy*'s *Chevron* Step One holding is not controlling in this case. ECF No. 46 at 26. The Secretary argues that the opinion in *Legacy* only applies narrowly to the specific issue in that case, namely the meaning of "eligible" as it pertained to Medicaid patient-days in the Medicaid fraction, and not to the meaning of the language in the Medicare fraction at issue in this case. ECF No. 46 at 26.

Courts considering the statutory interpretation of the Medicaid and Medicare fractions have concluded that the two fractions are separate and distinct. The *Metropolitan Hospital* court concluded that it is "clear from the statute" that "these two fractions are exclusive

of one another." *Metro. Hosp.*, 712 F.3d at 262-63. Nevertheless, they are interrelated. A Medicare Part A patient-day may not be counted as a Medicaid patient-day, because the DPP provision excludes the patient-days of patients who are entitled to Medicare Part A benefits from the Medicaid fraction. *See id.* (citing 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II)).

The *Legacy* court concluded that the clauses "entitled to benefits under [Medicare] part A" and "eligible for medical assistance under [Medicaid]" "serve different purposes" in the Medicare and Medicaid fractions respectively. *Legacy Emanuel*, 97 F.3d at 1266. Within the Medicare fraction, "the language 'entitled to benefits under [Medicare]' does not serve to define Medicare patients that are low-income." *Id.* The low-income status of patients in the Medicare fraction is determined by their entitlement to SSI. *Id.* "Within the Medicaid proxy, in contrast, the language 'eligible for medical assistance under [Medicaid]' defines the low-income status of patients." *Id.*

Departing from the Sixth Circuit's ambiguous *Chevron* Step Two conclusion in *Jewish Hospital*, the Ninth Circuit Court in *Legacy* reached a *Chevron* Step One decision regarding Congress's clear intent regarding the meaning of "eligible" in the Medicaid fraction. *See Legacy Emanuel*, 97 F.3d at 1265. The *Legacy* court held that the congressional intent regarding the use of "eligible" in the Medicaid fraction was clear, rather than reaching a holding regarding the interpretation of "entitled" in the Medicare fraction. *See id.* That decision is controlling in this circuit regarding the Medicaid fraction, but the *Legacy* court did not resolve "the precise

question at issue" in the matter before this Court regarding the interpretation of the phrase "entitled to benefits under [Medicare] part A." *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi). Accordingly, this Court undertakes a *Chevron* analysis in the specific context of the Medicare fraction within the DPP provision.

B. Chevron Step One Analysis

Employing the traditional tools of statutory construction, the Court first considers "whether Congress has directly spoken to the precise question at issue." *Chevron,* 467 U.S. at 842-43, 843 n.9. Courts may presume that "Congress legislates with knowledge of [the court's] basic rules of statutory construction." *McNary v. Haitian Refugee Ctr., Inc.*, 498 U.S. 479, 496 (1991). Traditional tools of judicial statutory construction include considering the plain meaning of the language in the statute, dictionary definitions, canons of construction, legislative purpose, and legislative history. *See, e.g.*, *Legacy Emanuel*, 97 F.3d at 1265.

Empire argues that the Secretary's interpretation of "entitled to benefits under [Medicare] part A" in the 2005 Final Rule's amendment of the DPP provision fails *Chevron* Step One because it is contrary to the plain language of the statute and is applied inconsistently within the statute. *See* ECF No. 34 at 20-23. The Secretary contends that 42 U.S.C. § 426 provides a clear meaning for the phrase "entitled to benefits under Medicare Part A" in the Medicare fraction. ECF No. 46 at 23. Additionally, the Secretary argues that if the Court finds the meaning of the word "entitled" in the Medicare fraction ambiguous, the Court should uphold the agency's interpretation of the statute as permissible under a *Chevron* Step Two analysis. ECF No. 46 at 5, 27.

Clarifying the meaning of "entitled" matters because an individual may satisfy the conditions for Medicare eligibility, but may not receive Medicare Part A benefits because Medicare Part A provides a limited benefit to hospitalized patients: beneficiaries are covered only for the first 90 days of any given hospitalization. 42 C.F.R. § 409.61(a)(1). Each Medicare Part A beneficiary also "has a non-renewable lifetime reserve" of 60 additional days of coverage which, until they are exhausted, can be used to cover periods of hospitalization lasting longer than 90 days. *Id.* § 409.61(a)(2).

By statute, Medicare generally pays after other sources of insurance, such as a worker's compensation plan. 42 U.S.C. § 1395y(b). Individuals may receive both Medicare Part A and Medicaid benefits. These individuals are "dual-eligible." *See Metro. Hosp.*, 712 F.3d at 252. Two scenarios exist in which a person may qualify for Medicare Part A and yet not receive or be "covered" by his or her Medicare Part A benefits. First, an individual may have other sources of insurance that must be exhausted before an individual receives Medicare Part A benefits. 42 U.S.C. § 1395y(b)(2) (describing the "Medicare Secondary Payer" system). Second, an individual may exhaust her Medicare Part A coverage by using all of the hospital care patient-days provided for under Medicare. *Id.* § 1395d(b)(1). In the first case, Medicare Part A benefits only begin when the individual's other coverage is exhausted. *Id.* § 1395y(b)(2). In the second case, Medicare no longer pays for the patient's hospital services. In either scenario, individuals who are qualified for Medicare Part A benefits do not receive those benefits because they have

either not exhausted their other coverage or they have exhausted their Medicare Part A coverage.

Under the Secretary's current policy, the Secretary counts all the patient-days of individuals qualified for Medicare Part A in the Medicare fraction of the DPP provision, regardless of whether they are receiving coverage for their hospital patient-days under Medicare Part A.

1. Plain Language

"In construing the provisions of a statute, we first look to the language of the statute to determine whether it has a plain meaning." *Satterfield v. Simon & Schuster, Inc.*, 569 F.3d 946, 951 (9th Cir. 2009). Where the statutory language is plain and "admits of no more than one meaning," the duty of interpretation does not arise. *Caminetti v. United States*, 242 U.S. 470, 485 (1917). "A fundamental canon of statutory construction is that, unless otherwise defined, words will be interpreted as taking their ordinary, contemporary, common meaning." *Perrin v. United States*, 444 U.S. 37, 42 (1979). However, the canon that courts "construe a statutory term in accordance with its ordinary or natural meaning" applies only "in the absence of [a statutory] definition." *FDIC v. Meyer*, 510 U.S. 471, 476 (1994).

i. No Statutory Definition Exists in 42 U.S.C. § 1395ww

No definition of the phrase "entitled to benefits under [Medicare] Part A" is provided in the DPP provision or elsewhere in the statutory section in which the DPP formula appears. *See* 42 U.S.C. § 1395ww; *see also Metro. Hosp.*, 712 F.3d at 256. However, the Secretary

argues that 42 U.S.C. § 426(a) provides a statutory definition of the phrase "entitled to benefits under [Medicare] Part A." *See* ECF No. 46 at 23. Subsection 426(a) provides that "every individual who . . . has attained age 65, and . . . is entitled to monthly [Social Security benefits] . . . shall be entitled to hospital insurance benefits under [Medicare Part A] for each month for which he meets the [above specified conditions]." The Secretary contends that, in the language of 42 U.S.C. § 426(a), "Congress has defined [']entitled to part A['] and foreclosed [Empire's] interpretation that ['entitled'] turns on whether a particular patient day is covered." ECF No. 46 at 23.

The Court disagrees. Subsection 426(c), titled "Conditions," states that "[f]or the purposes of subsection (a) . . . entitlement of an individual to hospital benefits for a month shall consist of entitlement to have payment made under, and subject to the limitations in, [Medicare Part A] on his behalf for inpatient hospital services . . . during such month." Furthermore, § 426 does not reference the DPP provision, so it is unclear whether Congress actually contemplated defining "entitled to benefits under [Medicare] part A" through § 426. The Court finds that the definition provided in subsection 426(a) is not dispositive with regards to the meaning of "entitled to benefits under [Medicare] part A" in the DPP provision within 42 U.S.C. § 1395ww. Therefore, the Court will consider the ordinary meaning of the word "entitled."

ii. Ordinary Meaning of "Entitled"

"Entitle" is defined in Black's Law Dictionary as "to grant a legal right to" and "to qualify for." *Entitle*,

Black's Law Dictionary (10th ed. 2014). Empire argues that, in the context of 42 U.S.C. § 1395ww, "entitled to benefits under [Medicare] Part A" means "granted a legal right to" actual payment of benefits under Medicare Part A. ECF No. 34 at 21. Conversely, the Secretary contends that the phrase "entitled to benefits under [Medicare] Part A" is properly interpreted as meaning "qualified for" benefits under Medicare Part A, regardless of whether payment is made. *See* ECF No. 46 at 23.

It appears to the Court that "entitle" has two plainly conflicting meanings. The Court thus finds that the plain meaning of "entitled" in this context does not demonstrate Congress's clear and unambiguous intent as required by *Chevron* Step One. *See Chevron*, 467 U.S. at 842-43. Therefore, the Court considers another canon of construction: whether Congress's intended meaning of "entitled to benefits under [Medicare] part A" may be inferred from other uses of the word "entitled" or the phrase "entitled to benefits under [Medicare] part A" within 42 U.S.C. § 1395ww.

iii. Consistent Use

Another rule of statutory construction is that "identical words used in different parts of the same act are intended to have the same meaning." *Gustafson v. Alloyd Co.*, 513 U.S. 561, 570 (1995). Conversely, the use of different language by Congress creates a presumption that Congress intended the terms to have different meanings. *See Washington Hosp. Center v. Bowen,* 795 F.2d 139, 146 (D.C. Cir. 1986).

The phrase "entitled to benefits under [Medicare] part A" appears seven times throughout 42 U.S.C.

§ 1395ww other than in the DPP provision, and three times within the DPP provision. *See* 42 U.S.C. § 1395ww. "Moreover, the phrase 'entitled to benefits under [Medicare] part A' appears in more than 30 other sections of the Medicare statute, indicating that the phrase has a specific, consistent meaning throughout the statutory scheme, rather than a varying, context-specific meaning in each section and subsection." *Metro. Hosp.*, 712 F.3d at 260. In the Medicare statute, several references to the phrase expressly recognize the difference between a patient who has exhausted his or her Medicare Part A coverage for a particular spell of illness and a patient who is not entitled to Medicare benefits at all. *Id.* For example, 42 U.S.C. § 1395l(t)(1)(B)(ii) provides coverage for certain outpatient-department services that are "furnished to a hospital inpatient who (I) is entitled to benefits under [Medicare] part A . . . but as exhausted benefits for inpatient services during a spell of illness, or (II) is not so entitled." The Court finds Congress's frequent use of the phrase "entitled to benefits under [Medicare] part A" and the logic of the *Metropolitan Hospital* decision persuasive but not dispositive.

In contrast, Empire argues that when Congress used the word "entitled" for Medicare Part A benefits and SSI benefits in the Medicare fraction, Congress intended the word to be applied consistently. ECF No. 34 at 23-24. Empire asserts that the Secretary interprets the word "entitled" differently within the same sentence of the statute, in conflict with Congress's intention and the canon of statutory construction that "identical words used in different parts of the same statute are generally presumed to have the same meaning."

Id. (quoting *IBP, Inc. v. Alvarez*, 546 U.S. 21, 34 (2005)). The Court agrees that the Secretary treats "entitled" for the purposes of Medicare Part A as "qualified for," and "entitled" for the purposes of SSI benefits as "granted a legal right to" actually payment. *See* 69 Fed. Reg. 49,098-99 (Aug. 11, 2004). The Secretary's inconsistent interpretation of "entitled" conflicts with the canon of construction holding that the same word used within a statute generally has the same meaning.

Taking both of these arguments into consideration, the Court concludes that Congress's intent regarding the interpretation of the phrase "entitled to benefits under [Medicare] part A" in the DPP provision is not clearly evinced by the repeated uses of the word "entitled" or the phrase "entitled to benefits under [Medicare] part A." Based on the absence of a statutory definition, the lack of clear ordinary meaning, and the Congress's repeated but unclear uses of the word "entitled" and phrase "entitled to benefits under [Medicare] part A," the Court finds that Congress's intent is unclear as to the meaning of "entitled to benefits under [Medicare] part A" in the DPP provision. Therefore, the Court next looks to the statutory purpose to determine whether Congress provided a clear and unambiguous intent for the meaning of the phrase "entitled to benefits under [Medicare] part A" in its expression of the purpose of the DSH provision. *See Chevron*, 467 U.S. at 842-43.

2. Statutory Purpose

If the statutory text is unclear, courts may look to the purpose of the statute to determine whether Congress clearly and unambiguously expressed its intent there. *See Chevron*, 467 U.S. at 843 n.9 ("If a court, employing traditional tools of statutory construction, ascertains

that Congress had an intention on the precise question at issue, that intention is the law and must be given effect."). "In ascertaining the plain meaning of the statute, the court must look to the particular statutory language at issue, as well as the language and design of the statute as a whole." *K Mart Corp. v. Cartier*, 486 U.S. 281 (1988). "[T]he function of the courts" in cases of statutory interpretation "is to construe the language so as to give effect to the intent of Congress." *United States v. American Trucking Ass'ns*, 310 U.S. 534, 542 (1940).

"Congress's 'overarching intent' in passing the [DSH] provision was to supplement the [PPS] payments of hospitals serving 'low income' persons." *Legacy Emanuel*, 97 F.3d at 1265. "Congress intended the Medicare and Medicaid fractions to serve as a proxy for all low-income patients." *Id.* In the Medicare fraction, the low-income status of Medicare patients receiving hospital care "is determined by their entitlement to SSI." *Id.* at 1256-66. In the Medicaid fraction, the number of Medicaid-eligible patient-days accounts for the low-income patients eligible to receive Medicaid and receiving hospital care. *Id.* at 1266. However, "knowing the statute's general purpose and that the two DPP fractions are mutually exclusive is insufficient to divine a clear congressional intent regarding whether a Medicare patient who has exhausted his or her days of inpatient services for a particular spell of illness is 'entitled to benefits under [Medicare] part A.'" *Metro. Hosp. v. United States HHS*, 712 F.3d 248, 263 (6th Cir. 2013).

Neither party's interpretation of "entitled" includes in the DPP calculation all groups of low-income patients.[1] *See id.* "Because either interpretation would necessarily exclude certain low-income patients from the DPP calculation," the Sixth Circuit in *Metropolitan Hospital* found "no support for a clear statutory mandate to account for *all* low-income patients between the two fractions." *Id.* Likewise, this Court finds no clear intent regarding the meaning of "entitled to benefits under [Medicare] part A" in the statutory purpose of 42 U.S.C. § 1395ww.

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[1] Under the Secretary's present interpretation of "entitled to benefits under [Medicare] part A," all patient-days of patients who satisfy the conditions for Medicare eligibility and who are receiving SSI payments are counted in the Medicare fraction. *See Metro. Hosp.*, 712 F.3d at 263. All patients who satisfy the conditions for Medicare eligibility are excluded from the Medicaid fraction. 42 C.F.R. § 412.106(b)(4). The Secretary's application of the DPP provision thus excludes patients who are "entitled" to Medicare and enrolled in SSI but are not receiving SSI payments, despite the fact that these patients are, by virtue of their enrollment in SSI, low income. *See Metro. Hosp.*, 712 F.3d at 263.

Under the Secretary's previous policy, which Empire advocates in this case, "any Medicare patient who has exhausted his or her days of inpatient hospital services for a particular spell of illness is no longer 'entitled to benefits under [Medicare] part A.'" *See id.* The patient's Medicare Part A exhausted days cannot be counted in the Medicare fraction, but these exhausted days may only be counted in the Medicaid fraction if the patient is Medicaid-eligible. *See* 42 C.F.R. § 412.106(b)(4). Therefore, this interpretation excludes patients who are enrolled in SSI and eligible for Medicare, but not eligible for Medicaid, despite the fact that these patients are also low income.

Neither the plain language of 42 U.S.C. § 1395ww nor the statutory purpose demonstrates a clear and unambiguous Congressional intent for the meaning of the phrase "entitled to benefits under [Medicare] part A" in the DPP provision. *See Chevron*, 467 U.S. at 842-43. Therefore, the Court concludes its *Chevron* Step One analysis and considers whether the Secretary's interpretation is permissible under *Chevron* Step Two.

C. Chevron Step Two Analysis

"[I]f the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute." *Chevron*, 467 U.S. at 843. "[U]nder *Chevron* step two, we ask whether an agency interpretation is 'arbitrary or capricious in substance,'" *Judulang v. Holder*, 565 U.S. 42, 52 n.7 (2011), or "manifestly contrary to the statute." *Mayo Found. for Med. Educ. & Research v. United States*, 562 U.S. 44, 53 (2011). "A court lacks authority to undermine the regime established by the Secretary unless her regulation is 'arbitrary, capricious, or manifestly contrary to the statute.'" *Sebelius v. Auburn Reg'l Med. Ctr.*, 133 S. Ct. 817, 826 (2013). Furthermore, "[a] court must uphold the Secretary's judgment as long as it is a permissible construction of the statute, even if it differs from how the court would have interpreted the statute in the absence of an agency regulation." *Id.*

Under *Chevron* Step Two, courts generally give agency statutory interpretations substantial deference "when it appears that Congress delegated authority to the agency generally to make rules carrying the force of law, and that the agency interpretation claiming deference was promulgated in the exercise of that authority."

Mead Corp., 533 U.S. at 226-27. An agency's interpretation of statutory authority is examined "in light of the statute's text, structure, and purpose." *Miguel-Miguel v. Gonzales*, 500 F.3d 941, 949 (9th Cir. 2007). The interpretation fails if it is "unmoored from the purposes and concerns" of the underlying statutory framework. *Judulang*, 565 U.S. at 64.

In the regulation implementing the DPP provision, the Secretary uses "entitled" only once in the numerator of the Medicare fraction, departing from the statutory language of 42 U.S.C. § 1395ww. *See* 42 C.F.R. § 412.106(b) (assessing patient-days of patients who were "entitled to both Medicare Part A (including Medicare Advantage (Part C)) and SSI"). The Secretary interprets this single use of "entitled" in different ways for counting patient-days of patients "entitled" to Medicare Part A and counting patient-days of patients "entitled" to SSI. The Secretary counts patient-days for which individuals are "entitled to [SSI benefits]" as only those days on which individuals actually receive payment of SSI benefits. In contrast, under the 2005 Final Rule, the Secretary counts patient-days for which individuals are "entitled to benefits under [Medicare] Part A" as all patient-days on which an individual qualifies for Medicare Part A, whether or not the individual actually receives Medicare Part A benefits on that day. This inconsistent application of the word "entitled" does not appear entirely reasonable; however, nothing in the language of 42 U.S.C. § 1395ww precludes the Secretary's interpretations in relation to Medicare Part A and SSI benefits. *See Metro. Hosp.*, 712 F.3d at 265-66.

Therefore, the Secretary's interpretation is not "manifestly contrary to the statute." *Chevron*, 467 U.S. at 843.

The Court next considers whether the Secretary has considered the "purposes and concerns" of the underlying statutory framework. *See Judulang*, 565 U.S. at 64. The Secretary provided the agency's reasons for reaching its interpretation of the phrase "entitled to benefits under [Medicare] part A" when the Secretary published the 2005 Final Rule. *See* 69 Fed. Reg. 49,098-99 (Aug. 11, 2004). The Secretary stated that the agency "proposed this change to facilitate consistent handling of [Medicare Part A] days across all hospitals." *Id.* at 49,098. The Secretary considered and responded to the comments that had been submitted before adopting a policy to include the patient-days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage. *Id.* at 49,098-99. Based upon the Secretary's rationale in the 2005 Final Rule, the Court concludes that the Secretary's decision to count all the patient-days of individuals qualified for Medicare Part A, regardless of whether they are receiving coverage under Medicare Part A, must be given controlling weight. *See Chevron*, 467 U.S. at 843.

The Court finds that Congress provided no express guidance regarding how Medicare Part A patient-days should be counted for the purposes of assessing the DPP in assessing the DSH adjustment. Therefore, the Court finds permissible the Secretary's interpretation of "entitled to benefits under [Medicare] part A" in § 1395ww, and, under *Chevron*, the Court defers to the Secretary's construction. *See Chevron*, 467 U.S. at

843. Although it finds that 42 C.F.R. § 412.106(b)(2) is substantively valid based upon the Secretary's statutory interpretation, the Court also must analyze whether 42 C.F.R. § 412.106(b)(2) is procedurally valid.

II. Procedural Validity of 42 C.F.R. § 412.106(b)(2)

Empire argues that the Secretary did not follow proper notice-and-comment procedures in the implementation of the 2005 Final Rule because the Secretary misstated his then-existing policy in the 2003 Notice of Proposed Rulemaking, invalidating the 2005 Final Rule. ECF No. 34 at 19-20. The Secretary contends that the 2005 Final Rule was properly adopted despite the Secretary's misstatement of the agency's policy in the 2003 Notice of Proposed Rulemaking; the Rule is a logical outgrowth of the proposed rule; and the Rule is, therefore, procedurally valid. *See* ECF No. 46 at 27-30.

A. Rulemaking Process Leading to the 2005 Final Rule

The rulemaking process leading to the promulgation of the 2005 Final Rule occurred over a two-year period. In both May 2003 and May 2004, the Secretary published a notice of proposed rulemaking in anticipation of promulgating a final rule for the upcoming federal fiscal year. Between May and July each year, an approximately two-month-long open comment period followed each notice of proposed rulemaking, one in 2003 and one in 2004. In August 2003 and August 2004, the Secretary promulgated final rules for the upcoming federal fiscal year, the 2004 Final Rule and the 2005 Final Rule, respectively.

The Secretary did not adopt the 2003 proposal in the 2004 Final Rule and stated that the Secretary would address the comments regarding the agency's proposal in a later document. Likewise, the 2004 notice of proposed rulemaking merely stated that the Secretary would address the comments that the agency had received in a forthcoming rule. *See* 69 Fed. Reg. 28,286 (May 18, 2004). The first time that the Secretary addressed the comments submitted regarding the 2003 notice of proposed rulemaking was in the promulgation of the 2005 Final Rule. *See infra* Part II.A.6.

A recent district court case decided in the D.C. Circuit, *Stringfellow Memorial Hospital v. Azar*, provides a thorough history of the rulemaking process for the 2005 Final Rule as it relates to the Secretary's amendment of his policy regarding the application of "entitled to benefits under [Medicare] part A" in the Medicare fraction of the DPP provision. *See Stringfellow Mem'l Hosp. v. Azar*, Civil Action No. 17-309 (D.D.C. June 29, 2018). The Court recommends reading *Stringfellow* for a detailed description of the Secretary's rulemaking process, which the Court will repeat here only in relevant part.

1. 2003 Notice of Proposed Rulemaking

In May 2003, the Secretary issued a notice of proposed rulemaking for the 2004 fiscal year that proposed a change in how he treated individuals not receiving Medicare Part A benefits for purposes of the DPP calculation and DSH adjustment. *See* 68 Fed. Reg. 27,154 (May 19, 2003). The Secretary inaccurately stated that the agency's then-existing policy counted all dual-eligible patient-days in the Medicare fraction, excluding them from the Medicaid fraction, even if the patient was not

receiving Medicare Part A benefits. *See id.* at 27,207-08. The Secretary proposed to change this policy for counting the patient-days of Medicare Part A beneficiaries whose Medicare Part A coverage had been exhausted. He proposed to count exhausted Medicare Part A patient-days in the Medicaid fraction of the DPP provision. *See id.* at 27,208-09.

2. Initial 2003 Comment Period for 2003 Proposed Rule

An initial open comment period followed the 2003 notice of proposed rulemaking, with a July 18, 2003 deadline for the submission of comments. 68 Fed. Reg. 27,154 (May 19, 2003).

Many commenters supported the policy that the Secretary had described as the then-existing policy: the inclusion of dual-eligible patient-days in the Medicare fraction of the DPP provision, regardless of whether the patient's Medicare Part A coverage had been exhausted. *See, e.g.*, AR at 486R; 583R; 718R; 816R. These commenters indicated that they opposed the proposed change to begin including dual-eligible exhausted patient-days in the numerator of the Medicaid fraction.

For example, the American Hospital Association ("AHA") opposed the proposed change because the [Centers for Medicare and Medicaid Services ("CMS")] provided "no justified reason for making this change, and there are clear reasons not to make this change." Administrative Record ("AR") at 754R. The AHA noted that "the proposed change would place a significant new regulatory and administrative burden on hospitals," and that "CMS clearly states in the proposed rule that the current formula is consistent with statutory intent."

Id. In addition, the AHA explained that "it is likely that this proposed change would result in reduced DSH payments to hospitals," because "[a]ny transfer of a particular patient day from the Medicare fraction (based on total Medicare patient days) to the Medicaid fraction (based on total patient days) will dilute the value of that day, and therefore reduce the overall patient percentage and the resulting DSH adjustment." *Id.* at 754-55R. The AHA stated that "the calculation of dual-eligible days must not be changed." *Id.* at 755R.

A number of commenters echoed the AHA, opposing the proposed change on the grounds that the change would result in large administrative burdens for hospitals. *See, e.g., id.* at 486R (comments of Association of American Medical Colleges that the "current policy is consistent with statutory intent" and that the proposed policy will impose a "new administrative burden . . . on hospitals to provide documentation"); *id.* at 583R (comments of Healthcare Association of New York State that "it will be difficult for hospitals to provide the data required under this proposal").

Two commenters supported the proposed policy change. *See id.* at 566R (comments in support from BlueCross BlueShield); *id.* at 860R (comments in support from the law firm Vinson & Elkins). In addition to supporting the Secretary's proposed policy, Vinson & Elkins also expressed confusion about the Secretary's statement of the then-existing policy. *See id.* at 860R. Vinson & Elkins "disagree[d] . . . that CMS' description of its past practice is correct." *Id.* Specifically, Vinson & Elkins noted that the proposed rule was "at odds with the plain language of the regulation" gov-

erning the DSH adjustment, which stated that the Medicare fraction included "'covered patient days' only"—in other words, unexhausted days only. *Id.* at 861R (quoting 42 C.F.R. § 412.106(b)(2)(i) before its amendment). That is, the Secretary's stated proposed rule was actually the manner in which dual-eligible exhausted days were currently being handled and the exact opposite of the policy the Secretary had put forth as the then-existing policy. Vinson & Elkins urged CMS to correct its misstatement, arguing that if the agency chose to stand by those statements, "it will squander its credibility with the courts and set[ ] itself up not only to lose as the issue is litigated but to subject itself to paying attorney fees and other sanctions." *Id.*

Southwest Consulting Associates ("SCA") also wrote to identify the misstatement, noting that "CMS' statement 'the days of patients who have exhausted their Medicare Part A coverage will no longer be included in the Medicare fraction' is inconsistent with CMS' current actual practice with respect to the Medicare fraction." *Id.* at 405R. SCA had obtained a letter from the U.S. Department of Health and Human Service's Office of General Counsel, dated August 14, 2001, "stating that only covered days [that is, unexhausted days] are used in the [Medicare] fraction." *Id.*; *see also id.* at 363R (letter from Linda Banks, CMS, to Christopher Keough, noting that "the Medicare/SSI denominator includes only the covered days," not exhausted days). Thus, SCA noted that "[t]o say that [exhausted] days 'will no longer be included'" in the Medicare fraction "may be a change in 'policy,' but it is clearly not a change in 'practice.' That begs the question—What was the 'policy'—what CMS professed or what it did?" *Id.* at 405R.

3. 2004 Final Rule

On August 1, 2003, the Secretary issued a final rule for the 2004 fiscal year. Regarding the treatment of dual-eligible patient-days, the Secretary noted that "[w]e are still reviewing the large number of comments received on the proposed provision relating to dual-eligible patient days in the May 19, 2003 [sic]. Due to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document." 68 Fed. Reg. 45,346, 45,421 (Aug. 1, 2003). The 2004 Final Rule did not acknowledge or address the commenters' concerns that the agency may have misstated its then-existing policy by confusing its current practice with its proposed practice. No other document or notice followed between August 1, 2003, and May 2004.

4. 2004 Notice of Proposed Rulemaking

In May 2004, the Secretary issued a notice of proposed rulemaking for the 2005 fiscal year for general changes to the Medicare system. The 2004 notice of proposed rulemaking stated that the comments relating to dual-eligible patient-days would be addressed in a forthcoming final rule. 69 Fed. Reg. 28,286 (May 18, 2004). The Secretary explained that "[d]ue to the number and nature of the public comments received, we did not respond to the public comments on these proposals in the [2004 Final Rule]." *Id.* The Secretary did not mention any possible misstatement of his policy for handling dual-eligible days or any confusion regarding the agency's current policy and its proposed policy.

5. 2004 Comment Period for 2004 Notice of Proposed Rulemaking and the Secretary's Clarification of the Agency's Policy

An open comment period followed the publication of the 2004 notice of proposed rulemaking. This comment period closed on July 12, 2004. 69 Fed. Reg. 28,196 (May 18, 2004). During the 2004 comment period, many of the same commenters again wrote to the Secretary, opposing the proposed rule and supporting the policy that the Secretary had described as the then-existing policy.

Approximately three days[2] before the 2004 comment period closed, the Secretary issued a clarification via the CMS website regarding the agency's statement of its then-existing policy for counting exhausted patient-days for dual-eligible individuals. *See* AR at 340R; *see also* 69 Fed. Reg. 49,098 (Aug. 11, 2004) ("A notice to this effect was posted on CMS's website . . . on July 9, 2004."). In the CMS website clarification notice, the Secretary noted his misstatement of the agency's then-

[2] During oral argument, both parties acknowledged that the Secretary published his statement four days before the end of the 2004 comment period. In its pleadings, Empire first states that the Secretary published the clarification of the agency's then-existing policy on July 9, 2004, ECF No. 34 at 19, but later states that the clarification was published on July 7, 2004. *See* ECF No. 48 at 12. The Federal Register indicates that the notice was published on the CMS website on July 9, 2004. 69 Fed. Reg. 49,098 (Aug. 11, 2004). The archived website page containing the notice indicates that it was last modified on July 7, 2004. AR at 340R. For the purposes of this Court's analysis, it makes no difference whether the Secretary cured his misstatement on July 7, 2004, or July 9, 2004, leaving between three and five days for interested parties to comment.

existing policy in the 2003 notice of proposed rulemaking, and concluded: "It has come to our attention, however, that [our previous statement of our policy] is not accurate. Our policy has been that only covered patient days are included in the Medicare fraction (42 C.F.R § 412.106(b)(2)(i))." AR at 340R.

Following the Secretary's clarification notice, numerous commenters submitted comments opposing the proposed rule. *See, e.g.*, *id.* at 30-31R (comments of California Healthcare Association dated July 12, 2004, which do not mention the website notice, and restate the policy and proposal in line with the Secretary's inaccurate statements in the 2003 notice of proposed rulemaking); *id.* at 130R (comments of New Jersey Hospital Association dated July 12, 2004, restating the inaccurate policy articulated by the Secretary in the 2003 notice of proposed rulemaking and objecting to the proposed rule); *id.* at 152R (comments of Catholic Healthcare West dated July 9, 2004, laying out a similar argument). The reasons commenters provided for this opposition were substantially the same as those submitted in the 2003 comment period regarding concerns about the administrative burden and costs of implementing the proposed change. As support for their opposition, commenters also cited the Secretary's 2003 statement that the agency's then-existing policy was consistent with statutory intent. *See, e.g.*, *id.* at 130R (comments of New Jersey Hospital Association).

Several commenters mentioned the Secretary's website posting in their comments. *See, e.g.*, AR at 82R (comments of the Federation of American Hospitals, stating that "CMS admitted in a July 7, 2004[,] bulletin that it had been mistaken in its assertion that Part A

Exhausted/Noncovered Days were in the Medicare percentage"). The Federation of American Hospitals ("FAH"), which had written in opposition to the proposed rule during the first comment period, AR at 789R (submitted July 8, 2003), wrote to discuss the Secretary's misstatement. *Id.* at 81-82R. In its July 12, 2004, comment, FAH explained that, "[w]hen drafting its comments for FY 2004, FAH took at face value CMS's statement that, historically, Part A Exhausted/Noncovered Days have been included in the Medicare fraction." *Id.* at 81R. "Assuming that this was true, and concerned that, if moved to the Medicaid fraction, the burden would be on the provider to identify these days, which might result in a lower number of days counted, FAH argued for a continuation of the existing policy to include these days in the Medicare percentage." *Id.* Since submitting its initial comments, however, "FAH ha[d] been informed that at least one knowledgeable fiscal intermediary, and possibly members of CMS staff, have indicated that further research has confirmed that such days are, in fact, not currently (and never were) included in the Medicare percentage." *Id.* at 82R. FAH thus urged the Secretary to "continue to accept comments on this issue." *Id.* at 81R. In addition, FAH argued that dual-eligible exhausted days should be included in the Medicare fraction, but that "[i]f such days are not counted in the Medicare fraction, then the days must be counted in the Medicaid fraction." *Id.* at 82R.

The National Association of Public Hospitals and Health Systems ("NAPH") submitted its comment on July 8, 2004, stating, "we are deeply troubled by the recent web posting of a modification of these comments on the CMS website." *Id.* at 288R. The NAPH comment

continued, "by posting [the notice] a few days before the FY 2005 IPPS proposed rule comments are due, CMS has limited the ability of the provider community to properly analyze and comment on this policy in the context of the proposed rule." *Id.* at 289R. NAPH expressed that it strongly opposed "a proposed change in the treatment of dual eligible patients who have exhausted their Medicare coverage for the purpose of counting patient days for the calculation of the Medicare DSH patient percentage." *Id.* at 286R.

6. 2005 Final Rule

In August 2004, the Secretary promulgated the 2005 Final Rule at issue in this case ("2005 Final Rule"). *See* 69 Fed. Red. 49,098 (Aug. 11, 2004). In the publication of the 2005 Final Rule, the Secretary acknowledged for the first time in the Federal Register that the agency had "misstated [its] current policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003," *id.* at 49,098, and noted that "[a] notice to this effect was posted on CMS's Web site on July 9, 2004," *id.* (internal citation omitted). The agency clarified that, "[i]n that proposed rule, we indicated that a dual-beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. . . . This statement was not accurate. Our policy has been that only covered patient days are included in the Medicare fraction." *Id.*

The Secretary responded to various comments and then adopted his final rule, the policy he had stated in 2003 as the agency's then-existing policy and the policy now at issue before this Court. The Secretary noted

that CMS had "received numerous comments that commenters were disturbed and confused by our recent Web site posting regarding our policy on dual-eligible patient days," and that many commenters "believed that this posting was a modification or change in our current policy" that required "formal notification by CMS" and an "opportunity for providers to comment." *Id.* The Secretary responded that the website notice "was not a change in our current policy" and that, because the posting "was not a new proposal or policy change," the Secretary did not need to "utilize the rule making process in correcting a misstatement that was made in the May 19, 2003[,] proposed rule regarding this policy." *Id.*

The 2005 Final Rule "adopt[ed] a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage." *Id.* at 49,099. In other words, the Secretary adopted the policy he had inaccurately described at the then-existing policy. The amended regulation also considered patients who elect coverage under Part C of the Medicare Act, the "Medicare Advantage" program that provides benefits through a managed care plan, to be "entitled to benefits under Part A" for purposes of the Medicare fraction. *See id.* Ultimately, the 2005 Final Rule led to the amendment of 42 C.F.R. § 412.106(b)(2), which removed "covered" from the language of the regulation describing the assessment of Medicare Part A patient-days in the Medicare fraction. Prior to the amendment of the rule, 42 C.F.R. § 412.106(b)(2) stated that the numerator of the Medicare fraction included "the number of *covered* patient days . . . furnished to patients who during that month were entitled to both Medicare

Part A and SSI." *See* ECF No. 34 at 12 (emphasis added).

B. Compliance with APA Notice Requirements

Empire disputes the validity of the Secretary's promulgation of the 2005 Final Rule, which did not adopt the Secretary's proposed rule, but instead implemented the rule the Secretary had described inaccurately as the agency's then-existing policy. *See* ECF No. 34 at 18.

It is undisputed that the Secretary misstated the agency's then-existing policy in the 2003 Notice of Proposed Rulemaking and failed to correct the misstatement until approximately three days before the conclusion of the comment period preceding the promulgation of the 2005 Final Rule. Therefore, the Court considers whether the Secretary's notice regarding the treatment of Medicare Part A patient-days in the DPP provision failed to comply with the APA's notice requirements and was procedurally insufficient.

The APA generally requires a federal agency engaged in rulemaking to comply with notice-and-comment procedures. *See* 5 U.S.C. § 553(b). Specifically, a "notice of proposed rulemaking" must be "published in the Federal Register" and must notify the public of "the time, place, and nature of public rule making proceedings," "the legal authority under which the rule is proposed," and "the terms or substance of the proposed rule or a description of the subjects and issues involved." *Id.* § 553(b)(1)-(3). "After notice required by this section, the agency shall give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments with or without opportunity for oral presentation." *Id.* § 553(c). The

agency must publish notice of a proposed rule more than thirty days before its effective date. *Id.* § 553(d). Certain agency rulemaking is required by statute to be made on the record after opportunity for an agency hearing. *Id.* § 553(c). "A decision made without adequate notice and comment is arbitrary or an abuse of discretion." *NRDC v. United States EPA*, 279 F.3d 1180, 1186 (9th Cir. 2002).

The object of the notice requirement is fair notice. *Long Island Care at Home, Ltd. v. Coke*, 551 U.S. 158, 174 (2007). Agencies "must provide notice sufficient to fairly apprise interested persons of the subjects and issues before the Agency." *NRDC*, 279 F.3d at 1186. Interested parties must have a meaningful opportunity to comment on the proposed regulation the agency contemplates. *See Safe Air for Everyone v. United States EPA*, 488 F.3d 1088, 1098 (2007).

Notice is generally considered adequate when interested parties reasonably could have anticipated the final rulemaking. *See NRDC*, 279 F.3d at 1186. In determining whether interested parties could reasonably have anticipated the final rule from the draft, "one of the salient questions is 'whether a new round of notice and comment would provide the first opportunity for interested parties to offer comments that could persuade the agency to modify its rule.'" *Id.* (quoting *Am. Water Works Ass'n v. EPA*, 40 F.3d 1266, 1274 (D.C. Cir. 1994)). Another consideration is whether the changes in the final rule are "a logical outgrowth of the notice and comments received." *Rybachek v. United States EPA*, 904 F.2d 1276, 1288 (9th Cir. 1990).

To determine whether the agency has complied with the APA notice requirements, the court inquires whether "the notice fairly apprise[s] the interested persons of the subjects and issues before the Agency." *Louis v. U.S. Dep't of Labor*, 419 F.3d 970, 975 (9th Cir. 2005). A Federal Register notice of proposed rulemaking must provide basic factual information about what an agency proposes to do. *State of Cal. ex rel. Lockyer v. FERC*, 329 F.3d 700, 708 (9th Cir. 2003) [hereinafter "*Lockyer*"]. "An interested member of the public should be able to read the published notice of [a rulemaking] and understand the 'essential attributes' of that [rulemaking]. . . . A member of the public should not have to guess the [agency's] 'true intent.'" *Id.* at 707.

Empire argues that the Secretary did not provide adequate notice under the APA regarding the impact the policy would have on Medicare Secondary Payer patient-days by removing the word "covered" from 42 C.F.R. § 412.106(b), and that interested parties were entitled to know that the proposed change would impact both kinds of patient-days. *See* ECF No. 34 at 20. The Secretary contends that notice was adequate because the two policies delineated in the 2003 Notice of Proposed Rulemaking encompassed both dual-eligible and Medicare Secondary Payer patient-days, and interested parties should have known that the proposed change would impact both kinds of patient-days. ECF No. 46 at 30. The Secretary argues that the legal question is only whether notice was adequate despite the Secretary's misstatement about the agency's current policy.

In support of his adequate notice argument, the Secretary argues that he received a number of comments

opposing the 2003 proposed rule and supporting the policy that the Secretary inaccurately described as the agency's then-existing policy, and that he provided an explanation for the rule ultimately adopted in the 2005 Final Rule. *See* 69 Fed. Reg. 49,098-99 (Aug. 11, 2004). The Secretary asserts that the comments that he received indicated that interested parties understood that a change in the policy relating to dual-eligible beneficiaries in the Medicare fraction was under consideration, and therefore that they meaningfully participated in the notice-and-comment process. *See* ECF No. 46 at 30. This, the Secretary contends, is sufficient to demonstrate that the Secretary provided notice sufficient to comply with the APA. *See* ECF No. 46 at 27-30.

The Court observes that Medicare is a particularly complex regulatory system, with many interrelated rules which may have significant impacts on both Medicare recipients and health care providers. In many administrative regimes, like Medicare, extensive administrative costs may be associated with the implementation of any policy change. The Court notes that many of the commenters who opposed the proposed change expressed concern for the administrative burden and costs that would be associated with implementing the proposed change. *See supra* Part II.A. Therefore, it is possible that the same commenters who expressed opposition to the Secretary's 2003 notice of proposed rulemaking would have expressed similar opposition to any proposed change in the Secretary's policy regarding dual-eligible patient-days. For example, one commenter, AHA, opposed the Secretary's proposed change, stating that "the calculation of dual-eligible days must not be changed." AR at 754-55R. However, when the AHA

argued against a change in policy, AHA took at face value the Secretary's statement of the agency's then-existing policy, AR at 81R, leading the Court to ask: Which policy was AHA advocating, the policy that the Secretary actually maintained at the time or the policy that the Secretary inaccurately stated that it maintained?

The Court finds that when the Secretary misstated the agency's then-existing policy and then failed to provide additional notice and time to comment after the Secretary corrected his misstatement, the Secretary's misstatement undermined the validity of the notice, making it insufficient "to provide the public with a meaningful 'opportunity to comment on [the proposed] provisions.'" *Hall v. United States iEPA*, 273 F.3d 1146, 1162 (9th Cir. 2001). The Court finds that interested parties could not have understood the essential attributes of the proposed rule when the Secretary and the agency misunderstood and misstated them. *See Lockyer*, 329 F.3d at 707; *see also NRDC*, 279 F.3d at 1186 (stating that one of the key considerations is "whether a new round of notice and comment would provide the first opportunity for interested parties to offer comments that could persuade the agency to modify its rule"). In addition, it is undisputed that the Secretary did not provide a 30-day period to receive comments, as required by 5 U.S.C. § 553(b), after the Secretary corrected his prior misstatement.

In this case, the Court finds that a new round of notice and comment would have provided the first meaningful opportunity for interested parties to offer comments. In order to preserve the democratic process we

value so highly, it is important to allow people to understand the actual issues being considered. When the Secretary misstated the then-existing policy, potential commenters could have been lulled into thinking that they did not have to comment. If the Secretary had made an accurate statement of the then-existing policy, certain commenters who did not file comments may have had the impetus to file a comment in order to affect the Secretary's promulgation of the rule. In fact, during the 2003 comment period, at least two commenters noted that they were confused by the Secretary's prior misstatement, *see infra* Part II.A.2. After the Secretary issued the notice correcting the policy statement in 2004, at least one commenter expressly stated that it had relied upon the Secretary's statement of the agency's policy when drafting its initial comments. *See infra* Part II.A.5. Additionally, after the Secretary published the notice regarding the misstatement of the agency's policy, the commenter, Federation of American Hospitals ("FAH"), urged the Secretary to continue to accept comments on this issue. *Id.*

Another aspect of adequate notice courts consider is whether the final rule is a logical outgrowth of the proposed rule. *See Rybachek*, 904 F.2d at 1288. In the case of *Long Island Care at Home v. Coke*, the Supreme Court considered a proposed rule subjecting certain individuals to wage and hour rules. *Id.*, 551 U.S. 158 (2007). "The clear implication of the proposed rule was that companionship workers employed by third-party enterprises that *were not* covered by the [Fair Labor Standards Act ('Act')] prior to the 1974 Amendments . . . *would* be included within the [new rule]." *Id.* at

174-75 (emphasis in original). The agency then withdrew the proposal and promulgated its final rule. "The result was a determination that exempted *all* third-party-employed companionship workers from the Act." *Id.* at 175. Concluding that the final rule was a logical outgrowth of the proposed rule, the Supreme Court stated, "We do not understand why such a possibility was not reasonably foreseeable." *Id.* Likewise, the Secretary argues that the agency's proposed rule created a reasonably foreseeable outcome. ECF No. 46 at 30. However, in *Long Island Care*, the interested parties could reasonably foresee the final rule because the agency accurately stated its then-existing policy and proposal. *See Long Island Care at Home*, 551 U.S. at 174-75. In this case, interested parties could not reasonably foresee the final rule because of the Secretary's misstatement about the agency's then-existing policy.

Despite the Secretary's failure to accurately state the agency's then-existing policy or to provide additional time for notice and comment after correcting his misstatement, the Secretary argues that the 2003 Notice of Proposed Rulemaking put interested parties on notice that either of the two options mentioned might be adopted. *See* ECF No. 48 at 15; *see also Stringfellow Memorial Hosp. v. Azar*, Civil Action No. 17-309 (D.D.C. June 29, 2018) (stating that the "2004 Proposed Rule thus put parties on notice that either of these two options might be adopted"). The Secretary argues that the 2005 Final Rule is a logical outgrowth of the 2003 and 2004 Notices of Proposed Rulemaking because the Secretary decided not to adopt the proposed change and, instead, adopted its stated policy. ECF No. 46 at

27-29. Citing an out-of-circuit case, the Secretary argues that "[a]n agency's 'refusal to adopt its proposed' rule is always a logical outgrowth of the proposal." *Id.* at 28 (quoting *Envt'l Integrity Proj. v. EPA*, 425 F.3d 992, 997 (D.C. Cir. 2005)).

The Court finds the Secretary's argument illogical in this case, where the Secretary misstated the agency's then-existing policy and failed to remedy its misstatement until approximately three days before the close of the 2004 comment period. The argument that an agency's refusal to adopt a proposed rule is a logical outgrowth of the proposal might be true when the agency's statement of its then-existing policy and its proposal are both accurate. Here, however, where the Secretary misstated the agency's then-existing policy, the Court finds that the Secretary's refusal to adopt the agency's proposed rule cannot be presumed to be a logical outgrowth of the proposal, because the inaccuracy of the policy statement necessarily distorts the context of the proposed rule. Without an accurate context in which to view the Secretary's proposed rule, interested persons cannot know what to expect and have no basis on which to make their comments.

The Court concludes that where interested parties did not have accurate notice of the then-existing policy and the potential change that the rule would effect, the interested parties are deprived of a meaningful opportunity to comment. The Court also concludes that interested parties could not have reasonably anticipated the Secretary's final rulemaking where the Secretary's notice of proposed rulemaking contained a misstatement of then-existing agency policy. *See NRDC, Inc. v. United States EPA*, 863 F.2d 1420, 1429 (9th Cir.

1988). The Court finds that a new round of notice and comment would provide the first opportunity for interested parties to offer meaningful comments in this case. *See NRDC*, 279 F.3d at 1186. Therefore, the Court finds that the 2005 Final Rule is not a logical outgrowth of the 2003 Notice of Proposed Rulemaking, and that the Secretary's notice was inadequate to satisfy the procedural rulemaking requirements of the APA.

C. Harmless Error Rule

Because the Court has found that the Secretary's notice was inadequate and that the 2005 Final Rule was not a logical outgrowth of the proposed rule, the Court is obligated to take "due account . . . of the rule of prejudicial error." 5 U.S.C. § 706(2); *see also Rybachek*, 904 F.2d at 1295. "To avoid gutting the APA's procedural requirements, harmless error analysis in administrative rulemaking must therefore focus on the process as well as the result." *Riverbend Farms, Inc. v. Madigan*, 958 F.2d 1479, 1487 (9th Cir. 1992).

The Ninth Circuit has held that "the failure to provide notice and comment is harmless only where the agency's mistake 'clearly had no bearing on the procedure used or the substance of the decision reached.'" *Id.* (quoting *Sagebrush Rebellion, Inc. v. Hodel*, 790 F.2d 760, 764-65 (9th Cir. 1986)). Otherwise, a failure to comply with APA requirements is harmful and prejudicial and in violation of the APA. *See* 5 U.S.C. § 706(2). The Ninth Circuit quoted the United States Supreme Court's approach to harmless error, in which the party "seeking to reverse the result of a civil proceeding will likely be in a position . . . to explain how he has been hurt by an error." *See Cal. Wilderness Coalition v. United States DOE*, 631 F.3d 1072, 1091 (9th Cir. 2011)

(quoting *Shinseki v. Sanders*, 129 S. Ct. 1696, 1706 (2009)). The Ninth Circuit concluded that the Supreme Court's approach is consistent with the Ninth Circuit's harmless error standard. *Id.* at 1091-92.

The Ninth Circuit has found agency error harmless in several cases. An error was harmless when an agency failed to comply with APA notice-and-comment requirements but held hearings in compliance with another federal statute. *See Sagebrush Rebellion, Inc.*, 790 F.2d at 763. When an agency erred in applying the good cause exception to the APA's notice-and-comment requirements, the court found harmless error because all the parties knew the ground rules and process, which has been in place for a decade. *See Riverbend Farms, Inc.*, 958 F.2d at 1485. Finally, the court found harmless error when an agency published a final determination early because it had complied substantially with all of the other APA requirements and there was no prejudice as a result of the error. *County of Del Norte v. United States*, 732 F.2d 1462 (9th Cir. 1984).

However, this case presents a different set of facts. The Court finds that the Secretary's late announcement of its misstatement on the CMS website, without providing publication in the Federal Register or any additional opportunity for public comment, undermined the substance of the decision reached because the Secretary did not have the benefit of useful comments by interested parties. *See Riverbend Farms, Inc.*, 958 F.2d at 1487. Furthermore, direct injury occurred. The Hospital was injured because of lack of reimbursement, *see* ECF No. 1, and the lack of reimbursement is because of the 2005 Final Rule that was promulgated without sufficient notice.

Therefore, the Court concludes that the Secretary's misstatement undermined the notice requirement under the APA to the extent that the Secretary provided inadequate, inaccurate notice in the 2003 and 2004 notices of proposed rulemaking and insufficient opportunity for meaningful comment after the Secretary corrected his misstatement. The Court finds that the Secretary's error was not harmless.

In conclusion the Court finds that although 42 C.F.R. § 412.106(b)(2) is substantively valid, it is procedurally invalid under the APA because the Secretary's notice and comment opportunity was inadequate and that the 2005 Final Rule was not a logical outgrowth of the proposed rule. The Court grants summary judgment in favor of Empire, and vacates the amendment of 42 C.F.R. § 412.106(b)(2) in the 2005 Final Rule. The Court enjoins the Secretary from applying to the Plaintiff Hospital for the 2008 fiscal year the 2005 Final Rule policy that unpaid Medicare Part A days are patient-days "entitled to benefits under [Medicare] part A" for the purposes of assessing the Medicare fraction of the DPP. The Court directs the Secretary to calculate the Plaintiff Hospital's DSH payment consistent with this Order and to make prompt payment of any additional amounts due to the Plaintiff Hospital plus interest calculated in accordance with 42 U.S.C. §1395oo(f)(2).

III. Empire's Challenge to the Secretary's Assessment of SSI Entitlement

Empire argues that the Secretary's "decision to include in the DSH calculation only those limited [SSI] beneficiaries receiving a cash SSI payment runs counter to the plain language of the DSH statute and Congress's intent to have Medicare-entitled SSI enrollees serve as

a proxy for low-income patients." ECF No. 34 at 30. Therefore, Empire argues, the Secretary's policy of using Social Security Administration payment codes to determine SSI benefit recipients is contrary to the DSH statute and regulation and "actually provides a *less* reliable index of the poverty of the population served by a given hospital." *Id.* at 31 (emphasis in original). Empire argues that the Secretary's SSI policy is due no *Chevron* deference, and that the Secretary's "interpretation to exclude unpaid SSI days from the DSH calculation is invalid under 5 U.S.C. § 706(2). *Id.* at 31-32.

The Secretary contends that the Board did not grant the Court jurisdiction to review the Secretary's policy regarding the methodology for identifying patients "entitled to SSI benefits." ECF No. 46 at 32-33. The Secretary argues that the Board's grant of expedited judicial review is narrow and limited in its scope to "the legal question" of "whether . . . 42 C.F.R. § 412.106(b)(2) is valid." *Id.* at 32.

The Medicare fraction in 42 C.F.R. § 412.106(b)(2) refers to SSI entitlement, and, therefore, the Secretary's interpretation of the phrase "entitled to [SSI] benefits" in 42 U.S.C. § 1395ww(d)(5)(F)(vi) arguably falls within the scope of this Court's expedited judicial review. However, the Court finds that Empire challenges the Secretary's policy regarding the determination of which individuals are entitled to SSI benefits, which is not adopted as a substantive rule and which does not relate to the specific legal question of the validity of 42 C.F.R. § 412.106(b). Instead, Empire asks this Court to determine whether the Secretary's policy regarding the determination of which individuals are entitled to SSI benefits is valid, which is not within the scope of the Board's

grant for expedited judicial review. Empire's attempts to frame the SSI entitlement issue in terms of the DPP provision fail. Accordingly, the Secretary's policy regarding the assessment of SSI entitlement falls outside the scope of the Court's jurisdiction in this matter and will not be addressed by the Court.

IV. Empire's Medicare Part C Challenge

Empire also challenges the validity of the inclusion of Part C coverage days in the Hospital's 2008 fiscal year DSH calculation. ECF No. 1 at 11. Both the Hospital and the Secretary have agreed that this Court should remand the Part C issue back to the Board. Accordingly, the Court remands the determination of the validity of the inclusion of Part C coverage days in the Hospital's 2008 fiscal year DSH calculation to the Provider Reimbursement Review Board.

Accordingly, **IT IS HEREBY ORDERED**:

1. Plaintiff's Motion for Summary Judgment, **ECF No. 34**, is **GRANTED IN PART** as to Empire's procedural claims and **DENIED IN PART** as to Empire's substantive claims, SSI-entitlement assessment claim, and Medicare Part C claim.

2. Defendant's Cross-Motion for Summary Judgment, **ECF No. 46**, is **DENIED**.

3. Plaintiff's challenge to the validity of the assessment of Medicare Part C days is remanded to the Provider Reimbursement Review Board.

4. The Court directs the Secretary to calculate the Plaintiff Hospital's DSH payment for the 2008 fiscal year consistent with this Order and to make prompt payment of any additional amounts

due to the Plaintiff Hospital plus interest calculated in accordance with 42 U.S.C. §1395oo(f)(2).

5. For the purposes of assessing the Medicare fraction of the disproportionate patient percentage for the Plaintiff Hospital, the Court enjoins the Secretary from applying the policy adopted in the 2005 Final Rule that unpaid Medicare Part A days are "days entitled to benefits under [Medicare] part A."

6. Judgment shall entered for **Plaintiff**.

7. The Parties shall each bear their own costs.

The District Court Clerk is directed to enter this Order, **enter judgment accordingly**, provide copies to counsel, and **close this case**.

DATED Aug. 13, 2018.

/s/ <u>ROSANNA MALOUF PETERSON</u>
ROSANNA MALOUF PETERSON
United States District Judge

APPENDIX C

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REMIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2671

PHONE: 410-786-2671
FAX: 410-786-5298

Internet: www.cms.gov/PRRBReview

Refer to: 15-3126GC [APR 08 2016]

Certified Mail

Delbert Nord
Quality Reimbursement Services, Inc.
112 N. University Road
Suite 308
Spokane Valley, WA 99206

RE: QRS Empire Health 2008 SSI Percentage
Provider Nos. Various
FYE 9/30/2008
PRRB Case No. 15-3126GC

Dear Mr. Nord:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' February 8, 2015 request for expedited judicial review (EJR) (received February 12, 2016) and the Providers' March 16, 2016 response to the Board's request for additional information (received March 18, 2016). The Board's determination with respect to the EJR request is set forth below.

Exhibit "A"

Background

The issue presented in the Providers' original hearing request for the group appeal is:

> Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/ Supplemental Security Income ("SSI") percentage.[1]

The Providers' EJR request states that they are challenging the validity of CMS' regulation, 42 C.F.R. § 412.106(b)(2), specifically the application of "entitled" to in the denominator of the SSI fraction for DSH purposes. The Providers explain that effective October 1, 2004, CMS amended section 412.106 to change the previous regulation from "Determines the number of **covered** patient days" to "Determines the number of patient days."[2, 3]

As a result of this change, the Secretary considers an individual to be "entitled to benefits under part A" (e.g., exhausted days, Part C days, Medicare secondary payor days). Regardless of whether the days were covered or paid by Medicare, they will be included in the denominator of the SSI fraction. This change only affected the denominator of the fraction. The Providers note that, for purposes of the numerator of the DSH fraction, the Secretary requires that a beneficiary be paid SSI

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[1] Providers' July 31, 2015 Hearing Request; Tab2 (received August 3, 2015).

[2] Providers' EJR request at 1.

[3] The proposed change to the regulation was published in the August 11, 2004 Federal Register (69 Fed. Reg. 48,916, 49,098), but the regulation itself was not changed until the publication of the August 22, 2007 Federal Register (72 Fed. Reg. 47,140, 47,383).

benefits during the period of his or her hospital stay in order for such days to be included in the numerator.[4]

The Providers point out that the Secretary includes covered; non-covered, exhausted benefit, Medicare secondary payor, and Medicare Part C days in the numerator of the SSI fraction calculations, but only if the individual has received SS1 cash payments.[5] The Secretary does not include days in the numerator when individuals were eligible for SSI but were not due payment.

In addition, the Providers note that the Secretary uses only three Social Security Administration payment status codes, CO1, MO1, and MO2, to identify SSI entitled individuals.[6] Further, the Secretary is aware of other payment codes, as identified in the August 16, 2010 Federal Register, that could be used to determine the numerator of the SSI fraction.[7]

The Providers also included the language from the statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi) regarding entitled days and the language from the pre-2004 version of 42 C.F.R. § 412.106 that uses the covered language, as contrasted with the 2004 change.

(vi) In this subparagraph, the term "disproportionate patient percentage" means, with respect to a cost reporting period of a hospital, the sum of—

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[4] *See* 75 Fed. Reg. 50,042, 50,280 (Aug. 16, 2010).

[5] *Id.* at 50,280-81.

[6] *Id.* at 50,281.

[7] *Id.* at 50,280-81.

(I) the **fraction** (**expressed** as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were **entitled** to benefits under part A of this subchapter and were entitled to supplementary security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were **entitled** to benefits under part A of this subchapter, and

(II) the **fraction (expressed** as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX of this chapter, but who were not entitled to benefits under part A of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.

The 2003 regulation [prior to the actual change in language in 2008] states:

(b) *Determination of a hospital's disproportionate patient percentage—*

(1) *General rule.* A hospital's disproportionate patient percentage is determined by adding the results of two computations and expressing that sum as a percentage.

(2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—

(i) Determines the number of **covered** patient days that—

(A) Are associated with discharges occurring during each month; and

(B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation;

(ii) Adds the results for the whole period; and

(ii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of patient days that—

(A) Are associated with discharges that occur during that period; and

(B) Are furnished to patients entitled to Medicare Part A.

The change to the regulation which first appeared in the 2008 regulations omits the word "covered" and now states that

(b) *Determination of a hospital's disproportionate patient percentage*—

(1) *General rule.* A hospital's disproportionate patient percentage is determined by adding the results of two computations and expressing that sum as a percentage.

(2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—

(i) Determines the number of [ ] patient days that—

(A) Are associated with discharges occurring during each month; and

(B) Are furnished to patients who during that month were entitled to both Medicare Part A (or Medicare Advantage (Part C)) and SSI, excluding those patients who received only State supplementation;

(ii) Adds the results for the whole period; and

(iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of patient days that—

(A) Are associated with discharges that occur during that period; and

(B) Are furnished to patients entitled to Medicare Part A (or Medicare Advantage (Part C)).

Decision of the Board

Deaconess Medical Center

Deaconess Medical Center (Deaconess) (provider number 50-0044) is one of two participants in this group appeal. Deaconess filed an individual appeal of the crossover bad debts issue, which was assigned case number 13-0041. Subsequently, the issue under appeal in this

case, DSH SSI percentage/systemic errors issue, was added to the individual appeal and transferred to the current case. Through a jurisdictional determination issued February 23, 2016, the Board concluded that it lacked jurisdiction over the original issue appealed in case number 13-0041, crossover bad debts. Since there was not a jurisdictionally valid appeal to which the DSH SSI percentage issue could be timely added and transferred, those requests were denied. As a result of this February 23, 2016 action, Deaconess Medical Center is no longer a participant in case number 15-3126GC its request for EJR is denied.

Valley Hospital Medical Center

With respect to jurisdiction, the Board finds that the Provider timely filed its request for hearing and the amount in controversy the $10,000 threshold for an individual appeal.[8] Consequently, the Board concludes that it has jurisdiction over the appeal for Valley Hospital Medical Center under the provisions of 42 C.F.R. § 405.1840(a).

Upon finding jurisdiction for the specific matter at issue, the regulation at 42 C.F.R. § 405.1842(b)(1) requires that the Board determine whether it lacks the authority to decide the legal question. Here, the Board finds that it lacks the authority to decide the whether the regulation, 42 C.F.R. § 412.106(b)(2) (2008) is valid; therefore, EJR is appropriate for the issue under dispute in this case.

The Board finds that:

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[8] *See* 42 C.F.R. § 405.1835(a) (2005).

1) it has jurisdiction over the matter for the subject year and Valley Hospital Medical Center is entitled to a hearing before the Board;

2) based upon the Provider's assertions regarding the application of 42 C.F.R. § 412.106(b)(2), there are no findings of fact for resolution by the Board; and

3) it is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867).

Accordingly, the Board finds that the application of 42 C.F.R. § 412.106(b)(2) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(l) and hereby grants expedited judicial review for the issue and the subject year. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under appeal in this case, the Board hereby closes the case.

Board Members Participating

Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Anderson, Esq.
Charlotte F. Benson, CPA

Jack Ahern, MBA

FOR THE BOARD

/s/ MICHAEL W. HARTY
MICHAEL W. HARTY
Chairman

Enclosure: 42 U.S.C. § 1395oo(f)(1)

cc: Byron Lamprecht, WPS
Wilson Leong, FSS

APPENDIX D

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Nos. 18-35845, 18-35872
D.C. No. 2:16-cv-00209-RMP
EASTERN DISTRICT OF WASHINGTON, SPOKANE

EMPIRE HEALTH FOUNDATION, FOR VALLEY HOSPITAL MEDICAL CENTER, PLAINTIFF-APPELLEE

v.

ALEX M. AZAR II, SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, DEFENDANT-APPELLANT

[Filed: Oct. 20, 2020]

ORDER

Before: M. SMITH and N.R. SMITH, Circuit Judges, and TUNHEIM,[*] District Judge.

Judge M. Smith voted to deny the petition for rehearing en banc, and Judges N.R. Smith and Tunheim so recommended. The full court has been advised of the petition for rehearing en banc and no judge has requested

[*] The Honorable John R. Tunheim, United States Chief District Judge for the District of Minnesota, sitting by designation.

a vote on whether to rehear the matter en banc. Fed. R. App. P. 35.

The petition for rehearing en banc is DENIED.

APPENDIX E

1. 42 U.S.C. 426(a)-(c) provides:

Entitlement to hospital insurance benefits

(a) Individuals over 65 years

Every individual who—

(1) has attained age 65, and

(2)(A) is entitled to monthly insurance benefits under section 402 of this title, would be entitled to those benefits except that he has not filed an application therefor (or application has not been made for a benefit the entitlement to which for any individual is a condition of entitlement therefor), or would be entitled to such benefits but for the failure of another individual, who meets all the criteria of entitlement to monthly insurance benefits, to meet such criteria throughout a month, and, in conformity with regulations of the Secretary, files an application for hospital insurance benefits under part A of subchapter XVIII,

(B) is a qualified railroad retirement beneficiary, or

(C)(i) would meet the requirements of subparagraph (A) upon filing application for the monthly insurance benefits involved if medicare qualified government employment (as defined in section 410(p) of this title) were treated as employment (as defined in section 410(a) of this title) for purposes of this subchapter, and (ii) files an application, in conformity with regulations of the Secretary, for hospital insurance benefits under part A of subchapter XVIII,

shall be entitled to hospital insurance benefits under part A of subchapter XVIII for each month for which he meets the condition specified in paragraph (2), beginning with the first month after June 1966 for which he meets the conditions specified in paragraphs (1) and (2).

(b) Individuals under 65 years

Every individual who—

(1) has not attained age 65, and

(2)(A) is entitled to, and has for 24 calendar months been entitled to, (i) disability insurance benefits under section 423 of this title or (ii) child's insurance benefits under section 402(d) of this title by reason of a disability (as defined in section 423(d) of this title) or (iii) widow's insurance benefits under section 402(e) of this title or widower's insurance benefits under section 402(f) of this title by reason of a disability (as defined in section 423(d) of this title), or

(B) is, and has been for not less than 24 months, a disabled qualified railroad retirement beneficiary, within the meaning of section 231f(d) of title 45, or

(C)(i) has filed an application, in conformity with regulations of the Secretary, for hospital insurance benefits under part A of subchapter XVIII pursuant to this subparagraph, and

(ii) would meet the requirements of subparagraph (A) (as determined under the disability criteria, including reviews, applied under this subchapter), including the requirement that he has been entitled to the specified benefits for 24 months, if—

(I) medicare qualified government employment (as defined in section 410(p) of this title) were treated as employment (as defined in section 410(a) of this title) for purposes of this subchapter, and

(II) the filing of the application under clause (i) of this subparagraph were deemed to be the filing of an application for the disability-related benefits referred to in clause (i), (ii), or (iii) of subparagraph (A),

shall be entitled to hospital insurance benefits under part A of subchapter XVIII for each month beginning with the later of (I) July 1973 or (II) the twenty-fifth month of his entitlement or status as a qualified railroad retirement beneficiary described in paragraph (2), and ending (subject to the last sentence of this subsection) with the month following the month in which notice of termination of such entitlement to benefits or status as a qualified railroad retirement beneficiary described in paragraph (2) is mailed to him, or if earlier, with the month before the month in which he attains age 65. In applying the previous sentence in the case of an individual described in paragraph (2)(C), the "twenty-fifth month of his entitlement" refers to the first month after the twenty-fourth month of entitlement to specified benefits referred to in paragraph (2)(C) and "notice of termination of such entitlement" refers to a notice that the individual would no longer be determined to be entitled to such specified benefits under the conditions described in that paragraph. For purposes of this subsection, an individual who has had a period of trial work which ended as provided in section 422(c)(4)(A) of this title,

and whose entitlement to benefits or status as a qualified railroad retirement beneficiary as described in paragraph (2) has subsequently terminated, shall be deemed to be entitled to such benefits or to occupy such status (notwithstanding the termination of such entitlement or status) for the period of consecutive months throughout all of which the physical or mental impairment, on which such entitlement or status was based, continues, and throughout all of which such individual would have been entitled to monthly insurance benefits under this subchapter or as a qualified railroad retirement beneficiary had such individual been unable to engage in substantial gainful activity, but not in excess of 78 such months. In determining when an individual's entitlement or status terminates for purposes of the preceding sentence, the term "36 months" in the second sentence of section 423(a)(1) of this title, in section 402(d)(1)(G)(i) of this title, in the last sentence of section 402(e)(1) of this title, and in the last sentence of section 402(f)(1) of this title shall be applied as though it read "15 months".

(c) Conditions

For purposes of subsection (a)—

(1) entitlement of an individual to hospital insurance benefits for a month shall consist of entitlement to have payment made under, and subject to the limitations in, part A of subchapter XVIII on his behalf for inpatient hospital services, post-hospital extended care services, and home health services (as such terms are defined in part E of subchapter XVIII) furnished him in the United States (or outside the United States in the case of inpatient hospital services furnished under the conditions described in section 1395f(f) of this title) during such month; except that

(A) no such payment may be made for post-hospital extended care services furnished before January 1967, and (B) no such payment may be made for post-hospital extended care services unless the discharge from the hospital required to qualify such services for payment under part A of subchapter XVIII occurred (i) after June 30, 1966, or on or after the first day of the month in which he attains age 65, whichever is later, or (ii) if he was entitled to hospital insurance benefits pursuant to subsection (b), at a time when he was so entitled; and

(2) an individual shall be deemed entitled to monthly insurance benefits under section 402 or section 423 of this title, or to be a qualified railroad retirement beneficiary, for the month in which he died if he would have been entitled to such benefits, or would have been a qualified railroad retirement beneficiary, for such month had he died in the next month.

2. 42 U.S.C. 1395ww(d)(5)(F) provides:

Payments to hospitals for inpatient hospital services

(d) Inpatient hospital service payments on basis of prospective rates; Medicare Geographical Classification Review Board

(5)(F)(i) Subject to subsection (r), for discharges occurring on or after May 1, 1986, the Secretary shall provide, in accordance with this subparagraph, for an additional payment amount for each subsection (d) hospital which—

(I) serves a significantly disproportionate number of low-income patients (as defined in clause (v)), or

(II) is located in an urban area, has 100 or more beds, and can demonstrate that its net inpatient care revenues (excluding any of such revenues attributable to this subchapter or State plans approved under subchapter XIX of his chapter), during the cost reporting period in which the discharges occur, for indigent care from State and local government sources exceed 30 percent of its total of such net inpatient care revenues during the period.

(ii) Subject to clause (ix), the amount of such payment for each discharge shall be determined by multiplying (I) the sum of the amount determined under paragraph (1)(A)(ii)(II) (or, if applicable, the amount determined under paragraph (1)(A)(iii)) and, for cases qualifying for additional payment under subparagraph (A)(i), the amount paid to the hospital under subparagraph (A) for that discharge, by (II) the disproportionate share adjustment percentage established under clause (iii) or (iv) for the cost reporting period in which the discharge occurs.

(iii) The disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (i)(II) is equal to 35 percent.

(iv) The disproportionate share adjustment percentage for a cost reporting period for a hospital that is not described in clause (i)(II) and that—

(I) is located in an urban area and has 100 or more beds or is described in the second sentence of

clause (v), is equal to the percent determined in accordance with the applicable formula described in clause (vii);

(II) is located in an urban area and has less than 100 beds, is equal to 5 percent or, subject to clause (xiv) and for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xiii);

(III) is located in a rural area and is not described in subclause (IV) or (V) or in the second sentence of clause (v), is equal to 4 percent or, subject to clause (xiv) and for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xii);

(IV) is located in a rural area, is classified as a rural referral center under subparagraph (C), and is classified as a sole community hospital under subparagraph (D), is equal to 10 percent or, if greater, the percent determined in accordance with the applicable formula described in clause (viii) or, subject to clause (xiv) and for discharges occurring on or after April 1, 2001, the greater of the percentages determined under clause (x) or (xi);

(V) is located in a rural area, is classified as a rural referral center under subparagraph (C), and is not classified as a sole community hospital under subparagraph (D), is equal to the percent determined in accordance with the applicable formula described in clause (viii) or, subject to clause (xiv) and for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xi); or

(VI) is located in a rural area, is classified as a sole community hospital under subparagraph (D), and is not classified as a rural referral center under subparagraph (C), is 10 percent or, subject to clause (xiv) and for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (x).

(v) In this subparagraph, a hospital "serves a significantly disproportionate number of low income patients" for a cost reporting period if the hospital has a disproportionate patient percentage (as defined in clause (vi)) for that period which equals, or exceeds—

(I) 15 percent, if the hospital is located in an urban area and has 100 or more beds,

(II) 30 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is located in a rural area and has more than 100 beds, or is located in a rural area and is classified as a sole community hospital under subparagraph (D),

(III) 40 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is located in an urban area and has less than 100 beds, or

(IV) 45 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is located in a rural area and is not described in subclause (II).

A hospital located in a rural area and with 500 or more beds also "serves a significantly disproportionate number of low income patients" for a cost reporting period if the hospital has a disproportionate patient percentage

(as defined in clause (vi)) for that period which equals or exceeds a percentage specified by the Secretary.

(vi) In this subparagraph, the term "disproportionate patient percentage" means, with respect to a cost reporting period of a hospital, the sum of—

(I) the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter and were entitled to supplementary security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter, and

(II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX, but who were not entitled to benefits under part A of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.

In determining under subclause (II) the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX of this chapter, the Secretary may, to the extent

and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under subchapter XI.

(vii) The formula used to determine the disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (iv)(I) is—

(I) in the case of such a hospital with a disproportionate patient percentage (as defined in clause (vi)) greater than 20.2—

(a) for discharges occurring on or after April 1, 1990, and on or before December 31, 1990, (P−20.2)(.65) + 5.62,

(b) for discharges occurring on or after January 1, 1991, and on or before September 30, 1993, (P−20.2)(.7) + 5.62,

(c) for discharges occurring on or after October 1, 1993, and on or before September 30, 1994, (P−20.2)(.8) + 5.88, and

(d) for discharges occurring on or after October 1, 1994, (P−20.2)(.825) + 5.88; or

(II) in the case of any other such hospital—

(a) for discharges occurring on or after April 1, 1990, and on or before December 31, 1990, (P−15)(.6) + 2.5,

(b) for discharges occurring on or after January 1, 1991, and on or before September 30, 1993, $(P-15)(.6) + 2.5$,[7]

(c) for discharges occurring on or after October 1, 1993, $(P-15)(.65) + 2.5$,

where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(viii) Subject to clause (xiv), the formula used to determine the disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (iv)(IV) or (iv)(V) is the percentage determined in accordance with the following formula: $(P-30)(.6) + 4.0$, where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(ix) In the case of discharges occurring—

(I) during fiscal year 1998, the additional payment amount otherwise determined under clause (ii) shall be reduced by 1 percent;

(II) during fiscal year 1999, such additional payment amount shall be reduced by 2 percent;

(III) during fiscal years 2000 and 2001, such additional payment amount shall be reduced by 3 percent and 2 percent, respectively;

(IV) during fiscal year 2002, such additional payment amount shall be reduced by 3 percent; and

(V) during fiscal year 2003 and each subsequent fiscal year, such additional payment amount shall be reduced by 0 percent.

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[7] So in original. Probably should be followed by "and".

(x) Subject to clause (xiv), for purposes of clause (iv)(VI) (relating to sole community hospitals), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) is less than 19.3, the disproportionate share adjustment percentage is determined in accordance with the following formula: $(P-15)(.65) + 2.5$;

(II) is equal to or exceeds 19.3, but is less than 30.0, such adjustment percentage is equal to 5.25 percent; or

(III) is equal to or exceeds 30, such adjustment percentage is equal to 10 percent,

where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(xi) Subject to clause (xiv), for purposes of clause (iv)(V) (relating to rural referral centers), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) is less than 19.3, the disproportionate share adjustment percentage is determined in accordance with the following formula: $(P-15)(.65) + 2.5$;

(II) is equal to or exceeds 19.3, but is less than 30.0, such adjustment percentage is equal to 5.25 percent; or

(III) is equal to or exceeds 30, such adjustment percentage is determined in accordance with the following formula: $(P-30)(.6) + 5.25$,

where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(xii) Subject to clause (xiv), for purposes of clause (iv)(III) (relating to small rural hospitals generally), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) is less than 19.3, the disproportionate share adjustment percentage is determined in accordance with the following formula: $(P-15)(.65) + 2.5$; or

(II) is equal to or exceeds 19.3, such adjustment percentage is equal to 5.25 percent,

where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(xiii) Subject to clause (xiv), for purposes of clause (iv)(II) (relating to urban hospitals with less than 100 beds), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) is less than 19.3, the disproportionate share adjustment percentage is determined in accordance with the following formula: $(P-15)(.65) + 2.5$; or

(II) is equal to or exceeds 19.3, such adjustment percentage is equal to 5.25 percent,

where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(xiv)(I) In the case of discharges occurring on or after April 1, 2004, subject to subclause (II), there shall be substituted for the disproportionate share adjustment percentage otherwise determined under clause (iv) (other

than subclause (I)) or under clause (viii), (x), (xi), (xii), or (xiii), the disproportionate share adjustment percentage determined under clause (vii) (relating to large, urban hospitals).

(II) Under subclause (I), the disproportionate share adjustment percentage shall not exceed 12 percent for a hospital that is not classified as a rural referral center under subparagraph (C) or, in the case of discharges occurring on or after October 1, 2006, as a medicare-dependent, small rural hospital under subparagraph (G)(iv).

3. 42 C.F.R. 400.202 provides in pertinent part:

Definitions specific to Medicare.

As used in connection with the Medicare program, unless the context indicates otherwise—

* * * * *

Entitled means that an individual meets all the requirements for Medicare benefits.

* * * * *

4. 42 C.F.R. 409.3 provides in pertinent part:

Definitions.

As used in this part, unless the context indicates otherwise—

* * * * *

Covered refers to services for which the law and the regulations authorize Medicare payment.

* * * * *

5. 42 C.F.R. 409.61 provides:

General limitations on amount of benefits.

(a) *Inpatient hospital or inpatient CAH services*—(1) *Regular benefit days.* Up to 90 days are available in each benefit period, subject to the limitations on days for psychiatric hospital services set forth in §§ 409.62 and 409.63.

(i) For the first 60 days (referred to in this subpart as *full benefit days*), Medicare pays the hospital or CAH for all covered services furnished the beneficiary, except for a deductible which is the beneficiary's responsibility. (Section 409.82 specifies the requirements for the inpatient hospital deductible.)

(ii) For the next 30 days (referred to in this subpart as *coinsurance days*), Medicare pays for all covered services except for a daily coinsurance amount, which is the beneficiary's responsibility. (Section 409.83 specifies the inpatient hospital coinsurance amounts.)

(2) *Lifetime reserve days*. Each beneficiary has a non-renewable lifetime reserve of 60 days of inpatient hospital or inpatient CAH services that he may draw upon whenever he is hospitalized for more than 90 days in a benefit period. Upon exhaustion of the regular benefit days, the reserve days will be used unless the beneficiary elects not to use them, as provided in § 409.65. For lifetime reserve days, Medicare pays for

all covered services except for a daily coinsurance amount that is the beneficiary's responsibility. (See § 409.83.)

(3) *Order of payment for inpatient hospital or inpatient CAH services.* Medicare pays for inpatient hospital services in the following order.

(i) The 60 full benefit days;

(ii) The 30 coinsurance days;

(iii) The remaining lifetime reserve days.

(b) *Posthospital SNF care furnished by a SNF, or by a hospital or a CAH with a swing-bed approval.* Up to 100 days are available in each benefit period after discharge from a hospital or CAH. For the first 20 days, Medicare pays for all covered services. For the 21st through 100th day, Medicare pays for all covered services except for a daily coinsurance amount that is the beneficiary's responsibility.

(c) *Renewal of inpatient benefits.* The beneficiary's full entitlement to the 90 inpatient hospital or inpatient CAH regular benefit days, and the 100 SNF benefit days, is renewed each time he or she begins a benefit period. However, once lifetime reserve days are used, they can never be renewed.

(d) *Home health services.* Medicare Part A pays for all covered home health services[1] with no deductible, and subject to the following limitations on payment for durable medical equipment (DME):

---

[1] Before July 1, 1981, Medicare Part A paid for not more than 100 home health visits during one year following the beneficiary's most recent discharge from a hospital or a SNF.

(1) For DME furnished by an HHA that is a nominal charge provider, Medicare Part A pays 80 percent of fair compensation.

(2) For DME furnished by an HHA that is not a nominal charge provider, Medicare Part A pays the lesser of the following:

(i) 80 percent of the reasonable cost of the service.

(ii) The reasonable cost of, or the customary charge for, the service, whichever is less, minus 20 percent of the customary (insofar as reasonable) charge for the service.

6. 42 C.F.R. 412.106(b) provides:

Special treatment: Hospitals that serve a disproportionate share of low-income patients.

(b) *Determination of a hospital's disproportionate patient percentage*—(1) *General rule*. A hospital's disproportionate patient percentage is determined by adding the results of two computations and expressing that sum as a percentage.

(2) *First computation: Federal fiscal year*. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—

(i) Determines the number of patient days that

(A) Are associated with discharges occurring during each month; and

(B) Are furnished to patients who during that month were entitled to both Medicare Part A (including Medicare Advantage (Part C)) and SSI, excluding those patients who received only State supplementation;

(ii) Adds the results for the whole period; and

(iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that

(A) Are associated with discharges that occur during that period; and

(B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).

(3) *First computation: Cost reporting period.* If a hospital prefers that CMS use its cost reporting period instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request including the hospital's name, provider number, and cost reporting period end date. This exception will be performed once per hospital per cost reporting period, and the resulting percentage becomes the hospital's official Medicare Part A/SSI percentage for that period.

(4) *Second computation.* The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:

(i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the

patient is eligible for inpatient hospital services under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.

(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.

(iii) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

(iv) For cost reporting periods beginning on or after October 1, 2009, the hospital must report the days in the numerator of the fraction in the second computation in a cost reporting period based on the date of discharge, the date of admission, or the dates of service. If a hospital seeks to change its methodology for reporting days in the numerator of the fraction in the second computation, the hospital must notify CMS, through its fiscal intermediary or MAC, in writing at least 30 days before the beginning of the cost reporting period in which the change would apply. The written notification must specify the methodology the hospital will use, the cost reporting period to which the requested change would apply, and the current methodology being used. Such a change will be effective only on the first day of a cost reporting period. If a hospital changes its methodology

for reporting such days, CMS or the fiscal intermediary or MAC may adjust the number of days reported for a cost reporting period if it determines that any of those days have been counted in a prior cost reporting period.

(5) *Disproportionate patient percentage.* The intermediary adds the results of the first computation made under either paragraph (b)(2) or (b)(3) of this section and the second computation made under paragraph (b)(4) of this section and expresses that sum as a percentage. This is the hospital's disproportionate patient percentage, and is used in paragraph (c) of this section.