No. 20-1312

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,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF THE FEDERATION OF AMERICAN HOSPITALS AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENT

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INTEREST OF *AMICUS CURIAE*[1]

The Federation of American Hospitals ("FAH") is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients in urban and rural communities with access to high-quality, affordable health care. Its members include teaching and non-teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals. They provide a wide range of acute, post-acute, emergency, children's, cancer care, and ambulatory services.

The FAH provides representation and advocacy on behalf of its members to Congress, the executive branch, the judiciary, media, academia, accrediting organizations, and the public. The FAH routinely submits comments to the Centers for Medicare & Medicaid Services ("CMS") on Medicare and Medicaid payment policies and rulemakings and offers guidance to courts regarding Medicare and Medicaid reimbursement principles.

FAH member hospitals are Medicare-participating providers that serve some of our country's most vulnerable communities. Approximately 90 percent of FAH member hospitals serve a significant number of low-income patients and therefore qualify for Medicare disproportionate

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[1] Pursuant to Supreme Court Rule 37.3(a), counsel of record for each party has provided written consent to the filing of this brief. No counsel for any party has authored this brief in whole or in part, and no person or entity, other than *amicus* or its counsel, made a monetary contribution intended to fund the preparation or submission of this brief.

share hospital ("DSH") payments under 42 U.S.C. § 1395ww(d)(5)(F).

Amicus curiae submits this brief in support of Respondent Empire Health because the question presented here—whether the Secretary of the United States Department of Health and Human Services ("Secretary") has permissibly treated patients who have exhausted their Medicare Part A benefits for days of inpatient care as being entitled to Part A benefits for such days in calculating Medicare DSH payments—is of tremendous importance to the FAH's members. The Secretary's treatment of these exhausted days has and continues to unlawfully depress Medicare DSH payments to hospitals that serve some of the country's most vulnerable patient populations, including the FAH's members.

SUMMARY OF ARGUMENT

The Medicare DSH adjustment serves a critical role in ensuring the appropriateness and adequacy of Medicare inpatient hospital payments to DSH hospitals—including FAH member hospitals. Recognizing that Medicare's inpatient prospective payment system ("IPPS") fails to capture the additional costs associated with treating low-income patients, Congress requires the Secretary to make Medicare DSH payments to those hospitals that serve a disproportionate share of low-income patients. The Secretary's policy at issue here, however, undermines the purpose of Medicare DSH adjustments by categorizing those patient days for which Medicare Part A benefits have been *exhausted* as days on which the beneficiary is *entitled to* such benefits. The FAH's members report that this exhausted-days policy

improperly reduces Medicare DSH payments associated with the inpatient care provided to these medically vulnerable, low-income patients by (1) inflating the denominator of the Medicare fraction with Medicare Part A exhausted days and (2) excluding from the numerator of the Medicaid fraction patient days for the many low-income, exhausted-days beneficiaries who are eligible for Medicaid.

Because the exhausted-days policy works against Congress' purpose in enacting the DSH statute, the FAH has informed the Secretary of its opposition to the inclusion of exhausted days in the Medicare fraction. Consistent with the purpose of providing additional payment to hospitals that dedicate a disproportionate share of their resources to serving low-income patients, patient days for Medicaid-eligible beneficiaries who have exhausted their Part A inpatient hospital benefits should be included only in the Medicaid fraction.

For these reasons and the reasons set forth in Respondent's Brief, the Court should uphold the Ninth Circuit's decision vacating the Secretary's exhausted-days policy in his Federal fiscal year ("FFY") 2005 final rule.

ARGUMENT

I. THE SECRETARY'S EXHAUSTED-DAYS POLICY IMPROPERLY REDUCES DSH PAYMENTS

The FAH's members and other hospitals nationwide have long been concerned by the Secretary's unlawful depression of Medicare DSH payments, effectuated here by treating patients for whom Medicare Part A provides no inpatient hospital benefits as nonetheless being "entitled to" Part A

benefits for that specific day of inpatient care. This approach reduces Medicare DSH payments by excluding Medicaid-eligible patients who have exhausted their Medicare Part A inpatient hospital benefits from the numerator of the Medicaid fraction, which is designed to capture Medicaid patient days for individuals not also entitled to Medicare Part A benefits for such days. This exhausted-days policy also generally inflates the denominator of the Medicare and supplemental security income ("SSI") fraction (the "Medicare fraction"). As applied to the exhausted-days issue before the Court, the Secretary's approach to Medicare DSH is inconsistent with the aim of the program and underpays hospitals for serving particularly vulnerable Medicare beneficiaries whose intensive health needs exhaust their hospital Medicare benefits such that their inpatient hospital days are noncovered.[2] The FAH's members report that the Secretary's treatment of exhausted days has depressed Medicare DSH payments associated with the inpatient care provided to these medically vulnerable, low-income patients.

As Respondent details (at 9-11), the amount of a hospital's Medicare DSH payments depends on the hospital's disproportionate patient percentage, which is the sum of the Medicare fraction and the Medicaid

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[2] Medicare beneficiaries can use 90 days of inpatient hospital services in a benefit period and have a lifetime reserve of 60 days of inpatient hospital services that they can use or not at the beneficiary's option. 42 C.F.R. § 409.61(a). These extraordinarily complex and sick patients who exhaust their Medicare Part A benefits have long inpatient stays and, consequently, are more likely to meet the asset and means testing required for Medicaid eligibility.

fraction. The DSH statute establishes the composition of those fractions, which necessitates identifying those patients who are "entitled to" or "not entitled to" Medicare Part A benefits for particular inpatient hospital "days," are "entitled to [SSI] benefits," and are "eligible for" Medicaid benefits. 42 U.S.C. § 1395ww(d)(5)(F)(vi), as summarized in the following table.

	Medicare Fraction	***Medicaid Fraction***
Numerator	Patient days for "patients who (for such days) were entitled to benefits under Part A" and "entitled to" SSI benefits	Patient days for patients "who (for such days) were eligible for" Medicaid but "were not entitled to benefits under Part A"
Denominator	Patient days for "patients who (for such days) were entitled to benefits under Part A"	"Total number of the hospital's patient days"

The Medicare DSH statute was adopted by Congress after it replaced the reasonable-cost reimbursement system with the IPPS. Medicare DSH payments supplement eligible hospitals' Part A payments in recognition of the additional costs—otherwise unaccounted for in the IPPS payments—associated with serving a high number of low-income patients. This purpose is uncontested by the Secretary, who characterizes Medicare DSH as an "ad-

justment that provides increased Medicare payments" to DSH hospitals. (Pet'r Br. at 4.) Yet, the Secretary's exhausted-days policy has the opposite effect, generally reducing Medicare DSH payments when hospitals care for patients who—as a result of their intensive care needs—have exhausted their inpatient hospital benefits such that Medicare Part A does not make payment.

For purposes of the Medicare fraction, the limiting factor for the numerator is the number of individuals entitled to SSI benefits. Including a broader pool of Medicare beneficiary patient days in the Medicare fraction (*e.g.*, patient days for which Medicare Part A does not make payment due to exhaustion of inpatient hospital benefits) will inflate the denominator. In other words, under the Secretary's exhausted-days policy, each day that the hospital treats an exhausted-days beneficiary who is not actively receiving SSI benefits reduces the Medicare fraction even though the hospital has no right to receive Part A payment for that care.

Although the inaccessibility of data on the exhausted-days policy has precluded robust analysis of the issue and the Secretary has not provided his own analysis, a study that reviewed Federal fiscal year data furnished by CMS for 52 Medicare DSH hospitals in 17 States confirms that the Secretary's policy on exhausted and noncovered days generally reduces the Medicare fraction. *Sw. Consulting 2004 DSH Dual Eligible Days Grp. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D36, at 10-11 (June 14, 2010) (hereinafter "*Southwest Consulting*"), https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/2010D36.pdf, *vacated on other grounds*, CMS Adm'r

Dec. (Aug. 12, 2010), https://www.cms.gov/Regulations-and-Guidance/Review-Boards/OfficeAttorneyAdvisor/Downloads/2010-D36.pdf. That *Southwest Consulting* analysis "concluded that in 94% of the cases analyzed, the SSI fraction would be *diluted*" by the Secretary's policy. *Id.* at 11 (emphasis added); *see also* Resp't Br. at 33. The average loss per hospital based on the Medicare fraction impact alone was $49,000 per annual cost reporting period. *Id.*

In contrast, if "entitled to" Medicare Part A benefits "for such days" is construed to mean inpatient hospital days for which Medicare Part A actually pays benefits, the Medicaid fraction will increase. Under this approach, the numerator of the Medicaid fraction increases for each such Medicare beneficiary who is also one of the 75.4 million Americans enrolled in Medicaid. CMS, April 2021 Medicaid & CHIP Enrollment Trends Snapshot 2, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/april-2021-medicaid-chip-enrollment-trend-snapshot.pdf. The denominator of the Medicaid fraction, which consists of the hospital's total patient days, is unchanged.

This assessment is confirmed by the *Southwest Consulting* analysis described above. Including exhausted and noncovered patient days in the Medicaid fraction "would *increase* the DSH calculation for every hospital by an average of $95,000." *Southwest Consulting* at 11 (emphasis added). Coupled with the reduction to the Medicare fraction, this results in a total difference in reimbursement (a "swing") of, on

average, $157,000 per hospital per cost reporting year under the Secretary's flawed policy.[3] *Id.*; *see also* Resp't Br. at 33 (noting that the Secretary's policy has reduced Medicare DSH payments by almost $150,000 per hospital per year) (citing Pls.' Opp. Def's. Cross-Mot. Summ. J. 41-42, *Catholic Health Initiatives Iowa, Corp. v. Sebelius*, 841 F. Supp. 2d 270 (D.D.C. 2012) (No. 10-0411), 2010 WL 11685305). When aggregated across the thousands of Medicare DSH hospitals and the years the Secretary's flawed policy has been in place, the Secretary has underpaid Medicare DSH hospitals on the order of billions of dollars.

Nonetheless, the Secretary argues that his exhausted-days policy "did not embody an effort to minimize disproportionate-share-hospital payments." Pet'r Br. at 43. Although the Secretary suggests that some hospitals favored the (misstated) policy in their 2003 comment letters on the FFY 2004 IPPS proposed rule, the Secretary does not actually argue or present data indicating that the policy has benefitted Medicare DSH hospitals. In fact, as described above, the data analysis that has been performed supports the logical conclusion that the Secretary's policy depresses Medicare DSH payments. Moreover, the FAH's member hospitals confirm their experience that the Secretary's exhausted-days policy operates

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[3] The *Southwest Consulting* analysis initially calculated this swing as $144,000 per hospital per cost reporting year, but the final analysis calculated "the impact – and therefore the amount in controversy – of counting the days in the SSI fraction instead of the Medicaid fraction (referred to as the 'swing') was a loss of $157,000 (as compared to $144,000) on average per hospital, per cost reporting year." *Id.*

as an aggregate reduction to Medicare DSH payments because it understates patient days associated with this medically vulnerable, low-income patient population.

II. THE SECRETARY'S EXHAUSTED-DAYS POLICY IS NOT SUPPORTED BY HOSPITALS, DESPITE THE GOVERNMENT'S ASSERTIONS OF HOSPITAL SUPPORT

The FAH's Medicare DSH hospital members do not support the Secretary's impermissible exhausted-days policy, despite the Secretary's assertions to the contrary because it works against the intent of the DSH statute. Put simply, when a hospital provides care for a beneficiary who is enrolled in Medicaid and has exhausted his or her Medicare Part A benefits, those dual-eligible exhausted patient days should *increase, not decrease*, the hospital's Medicare DSH payments. These are precisely the costly, low-income patient days that disproportionately burden DSH hospitals and drove Congress to require Medicare DSH payments.

The FAH has informed the Secretary of its unambiguous opposition to the inclusion of dual-eligible exhausted days in the Medicare fraction. In particular, in 2010, the FAH commented to the Secretary on the April 28, 2010 CMS Ruling (CMS Ruling No. CMS-1498-R, https://go.usa.gov/xsnnz),[4] making the FAH's views on the Secretary's exhausted-days policy clear: "The FAH believes that the language of the DSH Medicare statute requires the inclusion in

[4] This CMS Ruling, *inter alia*, purported to limit and resolve provider appeals involving certain Medicare DSH issues, including those involving Medicare exhausted days.

the Medicaid percent of days for patients who are dually eligible, but who have no covered or payable Part A benefit." FAH June 18, 2010 Ltr., at 36 (App'x at 3a). The FAH also stated:

> Essentially, FAH believes that dually eligible patients, by virtue of having exhausted their Medicare Part A benefits . . . no longer have any right or entitlement to Medicare coverage of (or payment for) those inpatient services/days. That is, the dually eligible patients were not "entitled" to Medicare Part A benefits for the days at issue. Thus, such dual eligible days belong solely in the Medicaid percent of the DSH computation.

Id. at 37 (App'x at 5a). In addition to explaining that dual-eligible exhausted days belong solely in the Medicaid fraction, the FAH reiterated that "the Medicare DSH statute does not mandate and, in fact, does not permit the inclusion in the SSI percent of dual eligible days where Medicare Part A does not make payment or provide coverage." *Id*. (App'x at 5a).

The Secretary's exhausted-days policy emerged from a flawed rulemaking process that misled hospitals as to the then-status quo treatment of exhausted days, generating confusion among commenters. As Respondent details (at 16-19), in the FFY 2004 IPPS proposed rule, the Secretary incorrectly stated that his then-current policy was to count dual-eligible patient days in the Medicare fraction, and exclude them from the Medicaid fraction, "even after the patient's Medicare coverage is exhausted." 68 Fed. Reg. 27,154, 27,207 (May 19, 2003), J.A. 46; *see also id.* at 27,207-08 ("As noted above, our current policy

regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."), J.A. 46. The Secretary then proposed to change that policy and "to begin to count in the Medicaid fraction of the DSH patient percentage the patient days of dual-eligible Medicare beneficiaries whose Medicare coverage has expired." *Id*. This latter proposal was not adopted in the FFY 2004 IPPS final rule. 68 Fed. Reg. 45,346, 56,421 (Aug. 1, 2003), J.A. 86.

Nor did the Secretary address any further change to his policy in the FFY 2005 IPPS proposed rule. 69 Fed. Reg. 28,196, 28,286 (May 18, 2004), J.A. 87-88. Yet, when finalizing the FFY 2005 IPPS final rule, the Secretary adopted precisely the opposite treatment of exhausted days from what had been proposed in the prior year's rulemaking. 69 Fed. Reg. 48,916, 49,099 (Aug. 11, 2004), J.A. 161, 173-174. Moreover, mere days before the termination of the FFY 2005 IPPS rulemaking comment period, the Secretary admitted in a web-posting that he had "misstate[d]" his current policy in the FFY 2004 IPPS proposed rule, and that his actual policy had been that only "covered" Medicare patient days were included in the Medicare fraction. J.A. 93-94.

This muddled and mercurial rulemaking process generated misinformed comments on the FFY 2004 proposed rule. Nevertheless, the Secretary cites comments the FAH and other hospitals made in conjunction with these misleading rulemakings in asserting that the challenged interpretation of "entitled to" in the Medicare fraction is a "reasonable policy choice consistent with the statute's objectives" warranting deference. Pet'r Br. at 43. Specifically,

the Secretary cites to commenters, including the FAH, as observing that the Secretary's original (and later abandoned) policy proposal (1) "would give rise to significant recordkeeping and other administrative burdens" and (2) "would have reduced [commenters'] payments." Pet'r Br. at 43-44 (citing J.A. 59-60, 68-69, 73-74, 79-80, 91, 114, 132-133, 150; and citing J.A. 54-55, 59-60, 66, 68-69, 71-74, 77-82, 90-92, 113-116, 132-133, 134-135, 147-151, 153-156, respectively).

But the Secretary misuses the FAH's and other hospitals' comments for these assertions. Critically, the Secretary fails to mention that many of the comments that he cites as allegedly supportive relied on his significant and later-admitted misrepresentation of agency policy in the May 19, 2003 proposed rule. This mistaken understanding was so material as to cause commenters that addressed the July 7, 2004 CMS web posting (J.A. 93-94), like the FAH, to "reconsider[]. . . those comments" and request that the agency take "additional comments pertaining to this issue" into consideration when submitting comments to the FFY 2005 proposed rule, for which the comment period would close just a few days after CMS acknowledged its error. *See* FAH comment letter submitted July 12, 2004, J.A. 152-56.

The Secretary's about-face and last-minute admission of material misstatements in the proposed rulemaking resulted in comments demonstrating concern and confusion by the hospital community. With the benefit of a more full understanding of the Secretary's exhausted-days practices and current policy, the FAH opposes including Part A exhausted days in the Medicare fraction. Consistent with the purpose of providing additional payment to hospitals

that serve a disproportionate share of low-income patients, Medicaid beneficiaries who have exhausted their Part A inpatient hospital benefits should be included only in the Medicaid fraction.

CONCLUSION

For the foregoing reasons and those contained in Respondent Empire Health's brief, the judgment of the Court of Appeals for the Ninth Circuit should be affirmed.

Respectfully submitted.

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October 25, 2021

APPENDIX

APPENDIX

[LOGO] Federation of American Hospitals

Charles N. Kahn III
President and CEO

June 18, 2010

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1498-P and CMS-1498-P2
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-1498-P and CMS-1498-P2; Medicare Program; Proposed Changes and Supplemental Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2011 Rates; ; 75 Fed. Reg. 23852 (May 4, 2010) and 75 Fed. Reg. 30918 (June 2, 2010)

Dear Ms. Tavenner:

The Federation of American Hospitals ("FAH") is the national representative of investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching, short-stay rehabilitation and long-term care hospitals in urban and rural America, and provide a wide range of ambulatory, acute and post-acute services. We appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' ("CMS") proposed rule ("Pro-

posed Rule" or "NPRM")[1] and supplemental proposed rule regarding changes to the hospital inpatient prospective payment system and fiscal year ("FY") 2011 rates and other issues. Please note that broad topic areas, under which we generally use the same numerical headings and subheadings as in the NPRM, organize our comments below. Thus, some numerical headings may not be represented below when no comment is submitted for that part of the NPRM. To the extent that the supplemental rule touches on an area addressed in the NPRM, we have identified our comments as relating to the supplemental rule in a subtitle of that comment. Supplement proposed rule changes not related to part of the original proposed rule are addressed at the end of this letter.

* * *

5. CMS Ruling (NPRM at 24006)

The FAH agrees with some aspects of CMS's April 28, 2010 DSH Ruling (CMS-1498-R) ("the Ruling"), particularly the use of an improved SSI matching process for settlement of pending appeals regarding the SSI match and open cost reports (as discussed above) and the favorable settlement of the labor/delivery days issue (as discussed below). However, the FAH believes the Ruling itself is invalid for a number of reasons. Therefore, the FAH asks CMS to withdraw the Ruling because it violates the Medicare Act's establishment of the PRRB appeal process, it violates the DSH statute, it violates the Medicare DSH regula-

[1] References in the titles of various sections below are to the specific parts of the Proposed Rule as they appear in the Federal Register and cites to the NPRM at a given page are references to the applicable starting page of the relevant discussion in the Federal Register.

tion in place prior to October 1, 2004, and it is predicated on erroneous factual assumptions. As a preliminary matter, CMS Rulings should be published in the Federal Register presumably to allow for notice and the ability to comment and to assure that they are carefully vetted in advance of such formal publication. 42 C.F.R. § 401.108(a).[7] Regardless of the reasons for the requirement, CMS has not followed the regulation and thus, if CMS is not inclined to withdraw the Ruling, then at the very least it should be published in the Federal Register in order to be effective.

* * *

b. With Respect to Dual Eligible Days, the Ruling Violates the DSH Statute

The Ruling mandates inclusion in the SSI percent of patient days associated with patients eligible for both Medicare and Medicaid ("dually eligible") but, for such days, there is no Medicare coverage and Medicare does not make payment. The FAH believes that the language of the DSH Medicare statute requires the inclusion in the Medicaid percent of days for patients who are dually eligible, but who have no covered or payable Part A benefit. 42 U.S.C. § 1395ww(d)(5)(F) establishes that the Medicaid proxy must include:

> 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

[7] Although the regulation indicates that rulings "may be published in the Federal Register", when the regulation is read in its entirety and in context, it is clear that the way a "precedent final opinion, order, statement of policy or interpretation" actually becomes a binding Ruling is when it is published in the Federal Register "as a CMS Ruling. . . ." 42 C.F.R. § 401.108(a).

> subchapter XIX of this chapter, but who were not **entitled** to benefits under part A of this subchapter. . . .

42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) (emphasis added). Accordingly, under the statute, the inclusion of patient days in the Medicaid proxy depends on whether the patients were eligible for Medicaid, but not entitled to Medicare benefits for the days in question.

Various federal courts have construed the terms "eligible" and "entitled" as used in the DSH statute. This case law shows that these terms are not synonymous or interchangeable. In *Jewish Hosp., Inc. v. Secretary of Health & Human Services*, 19 F.3d 270 (6th Cir. 1994), the Sixth Circuit found that the term "eligibility" refers to the "'qualification' for benefits or the capability of receiving those benefits." *Jewish Hosp.,* 19 F.3d at 274; *see also Legacy Emanuel Hosp. & Health Ctr. v. Shalala*, 97 F.3d 1261, 1265 (9th Cir. 1996). In contrast, the *Jewish Hosp.* court found that "[t]o be entitled to some benefit means that one possesses the right or title to that benefit" or "the absolute . . . right . . . to . . . payment." *See Jewish Hosp.*, 19 F.3d at 275; *see also Legacy Emanuel*, 97 F.3d at 1265. In other words, *Jewish Hosp.* and *Legacy Emanuel* establish that eligibility is **not** tied to payment for services, while entitlement **is** tied to payment. CMS acquiesced in those decisions through HCFA Ruling 97-2. Multiple other courts have endorsed the distinction drawn in *Jewish Hosp* and *Legacy Emanuel*. *See Cabell Huntington Hosp. v. Shalala*, 101 F.3d 984, 987 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala*, 83 F.3d 1041 (8th Cir. 1996) *affirming* 912 F. Supp. 438 (E.D. Mo. 1995). Indeed, two recent court cases validate FAH's view that dual eligible exhausted days are not days

"entitled to benefits under Part A." *See Northeast Hosp. Corp. v. Sebelius*, Case No. 09-0180 (D.D.C. March 30, 2010); *Metropolitan Hosp., Inc. v. U.S. Dep't of Health & Human Servs.*, Case No. 1:09-cv-128 (W.D. Mich. Apr. 5, 2010).

Essentially, FAH believes that dually eligible patients, by virtue of having exhausted their Medicare Part A benefits (exhausted) or receiving non-covered care or having their stay paid by an insurer primary to Medicare ("MSP"), no longer have any right or entitlement to Medicare coverage of (or payment for) those inpatient services/days. That is, the dually eligible patients were not "entitled" to Medicare Part A benefits for the days at issue. Thus, such dual eligible days belong solely in the Medicaid percent of the DSH computation.

c. With Respect to Dual Eligible Days, the Ruling Violates the Pre-2004 Regulation

The FAH believes that the Ruling constitutes improper retroactive rulemaking. First, as noted above, the Medicare DSH statute does not mandate and, in fact, does not permit the inclusion in the SSI percent of dual eligible days where Medicare Part A does not make payment or provide coverage. Rather, such days belong only in the Medicaid percent. Further, though, FAH believes that the pre-2004 regulation was clear in allowing inclusion in the SSI percent only of "covered" days. *See*, e.g., 42 C.F.R. § 412.106(b)(2) (2003). Unpaid, uncovered dual eligible days are not "covered" days and thus do not belong in the SSI percent under the plain language of the DSH regulation in existence through September 30, 2003. The Ruling's mandate to remand for inclusion of such days in the SSI percent therefore clearly

violates the existing regulation for any discharges prior to October 1, 2004 and is a clear example of improper retroactive rulemaking. Again, contrary to the eighth and final ruling on the last page of the Ruling, the FAH believes that the DSH statute does not mandate any such retroactive effect.

* * *