[ORAL ARGUMENT NOT YET SCHEDULED]
No. 16-5255

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

ALLINA HEALTH SERVICES *ET AL.*,

Appellants,

v.

NORRIS COCHRAN, ACTING SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Appellee.

On Appeal from the U.S. District Court for the District of Columbia

Appellants' Opening Brief

Stephanie A. Webster
Pratik A. Shah
Christopher L. Keough
James H. Richards
AKIN GUMP STRAUSS HAUER & FELD LLP
1333 New Hampshire Ave., NW
Washington, D.C. 20036
202-887-4000
swebster@akingump.com

Counsel for Appellants

Hyland Hunt, *Of Counsel*
DEUTSCH HUNT PLLC
300 New Jersey Ave. NW, Ste. 900
Washington, D.C. 20001
202-868-6915

CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

A. Parties and Amici

A complete listing of the Appellant hospitals, plaintiffs below, is set forth below:

1. Allina Health System d/b/a Abbott Northwestern Hospital
2. Allina Health System d/b/a United Hospital
3. Allina Health System d/b/a Unity Hospital
4. Florida Health Sciences Center, Inc. d/b/a Tampa General Hospital
5. Montefiore Medical Center
6. Mount Sinai Medical Center of Florida, Inc. d/b/a Mount Sinai Medical Center
7. New York - Presbyterian / Queens
8. The New York Methodist Hospital
9. The New York and Presbyterian Hospital d/b/a New York Presbyterian Hospital / Weill Cornell Medical Center

Pursuant to Circuit Rule 26.1, the undersigned certifies that no Appellant has a parent company, and no publicly-held corporations have a 10 percent or greater ownership interest in any of the Appellants.

Appellee, defendant below, is Norris Cochran, Acting Secretary of the United States Department of Health and Human Services.[1]

There are no intervenors or amici in this action.

B. Rulings Under Review

The ruling under review is the memorandum opinion and order issued by the Honorable Gladys Kessler on August 17, 2016, in civil action number 14-1415. *Allina Health Servs. v. Burwell*, --- F. Supp. 3d ----, 2016 WL 4409181 (D.D.C. Aug. 17, 2016).

C. Related Cases

The case on review was previously before the United States District Court for the District of Columbia. It was not previously before this Court or any other court. There are two related cases now pending before the United States District Court for the District of Columbia:

1. *Allina Health System v. Burwell*, civil action number 16-0150, which involves all of the Appellant hospitals in this case and which challenges the Secretary's remand decision after this Court's vacatur of the 2004 rule attempting to change the legal standard governing the treatment of Medicare part C days in the

[1] Pursuant to Federal Rule of Appellate Procedure 43(c)(2), Norris Cochran, the Acting Secretary of the Department of Health and Human Services, has been substituted for former Secretary Sylvia M. Burwell.

Medicare part A disproportionate share hospital ("DSH") payment adjustment in *Allina Health Services v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014) ("*Allina I*").

2. *Allina Health System v. Burwell*, civil action number 15-0800, in which three of the Appellant hospitals in this case are also plaintiffs. The remaining claims in that case relate to the calculation of the DSH payment adjustment after October 1, 2004 and may be affected by this litigation.

/s/ Stephanie A. Webster
Stephanie A. Webster

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GLOSSARY

APA	Administrative Procedure Act
Board	Provider Reimbursement Review Board
CMS	Centers for Medicare and Medicaid Services
DSH	Disproportionate Share Hospital
M+C	Medicare+Choice
Secretary	Norris Cochran, Acting Secretary, United States Department of Health and Human Services
SSI	Supplemental Security Income

STATEMENT OF JURISDICTION

The Appellant hospitals brought this action in the district court under 42 U.S.C. § 1395oo(f)(1) for expedited judicial review of a determination by the Secretary of Health and Human Services ("Secretary"). The district court found jurisdiction and granted the Secretary's motion for summary judgment in a memorandum opinion and order filed on August 17, 2016. The hospitals timely filed a notice of appeal on August 26, 2016. This Court has jurisdiction pursuant to 28 U.S.C. § 1291.

STATUTES AND REGULATIONS INVOLVED

Relevant statutory and regulatory provisions appear in the Addendum.

ISSUES PRESENTED FOR REVIEW

The questions presented are:

1. Whether the Medicare Act, 42 U.S.C. § 1395hh, or the Administrative Procedure Act ("APA"), 5 U.S.C. §§ 551 *et seq.*, required the Secretary to undertake notice-and-comment rulemaking to change the substantive legal standard under the governing Medicare payment regulation.

2. Whether the Secretary's unacknowledged and unexplained reversal of that standard is arbitrary and capricious.

INTRODUCTION

Hospitals that provide a disproportionate share of care to low-income patients are entitled to additional Medicare part A payment for inpatient hospital services, known as the disproportionate share hospital ("DSH") payment adjustment. The calculation of that payment depends, in part, on whether the low-income patients were "entitled to benefits under part A" of Medicare for their days in the hospital. *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi). Like two prior cases before this Court, *Northeast Hospital* and *Allina I*,[2] this case involves the Secretary's change in the DSH payment standard relating to patient days that were not covered (*i.e.*, paid) under the Medicare part A program because the patients had elected to receive benefits under Medicare part C plans instead.

For decades, consistent with the procedural requirements of the Medicare Act and the APA, the Secretary has routinely undertaken notice-and-comment rulemaking when changing substantive Medicare payment standards concerning the DSH payment calculation and part C days in that calculation. Just days after this Court's 2014 vacatur of the Secretary's flawed rulemaking first trying to reverse the payment standard, however, the Secretary this time issued a rule skipping notice-and-comment procedures altogether. The Secretary again flipped

[2] *See Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1 (D.C. Cir. 2011); *Allina Health Servs. v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014) (*Allina I*).

the now reinstated DSH payment standard to achieve the same (vacated) result, only for a different year, all without offering any explanation at all. That hasty maneuver violates the rulemaking requirements of both the Medicare Act and the APA, and is otherwise arbitrary and capricious.

The Secretary's bungled attempts to alter the longstanding standard under the original 1986 DSH payment regulation trace back to 2003. After "proposing to clarify" in 2003 that the existing regulation did not include part C patient days as part-A-entitled days in the DSH payment calculation, the Secretary adopted a 2004 final rule making a "volte-face." *Allina I*, 746 F.3d at 1111.[3]

Though not acknowledged by the Secretary then (or now), the 180-degree reversal implicated hundreds of millions of dollars in reimbursement to hospitals for the additional costs of services to low-income patients. Appellants filed suit in *Allina I*, arguing (among other things) that the 2004 rule was invalid for lack of sufficient notice and opportunity for comment.

While *Allina I* was pending before this Court in 2013, "in an abundance of caution," the Secretary engaged in new notice-and-comment rulemaking with

[3]In the first case challenging this abrupt change, this Court held that the 2004 change in legal standard could not be applied retroactively. *See Northeast Hospital*, 657 F.3d at 16-17.

prospective effect only, just readopting the payment standard change initially attempted in the inadequate 2004 rule.

Shortly thereafter, this Court affirmed the district court's vacatur of the 2004 rule based on the agency's deficient notice, and declined the Secretary's invitation to decide whether the Secretary could make the same change again without notice and comment rulemaking. *Id.*

Within days of the vacatur becoming final, in June 2014, the Secretary put that question to the test. In issuing binding DSH payment calculations for hospitals nationwide for a year (2012) between the restored pre-2004 regulation and the 2013 readopted rule, the Secretary—without notice and comment—summarily reinstated the change made by the 2004 rule. That issuance, which the district court (contrary to the Secretary's argument) deemed a rule, precipitated the present suit.

Concerned about exactly the sort of change sought by the Secretary here, Congress enacted specific notice-and-comment rulemaking requirements for Medicare. The Medicare Act requires notice-and-comment rulemaking whenever the agency makes a change in a "substantive legal standard" governing payment for services, whether it be announced through a "rule, requirement, or other statement of policy." 42 U.S.C. § 1395hh(a)(2). This process is crucial for hospitals and other providers trying to make hard decisions within limited budgets

about services to furnish, staffing, and other operating and capital expenditures to meet the health care needs of their communities, including those who lack the means to pay for their care. A payment standard the Secretary adopted and previously tried to change through notice-and-comment rulemaking, especially one with tremendous financial consequences for safety net hospitals, triggers these special Medicare notice-and-comment protections.

In any event, under this Court's established precedent, the APA also forbids the Secretary from foregoing notice-and-comment rulemaking because his action is inconsistent with the pre-2004 regulation that itself was promulgated pursuant to notice-and-comment rulemaking. That regulation, reinstated by the *Allina I* vacatur, excludes part C days from part-A-entitled days because they are not covered and paid under part A. The APA forbids the Secretary from now including them as part-A-entitled—plainly contradicting the restored regulation—except through proper notice-and-comment rulemaking.

The trouble with the Secretary's bypass of notice and comment is only underscored by the complete lack of rationale offered for the latest attempt at a rule restoring the change (which the agency apparently still denies even in the face of contrary circuit precedent). Some combination of the Secretary's words cobbled together *post-hoc* from three other non-contemporaneous documents—the inadequately explained 2004 rule, the preordained, prospective 2013 rule, and the

late 2015 *Allina I* remand decision issued without public comment—cannot redeem the Secretary's rash approach. The Secretary's refusal to address an important aspect of the problem, the undeniable fiscal impact of the change, has just continued. Even apart from meeting notice-and-comment requirements, reasoned decision-making requires the agency to acknowledge and explain the departure from the pre-2004 payment standard.

Under the Medicare Act and the APA, the Secretary cannot persist in this haphazard way. The law requires more than the no-notice, no-explanation about-face the agency (again) attempted here.

STATEMENT OF THE CASE

I. The Medicare Program

The Secretary administers the federal Medicare program, which provides health insurance for some of the nation's most vulnerable populations, the elderly and disabled. *See* 42 U.S.C. §§ 1395 *et seq*.

The Secretary does not just act as a regulator of a massive federal program; he also acts as a participant in the health care market. Spending on health care accounts for nearly 18% of the national economy, and Medicare spending in particular was approximately $646.2 billion, representing 15% of the federal

budget for 2015.[4] When the Secretary sets Medicare reimbursement rates, his decisions affect countless providers, including those that do not participate in the Medicare program. *Cf.* Chapin White, *Contrary to Cost-Shift Theory, Lower Medicare Hospital Payment Rates for Inpatient Care Lead to Lower Private Payment Rates*, 32 Health Affairs 935, 941 (2013) (finding that lower Medicare rates resulted in lower private payer rates). The Secretary's agency, the Centers for Medicare and Medicaid Services ("CMS"), reports that there are more than 6,000 hospitals, approximately 300,000 other institutional providers, and more than 1.2 million physicians and other non-institutional providers that participate in the Medicare program. *See* CMS, CMS Fast Facts (July 7, 2016).[5]

Medicare furnishes benefits to qualified individuals through different programs, organized under different parts of the Medicare statute, three of which are pertinent here.

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[4] Ctrs. for Medicare and Medicaid Servs. ("CMS"), National Health Expenditure Fact Sheet (Dec. 2, 2016), *available at* https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html; CMS Press Release, *CMS Releases 2015 National Health Expenditures* (Dec. 2, 2016), *available at* https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-12-02.html; Congressional Budget Office, Updated Budget Projections: 2016 to 2026 (Mar. 2016) at 15, 21, 22, *available at* https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51384-marchbaselineonecol.pdf.

[5] *Available at* https://www.cms.gov/fastfacts/.

Medicare part A entitles an individual to Medicare benefits for inpatient hospital services and other covered services. *See* 42 U.S.C. §§ 426(c), 1395d(a)(1), 1395f(a)-(b), 1395x(u). For most hospitals, including Appellant hospitals, payment for the operating costs of inpatient hospital services is made at predetermined rates under the part A inpatient hospital prospective payment system. *See id.* § 1395ww(d).

Medicare part B is an optional program, requiring payment of premiums, to cover medical and other health services, including physicians' services, that part A does not cover. *See id.* §§ 1395j – 1395w-4. As under part A, Medicare payment under part B is made by the Secretary on a fee-for-service basis either to the beneficiary or directly to the physician or other service provider that has accepted assignment of benefits. *See id.* §§ 1395k, 1395*l*.

Medicare part C (also known as "Medicare Advantage" or "M+C") is a managed care program enacted in 1997 as an alternative to the traditional part A and part B fee-for-service programs. *See id.* § 1395w-21(a). A Medicare beneficiary who is enrolled in parts A and B can elect to receive benefits through enrollment in a part C plan in lieu of the benefits that would otherwise be payable through the fee-for-service program. *See id.* §§ 1395w-21(a)(1), (i)(1); *Northeast Hosp.*, 657 F.3d at 6.

II. Rulemaking Under The Medicare Act

In light of the importance of the Medicare program to the nation's health care system and economy, Congress established specific requirements for adopting regulations through notice-and-comment rulemaking under the Medicare program. The Medicare Act provides that "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing the payment for services . . . shall take effect unless it is promulgated by the Secretary by regulation." 42 U.S.C. § 1395hh(a)(2).

The Medicare Act does not incorporate by reference the APA's rulemaking exemption for "interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice." 5 U.S.C. § 553(b)(A). Instead, the Medicare Act requires notice-and-comment rulemaking with a comment period of at least 60 days for a substantive legal standard governing payment unless one of three specified exceptions is met: (1) a statute specifically permits a rule to be issued with no prior public comment or a shorter comment period; (2) a statute specifies a deadline for rulemaking that falls within 150 days of the statute's enactment; or (3) the APA's good cause exemption (*id.* § 553(b)(B)) is satisfied. 42 U.S.C. § 1395hh(b).

Further, a change in a substantive payment standard, including one in an interpretative rule or statement of policy, can be applied retroactively only if "the

Secretary determines that . . . retroactive application is necessary to comply with statutory requirements" or "failure to apply the change retroactively would be contrary to the public interest." *Id.* § 1395hh(e)(1)(A).

Not all rules, requirements, and policy statements are subject to the notice-and-comment requirement, but the Medicare Act requires the Secretary to publish in the Federal Register a list of all "manual instructions, interpretative rules, statements of policy, and guidelines of general applicability" that are not otherwise published as required by the Act's notice-and-comment rulemaking provisions. *Id.* § 1395hh(c)(1).

Furthermore, the Medicare Act provides that "[i]f the Secretary publishes a final regulation . . . that is not a logical outgrowth of a previously published notice," it "shall not take effect until there is the further opportunity for public comment and publication of the provision again as a final regulation." *Id.* § 1395hh(a)(4).

III. Medicare Part A DSH Payment

Medicare part A provides an add-on DSH payment to hospitals treating a large proportion of low-income patients. *Id.* § 1395ww(d)(5)(F). This payment adjustment, based on two fractions, is intended to compensate for the higher-than-average costs incurred by these hospitals. *See Allina I*, 746 F.3d at 1105; 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I)-(II). Both fractions, in inverse fashion, depend on the

number of inpatient days for patients who are "entitled to benefits under part A" for their "patient days" in a hospital fiscal year. 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I)-(II); *see also Allina I*, 746 F.3d at 1105 (explaining use of "entitled to benefits" in the calculation of the two DSH fractions).

The first fraction, the "part A/SSI" fraction, measures the proportion of the total number of days for all patients "entitled to benefits under part A" consisting of days for patients who *are* both "entitled to benefits under part A" of Medicare and "entitled to supplementary security income [("SSI")] benefits" "for such days." 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The second fraction, the "Medicaid" fraction, measures the ratio of patient days for patients who are Medicaid-eligible but "*not* entitled to benefits under part A" to the number of total patient days. *Id.* § 1395ww(d)(5)(F)(vi)(II) (emphasis added). Patients are either part-A-entitled or not for their inpatient days, so a given patient day can be counted in the numerator of one fraction or the other, but not both. *See Allina I*, 746 F.3d at 1108 ("[T]he statute unambiguously requires that Part C days be counted in one fraction or the other….").

Since 1986, when Congress mandated the DSH payment formula, the Secretary has repeatedly used notice-and-comment rulemaking, at least six times, to determine whether patient days that were not paid under part A were to be treated as part-A-entitled days in the DSH calculation, including in 1986 (adopting

a requirement that days must be covered and paid under part A to be included as part-A-entitled), 51 Fed. Reg. 16,772, 16,777 (May 6, 1986); in 2004 (attempting to reverse that requirement through rule later vacated in *Allina I*), 69 Fed. Reg. 48,916, 49,098-99 (Aug. 11, 2004); in 2005 (addressing "days for which Medicare was not the primary payer"), 70 Fed. Reg. 42,278, 47,441 (Aug. 12, 2005); in 2007 (implementing additional changes to the regulation's text consistent with the 2004 rule), 72 Fed. Reg. 47,130, 47,384 (Aug. 22, 2007); in 2010 (further amending the regulation text with respect to part C days), 75 Fed. Reg. 50,042, 50,285 (Aug. 16, 2010); and in 2013 (to prospectively reinstate the 2004 rule vacated in *Allina I*), 78 Fed. Reg. 50,496, 50,614 (Aug. 19, 2013).

The agency also has used notice-and-comment rulemaking, at least ten times, to implement payment standards on other categories of patient days in the DSH calculation. *See* 63 Fed. Reg. 40,954, 40,985 (July 31, 1998) (days for patients who were eligible for Medicaid but for which Medicaid did not make payment); 65 Fed. Reg. 3,136, 3,136-39 (Jan. 20, 2000) (days for patients eligible for Medicaid expansion waiver programs); 68 Fed. Reg. 45,346, 45,416-18 (Aug. 1, 2003) (patient days in units or wards providing services generally payable under part A); *id.* at 45,418-19 (outpatient observation days and patient days in swing beds used to provide skilled nursing services); *id.* at 45,419-20 (patient days in labor/delivery rooms); *id.* at 45,420-21 (days for patients with limited benefits

under Medicaid expansion waivers); 69 Fed. Reg. at 49,096-98 (outpatient observation days for patients ultimately admitted as an inpatients); 74 Fed. Reg. 43,754, 43,899-901 (Aug. 27, 2009) (labor/delivery room patient days); *id.* at 43,905-08 (outpatient observation days); 75 Fed. Reg. 50,042, 50,275-86 (Aug. 16, 2010) (SSI-entitled days for the part A/SSI fraction).

IV. Part C Days In The Part A DSH Calculation And The Secretary's Initial About-Face

Prior to a 2004 rulemaking, the "Secretary treated Part C patients as *not* entitled to benefits under Part A," "excluding Part C days from the Medicare [part A/SSI] fraction and including them in the Medicaid fraction." *Allina I*, 746 F.3d at 1106, 1108; *see also Northeast Hosp.*, 657 F.3d at 16-17 (holding policy announced in 2004 "contradicts [the Secretary's] former practice of excluding [part C] days from the Medicare fraction."). The pre-2004 regulation directed the Secretary to include as Medicare part-A-entitled days in the DSH calculation "the number of *covered* patient days that . . . [we]re furnished to patients who . . . were entitled to both Medicare Part A and SSI." 42 C.F.R. § 412.106(b)(2)(i) (2003) (emphasis added); *see also id.* § 409.3 (defining "covered" as services for which payment is authorized). As explained by the Secretary when it was adopted, this regulation mandated that only "covered Medicare Part A inpatient days" be included in the part A/SSI fraction. 51 Fed. Reg. at 16,777; *Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914, 921 n.5 (D.C. Cir. 2013) (noting

that the pre-2004 regulation limited the part A/SSI fraction to "covered Medicare Part A inpatient days.").

As the Secretary recently confirmed again, from 1986 through 2004, the Secretary followed this regulation, treating days as part-A-entitled only if the days were "covered"—meaning paid—by Medicare part A. Transmittal 279, Change Request 9896, CMS Pub. 100-06 (Dec. 16, 2016) (stating that prior to the 2004 rulemaking, inpatient days were included in the part A/SSI fraction "only if the inpatient hospital days were 'covered' under Medicare Part A" and that the 2004 rule "amended the DSH regulations by eliminating the requirement that Part A inpatient hospital days must be covered in order for such days to be included in the Medicare-SSI fraction").[6] Consistent with the regulation in effect at the time, the part A/SSI fractions before 2004 thus included only days "covered" under part A and therefore excluded part C days. *See, e.g.*, HCFA Pub. 60A, Transmittal No. A-98-36 (Oct. 1, 1998) (transmitting part A/SSI fractions that excluded part C days, specifying that the fractions include only "covered Medicare days," and referring to the ratio of SSI days and "covered Medicare days" as "the ratio of Medicare Part

[6] *Available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R279FM.pdf.

A patient days attributable to SSI recipients").[7]

In 2004, the Secretary issued a final rule making a change to begin treating days not paid by part A, including part C days, as part-A-entitled days in the DSH calculation. 69 Fed. Reg. at 49,099.[8] The final rule was an about-face from the proposed rule published in 2003, which had indicated the agency's intent only "to clarify" the longstanding standard under the existing regulation of including only covered part A days because "once a beneficiary has elected to join [a part C] plan, that beneficiary's benefits are no longer administered under Part A." 68 Fed. Reg. 27,154, 27,208 (May 19, 2003). The final rule nevertheless reversed course and announced that part C patient days would be considered part-A-entitled days for both fractions. *Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 81 (D.D.C.

[7] Even though the Secretary changed the DSH rule effective October 1, 2004 to eliminate the requirement that days be "covered," when he transmitted the part A/SSI fractions for Federal fiscal years 2005 and 2006, those fractions continued to exclude part C days. *See e.g.*, CMS Pub. 100-04, Transmittal 1091 (Oct. 27, 2006), *reprinted in* Medicare & Medicaid Guide (CCH) ¶ 156,277 (transmittal for Federal fiscal year 2005 part A/SSI fractions specifying that the fractions include only "covered Medicare days").

[8] When the Secretary initially changed the regulation, he admitted that there had been a "policy change." *See* 69 Fed. Reg. at 49,770 (including part C days in description of "policy changes" analyzed in conducting impact analysis under the Regulatory Flexibility Act); 72 Fed. Reg. at 47,384 (referencing "policy change" on part C days in the DSH calculation in describing later technical correction to regulation implementing that change). In the ensuing litigation, as described herein, the Secretary has denied that such a change occurred. *See, e.g.*, *Northeast Hosp.*, 657 F.3d at 15; *Allina I*, 746 F.3d at 1108.

2012), *aff'd in part and rev'd in part*, 746 F.3d 1102 (D.C. Cir. 2014); 69 Fed. Reg. at 49,099. In pertinent part, the final rule made a key change to the regulation text: it deleted the requirement that days must be "covered" by Medicare part A to be included as part-A-entitled days in the DSH calculation. *Compare* 42 C.F.R. § 412.106 (b)(2)(i) (2003) *with* § 412.106(b)(2)(i) (2004); *see also* 69 Fed. Reg. at 49,246. [9]

V. The Original *Allina I* Litigation

After the Secretary issued calculations in 2009 that implemented the 2004 rule change for part C days for the first time (for Federal fiscal year 2007), the hospitals in this case, along with twenty-one others, filed suit. They alleged, *inter alia*, that the 2004 rule was invalid because it was not the "logical outgrowth" of a proposed rule and because the agency's "cursory explanation in the 2004 Final

[9] In 2007, without providing notice or the opportunity for comment, the Secretary further amended the text of the DSH regulation governing part C days. 72 Fed. Reg. at 47,384. Following the amendments in 2004 and 2007, the regulation provided that the part A/SSI fraction would include not just "covered" part A patient days, but all days for "patients entitled to Medicare Part A (or Medicare Advantage (Part C))." *Id.* at 47,411 (amending 42 C.F.R. § 412.106(b)(2)(i)(B) and (iii)(B)). The revised text of the regulation recognizes that patients could be "entitled to Medicare Part A" for their days, on the one hand, "or Medicare Advantage (Part C)," on the other hand. *Id.*; *see also Allina I*, 904 F. Supp. 2d at 82. In 2010, the Secretary further amended the DSH regulation, changing the word "or" to "including." 75 Fed. Reg. at 50,285-86, 50,414. The district court in *Allina I* noted that this further change was made "in an apparent attempt to bolster" the Secretary's litigation position. *See* 904 F. Supp. 2d at 82 n.5.

Rule" failed to acknowledge or explain its departure from past policy. *Allina I*, 904 F. Supp. 2d at 89. The district court agreed in its late 2012 decision and vacated the 2004 rule on both grounds. *Id.* at 89-93, 95.

In 2013, the Secretary engaged in a new, prospective rulemaking on the treatment of part C days. The Secretary "proposed to readopt the policy of counting the days of patients enrolled in [part C] plans in the Medicare [part A/SSI] fraction," asserting that he was taking this action "in an abundance of caution," due to the *Allina I* litigation. 78 Fed. Reg. 50,496, 50,615 (Aug. 19, 2013). Effective October 1, 2013, the standard governing part C days in the DSH calculation became the same as the now vacated rule had been. *See id.* at 50,619 (rule "readopt[ion]" applies to "FY 2014 and subsequent years" only). Although commenters raised both issues, the Secretary neither acknowledged that the reinstituted change first made in 2004 was a policy change, nor addressed its financial consequences. *See id*. at 50,619-20. Nor did the Secretary attempt to use his limited power under the Medicare statute to engage in retroactive rulemaking to make the new rule effective to the pre-2014 years at issue in *Allina I* and here, in *Allina II*. *See id.* at 50,613-20; 42 U.S.C. § 1395hh(e).

In April 2014, this Court affirmed the district court's conclusion that "the Secretary's final rule was not a logical outgrowth of the proposed rule." *Allina I*, 746 F.3d at 1109. This Court did not reach the arbitrariness of the Secretary's

explanation. *Id.* at 1111. With respect to remedy, this Court held that the district court "correctly concluded that vacatur was warranted," but reversed the part of the district court's order directing the Secretary "to recalculate the hospitals' reimbursements 'without using the interpretation set forth in the 2004 Final Rule.'" *Id.* Rejecting the Secretary's invitation to decide the issue, this Court explained that the "question whether the Secretary could reach the same result" on remand through an adjudication "was not before the district court," and that the district court therefore should simply have "remand[ed] after identifying the error." *Id.*

More than a year and a half after this Court's *Allina I* decision (and more than a year after the hospitals filed suit in the district court in this case, *Allina II*), the Secretary issued a decision on remand. Mem. Op. 7, JA___. As in the vacated 2004 rule, the decision concluded that part C days should be included as part-A-entitled days in the part A/SSI fraction and excluded from the numerator of the Medicaid fraction for the 2007 periods at issue in that initial case. *Id.* The hospitals in *Allina I* have challenged the remand decision in a suit now pending before the district court, *Allina Health Sys., et al. v. Burwell*, No. 16-cv-00150 (D.D.C. Jan. 29, 2016).

VI. The Present Litigation

In June 2014, just sixteen days after this Court's decision in *Allina I* became final, the Secretary published part A/SSI fractions for Federal fiscal year 2012

applying the standard from the recently vacated rule. The issuance for every hospital nationwide offered only a cursory note stating that the part A/SSI fractions "includ[e] MA [*i.e.*, Medicare Advantage part C] Claims Submissions."[10] The Secretary proceeded without notice, comment opportunity, or explanation for the departure from the reinstated regulation even though the issuance was binding on the agency, its contractors, and hospitals for purposes of final Medicare DSH payment determinations. *See id.*; 42 C.F.R. § 412.106(b)(2); *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20, 24 (D.D.C. 2008).

The nine Appellant hospitals in this case, who were also plaintiffs in *Allina I*, filed appeals to the Secretary's Board and sought authorization for expedited judicial review. Administrative Record ("AR") 236-314; 747-817, JA __. The Board granted that request under 42 U.S.C. § 1395oo(f), concluding that it lacked authority "to decide the legal question of whether the regulation regarding the treatment of Medicare Part C days is valid and whether the Secretary's actions subsequent to the decision in *Allina* are legal." AR 6, 320, JA __. The hospitals timely filed suit in the district court.

The district court held that the agency's June 2014 issuance was a "rule," not "a step in an adjudication" as the Secretary had argued. Mem. Op. 17, JA___.

[10] 2012 Part A/SSI Fraction Data File, *available at* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY-2012-SSI-Ratios-for-web-posting.zip.

The court further concluded that the rule was an "interpretative" one exempt from the APA's notice-and-comment requirements, but did not address the requirement of the reinstated pre-2004 regulation that days must be "covered" to be included in the DSH calculation as part-A-entitled days. Mem. Op. 16-20, JA __.

The district court also found no requirement for notice-and-comment rulemaking under the Medicare Act, effectively equating the requirements of the Medicare Act and the APA, but did not provide any analysis of the Medicare rulemaking provision's text, structure, or legislative history. Mem. Op. 20-21, JA __.

Finally, the district court found that the June 2014 issuance was not arbitrary and capricious, relying on the vacated 2004 rule, the 2013 prospective rule, and *post-hoc* rationalizations in the agency's *Allina I* remand decision. Mem. Op. 24-30, JA __.

SUMMARY OF ARGUMENT

Financial, market, and public policy consequences like the loss of hundreds of millions of dollars in payments for costs incurred by safety-net hospitals—the result here—exemplify why Congress required the Secretary to engage in notice-and-comment rulemaking when making substantive changes in Medicare payment standards. The district court's decision, which misunderstands that requirement, must be reversed.

I. When the Secretary issued the June 2014 rule treating part C days as part-A-entitled in the DSH calculation, just days after the *Allina I* vacatur of the 2004 rule became final, he ignored the notice-and-comment rulemaking requirements of the Medicare Act and the APA triggered by the vacatur's restoration of the pre-2004 regulation and the standard embodied therein.

Under the plain terms of the Medicare Act—regardless of whether the Secretary's issuance is a "rule" (legislative or other), a "requirement," or a "statement of policy"—the agency is required to provide notice and comment before establishing or changing a "substantive legal standard" governing payment. 42 U.S.C. § 1395hh(a)(2). In June 2014, the Secretary determined that, for purposes of the part A DSH payment, patients who meet part A enrollment criteria, but elect instead to receive benefits under part C, would be considered "entitled to benefits under part A." That issuance, which put hundreds of millions of dollars of hospital payments at stake, triggered the Act's notice-and-comment requirements because it plainly changed the substantive legal standard governing payment under the reinstated pre-2004 rule. *See Northeast Hosp.*, 657 F.3d at 17 (holding that the now vacated 2004 rule "change[d] the legal consequences of treating low-income patients.").

The Secretary's "volte-face" implicated not only a Medicare payment standard, but a pre-existing regulation providing that only days "covered" (*i.e.*,

paid) under part A could be included as part-A-entitled days. Under the APA, the Secretary can take an inconsistent position, effectively amending that reinstated regulation, only if he engages in proper notice-and-comment rulemaking for the years governed by the reinstated regulation (fiscal years prior to 2014). The Secretary bypassed this requirement despite the agency routinely using notice and comment rulemaking to establish or change Medicare payment standards, including ones governing DSH.

II. The June 2014 issuance is also invalid because it completely lacks explanation. Under the longstanding law of this circuit, the Secretary is not permitted to defend it through *post-hoc* rationalizations. Regardless, the deficient prior rulemakings and later litigation documents offered *post-hoc* themselves fail to address important aspects of the problem, including the hundreds of millions of dollars implicated by the policy switch and its inconsistency with the Secretary's historical view of congressional intent. Instead, they still deny that any policy change has ever occurred, a position that has been repeatedly rejected by this Court. The district court's decision incorrectly excused the Secretary for these lapses.

STANDARD OF REVIEW

This Court reviews the district court's grant of summary judgment *de novo*, "'without deference to the decision of the district court.'" *Se. Ala. Med. Ctr. v.*

Sebelius, 572 F.3d 912, 916 (D.C. Cir. 2009) (quoting *Methodist Hosp. of Sacramento v. Shalala*, 38 F.3d 1225, 1229 (D.C. Cir. 1994)).

ARGUMENT

I. Notice-And-Comment Rulemaking Is Required For A Payment Standard Change That Is Irreconcilable With The Pre-2004 Regulation Restored By The Vacatur Of The 2004 Rule

The pre-2004 regulation reinstated by the *Allina I* vacatur specified that only covered part A patient days could be treated as part-A-entitled days in the DSH calculation, which compelled the Secretary to exclude part C days from the count of part A days. The 2014 issuance doing the exact opposite—to include part C days as part-A-entitled days—changes a substantive legal standard governing DSH payments and is incompatible with the regulation. Therefore, both the Medicare Act and the APA demand notice and comment rulemaking.

A. The Medicare Act Requires Notice-And-Comment Rulemaking To Change The Substantive Payment Standard On Part C Days In The DSH Payment Calculation

The Medicare Act expressly requires the Secretary to engage in notice-and-comment rulemaking before changing the operative legal standard governing when to treat days not paid by part A as part-A-entitled days in the DSH payment calculation. The Medicare statute requires notice and comment for *any* "rule, requirement, or other statement of policy" governing substantive payment standards; it incorporated only some of the APA's rulemaking exemptions (and *not* the one for interpretative rules); and it requires the Secretary to provide another

opportunity for comment if a regulation is vacated for insufficient notice—precisely what occurred here when this Court vacated the 2004 rule. 42 U.S.C. § 1395hh(a)(2) & (a)(4). Congress imposed notice-and-comment requirements in the Medicare Act beyond those already imposed by the APA because it was concerned that in the Medicare context, "important policies [were] being developed without benefit of the public notice and comment period." H.R. Rep. No. 100-391(I), at 430 (1987), *reprinted in* 1987 U.S.C.C.A.N. 2313-1, 2313-250. The district court's conclusion that the statute simply repeats the APA's rulemaking requirements is erroneous.

1. The Plain Language of Section 1395hh(a)(2) Requires Notice-and-Comment Rulemaking

Section 1395hh(a)(2) of the Medicare statute mandates that "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment for services . . . shall take effect unless it is promulgated by the Secretary by regulation," *i.e.*, notice-and-comment rulemaking. 42 U.S.C. § 1395hh(a)(2). That provision required notice-and-comment rulemaking here because the Secretary's June 2014 issuance treating part C days as part-A-entitled days was, just like the invalidated rule at issue in *Allina I*, a "rule, requirement, or other statement of policy" that changed the substantive legal standard governing payment for hospitals that serve a disproportionate share of low-income patients.

Prior to the (now null) 2004 rule change, the standard for part A treatment in the DSH calculation was coverage and payment under part A, which meant that part C days were *not* treated as part-A-entitled days. *See Northeast Hosp.*, 657 F.3d at 6; *Allina I*, 746 F.3d at 1106. The June 2014 issuance changed that standard from coverage under part A to satisfaction of part A enrollment criteria, meaning that even if a patient was enrolled in and received benefits under part C in lieu of benefits otherwise provided under part A, that patient's days would be included as days for which the patient was entitled to benefits under part A. *See* 2012 Part A/SSI Fraction Data File (stating that the part A/SSI fractions "includ[e] MA [*i.e.*, Medicare Advantage part C] Claims Submissions").[11] The changed standard falls comfortably into the plain meaning of a "rule, requirement, or other statement of policy" changing a "substantive legal standard" governing "payment for services."

First, the district court found that the June 2014 issuance was a rule, Mem. Op. 17, JA___, but at the very least it constituted a "statement of policy" or a "requirement," 42 U.S.C. § 1395hh(a)(2). Moreover, the rule alters the substantive legal standard because it defines and regulates the rights of hospitals to DSH payments meant to compensate them for services to low-income patients. *See Northeast Hosp.*, 657 F.3d at 17 ("Any rule that alters the method for calculating

[11] *Available at* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY-2012-SSI-Ratios-for-web-posting.zip.

those [DSH] fractions . . . changes the legal consequences of treating low-income patients."); Black's Law Dictionary 1567 (9th ed. 2009) (defining "substantive law" as "[t]he part of the law that creates, defines, and regulates the rights, duties, and powers of parties"). It does so by supplying the legal rule of decision to be used by the agency's staff and contractors when determining whether a day should be counted as a part-A-entitled day in the DSH calculation, and therefore, how much payment a hospital will receive. *See Gentiva Healthcare Corp. v. Sebelius*, 857 F. Supp. 2d 1, 12-13 (D.D.C. 2012) (an agency changes a "substantive legal standard" when it changes the "standard[] deployed in making [a] decision."); *cf. Plaut v. Spendthrift Farm, Inc.*, 514 U.S. 211, 218 (1995) (discussing a provision of the Securities Exchange Act that sets out "substantive legal standards for the Judiciary to apply"); *Comm. of U.S. Citizens Living in Nicar. v. Reagan*, 859 F.2d 929, 942 (D.C. Cir. 1988) (concluding that judgments of the International Court of Justice do not establish "substantive legal standards" for reviewing agency actions because its judgments do not "regulate the actions of the United States toward its own citizens").

Further, it "govern[s] . . . payment for services," 42 U.S.C. § 1395hh(a)(2), because the standard embodied in the 2014 issuance is binding on the agency and its contractors, and cannot be altered when the final DSH payment determinations are made for the hospitals. 42 C.F.R. § 412.106(b)(2); *Baystate*, 545 F. Supp. 2d at

24. Indeed, a reversal in the governing standard that directly affects payment of hundreds of millions of dollars cannot sensibly be deemed anything but a change to a "substantive legal standard" governing "payment for services." Under Section 1395hh(a), the new standard in the June 2014 issuance can be established only through notice-and-comment rulemaking.

In addition, Congress mandated that if the agency started a rulemaking without adequate notice, it must provide a "further opportunity for public comment" following the rulemaking timetables prescribed by the Medicare Act to put the policy into "effect." 42 U.S.C. § 1395hh(a)(4) ("If the Secretary publishes a final regulation … that is not a logical outgrowth of a previously published notice," it "shall not take effect until there is the further opportunity for public comment and a publication of the provision again as a final regulation."). Yet the Secretary here has implemented the new standard without any notice or period for comment whatsoever. That is impermissible.

Requiring notice-and-comment rulemaking pursuant to section 1395hh(a)(4) is also consistent with the Medicare Act's provision permitting retroactive rulemaking in some circumstances—a power that most agencies lack. *See id.* § 1395hh(e); *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 208 (1988) ("[A] statutory grant of legislative rulemaking authority will not, as a general matter, be understood to encompass the power to promulgate retroactive rules unless that

power is conveyed by Congress in express terms."). The Medicare Act allows retroactive rulemaking to change substantive payment standards but only if "the Secretary determines that . . . retroactive application is necessary to comply with statutory requirements" or "failure to apply the change retroactively would be contrary to the public interest." 42 U.S.C. § 1395hh(e)(1)(A). The agency declined to invoke that authority or to even try to make any such finding when it engaged in rulemaking on the part C days issue in 2013, during the pendency of the *Allina I* appeal to this Court, and instead expressly made that new rule prospective only. 78 Fed. Reg. at 50,615, 50,619. To allow the agency to depart from the reinstated pre-2004 legal standard for the period between the vacated rule and the effective date of the new "abundance of caution" 2013 prospective rulemaking, without notice and comment, subverts the express parameters for retroactive rulemaking under the Medicare Act. The agency cannot do indirectly what it did not do directly consistent with the rulemaking requirements of the Medicare Act.

2. The Text and Structure of Section 1395hh as a Whole Show that Its Notice-and-Comment Requirement Extends Beyond Legislative Rules

The district court exempted the Secretary from notice and comment because it deemed the June 2014 issuance an interpretative rule in the APA sense. Mem. Op. 21, JA____. But the Medicare Act's text and structure foreclose the district

court's conclusion that the Medicare Act does nothing more than reiterate the APA's framework for when notice and comment is required.

a. First, when setting out its notice-and-comment rulemaking requirements, section 1395hh uses different concepts and terminology than the APA. It applies those requirements with respect to any "rule, requirement, or other statement of policy" that changes a "substantive legal standard governing . . . the payment for services" covered under Medicare. 42 U.S.C. § 1395hh(a)(2). The APA, in contrast, requires notice and comment only for certain kinds of "rules," 5 U.S.C. § 553(b),[12] exempts "statements of policy," *id.* § 553(b)(3)(A), and does not impose obligations regarding agency "requirements," *id.* § 551(5) (limiting "rule making" requirements to "rule[s]").[13] Moreover, the APA nowhere uses the term "substantive legal standard" for any purpose, much less to describe when notice and comment is required.

Given that the Medicare Act came after the APA, it is fair to presume that if Congress wanted merely to repeat the same notice-and-comment requirement, it

[12] Under the APA, rulemaking is not required for "interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice." 5 U.S.C. § 553(b)(3)(A).

[13] Congress's use of the disjunctive when listing "requirement" and "rule" in the Medicare Act indicates that a "requirement" is something different from a "rule." *See, e.g., Loughrin v. United States*, 134 S. Ct. 2384, 2390 (2014) ("To read the next clause, following the word 'or,' as somehow repeating that requirement, even while using different words, is to disregard what 'or' customarily means.").

would have used the same terminology. *Cf. Russello v. United States*, 464 U.S. 16, 23 (1983) ("[Where] Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion.") (alteration in original) (internal quotation marks and citations omitted). It did not.

b. *Second*, when Congress intended to incorporate the APA's exceptions to notice-and-comment rulemaking, it did so expressly. Medicare Act section 1395hh(b) expressly incorporates the APA's "good cause" exemption. *See* 42 U.S.C. § 1395hh(b)(2)(C) (requiring notice and comment unless the APA's notice-and-comment requirement "does not apply pursuant to [the "good cause" exemption in] subparagraph (B)" of 5 U.S.C. § 553(b)).

In stark contrast, the Medicare Act does *not* incorporate subparagraph (A) of 5 U.S.C. § 553(b), which is the exception to the APA's notice-and-comment requirement for "interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice." *Id.* § 553(b)(A). Congress thus plainly did not intend for that exception to apply for the notice-and-comment requirement under the Medicare Act. Other than the explicitly incorporated APA good cause exemption, the Medicare Act's rulemaking provision enumerates exemptions relating only to the timetables for notice and comment. *See* 42 U.S.C. § 1395hh(b). Congress clearly considered exemptions to the Medicare Act's

notice-and-comment rulemaking requirement, and if it had meant to adopt the APA's framework wholesale or parts of the framework other than the "good cause" exemption, it would have done so.

c. *Third*, Congress's references to "interpretative" rules in section 1395hh indicate that Congress did not intend to adopt a blanket APA-like notice-and-comment exemption for interpretative rules. Section 1395hh(c)(1)(B) imposes a separate obligation on the Secretary to publish in the Federal Register a list of, *inter alia*, "interpretative rules" that "are not published pursuant to subsection (a)(1)" rulemaking. That language presupposes that some interpretative rules *are* subject to the notice-and-comment requirement of paragraph (a), and reflects that section 1395hh(a)(2) requires notice and comment only for the subcategory of agency issuances that establish or change a "substantive legal standard governing ... payment for services" or two other subject areas (scope of benefits and eligibility). If notice and comment were not required for *some* interpretative rules under paragraph (a), it would be unnecessary for section (c) to specify that the list-publication requirement applies only when an interpretative rule has *not* been published with notice and comment. *See also* H.R. Rep. No. 100-495, at 563 (1987) (Conf. Rep.), *reprinted in* 1987 U.S.C.C.A.N. 2313-1245, 2313-1309 (describing provision as requiring publication of list of "interpretative rules"

"which . . . are not published *as required by* [§ 1395hh(a)(2)] above") (emphasis added).

In addition, the Medicare Act's provision permitting limited retroactive rulemaking in section 1395hh(e)(1)(A) applies to "substantive changes" in "interpretative rules" (as well as "statements of policy"), indicating that those agency issuances can change "substantive legal standards" within the meaning of the Medicare Act's rulemaking provision. 42 U.S.C. § 1395hh(e)(1)(A).

Contrary to the district court's suggestion, Mem. Op. at 20, JA ___, this Court's passing dictum in *Monmouth Medical Center v. Thompson*, 257 F.3d 807 (D.C. Cir. 2001), does not compel a contrary conclusion—and certainly does not support the notion that the Medicare Act's notice-and-comment requirements are in all respects limited to those imposed by the APA. The sum total of *Monmouth*'s analysis of this proposition is the following:

> We have not had an opportunity to decide whether the Medicare Act requirement of notice and comment for "changes [of] a substantive legal standard" creates a more stringent obligation than the APA or whether it somehow changes the dividing line between legislative and interpretive rules. But it seems fair to infer that, as the Medicare Act was drafted after the APA, § [1395]hh(c)'s reference to "interpretive rules" without any further definition adopted an exemption at least *similar* in scope to that of the APA. We see no reason to explore the possibility of a distinction here.

Id. at 814 (internal citations omitted). It is clear that this Court did not engage in any meaningful analysis of the provisions cited above, which would have been

wholly unnecessary to the decision; to the contrary, it *expressly declined* "to explore the possibility of a distinction" between the two statutes. The Medicare Act uses terms that may share a meaning under the APA—*e.g.*, interpretative rules—but it does not adopt the same *exemptions* as the APA.[14]

d. *Finally*, unlike the APA, the Medicare Act (as noted above) imposes a requirement to permit "further opportunity for public comment" if a final regulation is not a logical outgrowth of a proposed regulation. *See* 42 U.S.C. § 1395hh(a)(4) ("If the Secretary publishes a final regulation . . . that is not a logical outgrowth of a previously published notice," it "shall not take effect until there is the further opportunity for public comment and a publication of the provision again as a final regulation."). This requirement should be all the more

[14] None of the out-of-circuit cases relied upon by the district court—which it acknowledged reached a similar conclusion "without thorough analysis" (Mem. Op. at 20-21, JA ___)—is persuasive. In *Warder v. Shalala*, 149 F.3d 73 (1st Cir. 1998), the court assumed (without deciding) that the Medicare Act was the same as the APA. *Id.* at 79 n.4 ("We proceed herein as if the SSA's exemption for interpretive rules were identical to the APA's . . . [The plaintiff] has not argued that the two standards are materially different."). In *Baptist Health v. Thompson*, 458 F.3d 768 (8th Cir. 2006), the court engaged in no analysis and relied on a case that actually did not address the question. *See id.* at 776 n. 8 ("[W]e agree with the courts that have held that this provisions imposes no standards greater than those established by the APA." (citing *Erringer v. Thompson*, 371 F.3d 625, 633 (9th Cir. 2004)). And, in *Erringer*, the Ninth Circuit (like this Court) specifically declined to answer the question of whether the APA and Medicare Act's rulemaking requirements differ. *See* 371 F.3d at 633 ("We have yet to determine whether the Medicare Act's language somehow draws the line between substantive and interpretative rules in a different place than the APA and decline to do so here.").

important when there has been a vacatur reinstating the prior regulation, as in this case. *See Allina I*, 904 F. Supp. 2d at 94-95, *aff'd* 746 F.3d at 1111. Contrary to section 1395hh(a)(4), the Secretary here has effectively readopted the vacated rule for the periods prior to 2014 without any opportunity for comment.

All the textual differences between the Medicare Act and the APA matter. *See Allina I*, 746 F.3d at 1109 (noting, regarding section 1395hh(a)(4), "that the Medicare statute is similar to the APA hardly means it is identical" but declining to decide the question). Congress's careful choice to use different terms in the Medicare Act and incorporate by reference only select parts of the APA's framework indicates its intent to do more than replicate the APA within the later enacted Medicare Act rulemaking provision. Instead, Congress intended to offer additional protection to those who furnish health care from changing standards, adopted without public input, that govern payment in the massive Medicare program.

3. Legislative History Confirms that the Medicare Act Imposes a Notice-and-Comment Obligation Distinct from the APA's

The legislative history of the Medicare rulemaking provision confirms that Congress intended to broaden the notice-and-comment obligation for the Secretary beyond the APA's requirements.

Congress first added a notice-and-comment requirement to the Medicare Act in 1986, long after the agency had obligated itself to follow the APA even for rules related to "benefits." *See* 36 Fed. Reg. 2,531, 2,532 (Feb. 5, 1971) (obligating the Secretary to "utilize the public participation procedures of the APA" in issuing "rules and regulations relating to . . . benefits . . . ."). In that first enactment, Congress obligated the Secretary to provide notice and 60 days for comment prior to publishing a Medicare regulation except in certain circumstances (*e.g.*, when the APA's "good cause" exemption applies). *See* Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9321(e), 100 Stat. 1874, 2017 (1986).

Just one year later, in the face of widespread complaints regarding standards governing payment being issued without notice-and-comment rulemaking, Congress revisited the specific Medicare rulemaking obligation because it remained concerned that "important policies [were] being developed without benefit of the public notice and comment period" because the Medicare Act did not "define a regulation for that [rulemaking] purpose." H.R. Rep. No. 100-391(I), at 430 (1987), *reprinted in* 1987 U.S.C.C.A.N. 2313-1, 2313-250. Accordingly, Congress adopted a new definition of "those policies which must be subject to the rulemaking procedures." *Id.* As discussed below, Congress plainly intended to subject *more* policies to notice and comment than the agency had been promulgating through rulemaking when it was bound only by the APA.

The initial standard for rulemaking adopted in the House bill—applying to any "rule, requirement, or other statement of policy" that has a "significant effect on . . . the payment for services"—was different from the APA's standard. *See* H.R. Rep. No. 100-495, at 563 (1987), *reprinted in* 1987 U.S.C.C.A.N. 2313-1245, 2313-1309. Although the Conference Committee amended the provision's rulemaking trigger to the change or establishment of a "substantive legal standard," Congress did not intend to import wholesale the APA's distinction between legislative and interpretative rules. To the contrary, the legislative history reflects Congress's understanding that under the conference amendment, any "[s]ignificant policy changes would be required to be promulgated as regulations," House Ways and Means Committee Summary of Conference Agreement, 12-13 (Dec. 22, 1987), and the heading enacted by the full Congress described the provision as requiring "publication as regulations of significant policies," Pub. L. No. 100–203, § 4035(b), 101 Stat. 1330, 1330-78 (1987) (capitalization omitted). Moreover, as noted above (*supra* at 30-31), if Congress had intended to do so, it presumably would have simply incorporated the APA interpretative rule exemption by name, or by simple cross-reference, as it did the year before for the "good cause" exemption. *See* 42 U.S.C. § 1395hh(b).

This case vividly illustrates the concerns that animated Congress's decision to require that more actions be subject to prior public comment. The Medicare

program is enormous. Agency payment rules about things that might appear to be details, like the issuance here, implicate hundreds of millions of dollars in payments, and large shifts in payments—especially no-notice shifts, with no time to plan—necessarily affect the ability of health care providers to plan for and provide care to the vulnerable elderly and disabled populations that Medicare serves. Congress wisely found it appropriate for this agency to engage in notice-and-comment rulemaking when adopting or changing payment standards of the sort at issue, in part so that these tremendous financial impacts are appropriately and timely considered.

Congress's elucidation of special rules for Medicare policies—particularly those that change standards—demand especially careful adherence following the Supreme Court's decision in *Perez v. Mortgage Bankers Ass'n*, 135 S. Ct. 1199 (2015). Prior to that case, the difference between the APA and Medicare Act's rulemaking provisions made little difference in this Circuit because amendments to prior interpretative rules were likewise subject to notice and comment under the APA, permitting the Court to decline to answer whether the Medicare Act required more than the APA. *See Monmouth Med. Ctr.*, 257 F.3d at 814 ("[C]haracterization as an interpretive rule does not relieve the Secretary of notice and comment requirements when a valid interpretation exists."). Following *Mortgage Bankers*, however, it is now critical to examine the Medicare Act's special provision

requiring notice and comment for policy changes that establish or change substantive payment standards. *Cf.* 135 S. Ct. at 1209 (noting that Congress sometimes adopts special protections to address "an agency adopt[ing] an interpretation that conflicts with its previous position").

B. The APA Required Notice And Comment For The 2014 Issuance

1. An Agency Cannot Depart from Its Regulation Without Notice and Comment

Under established circuit precedent applying the APA, "[u]nless and until [an agency] amends or repeals a valid legislative rule or regulation, [the] agency is bound by such a rule or regulation," *Am. Fed'n of Gov't Emps. v. Fed. Lab. Rels. Auth.*, 777 F.2d 751, 759 (D.C. Cir. 1985). This means the Secretary may not take a position inconsistent with his regulation in a binding issuance applicable to all hospitals nationwide without notice and comment, as occurred here.

As an initial matter, new "rules *that work substantive changes* . . . to prior regulations are subject to the APA's procedures." *U.S. Telecom Ass'n v. FCC*, 400 F.3d 29, 34-35 (D.C. Cir. 2005) (internal quotation marks and citations omitted; emphasis in original). The agency "may not alter, without notice and comment, [its] regulations . . ., unless such a change can be legitimately characterized as merely a permissible interpretation of the regulation, consistent with its language and original purpose." *Nat'l Fam. Plan. & Reprod. Health Ass'n, Inc. v. Sullivan*, 979 F.2d 227, 234 (D.C. Cir. 1992). Stated another way, if the agency "adopt[s] a

new position inconsistent with any of the Secretary's existing regulations," then "APA rulemaking would still be required" even for a "prototypical example of an interpretive rule." *Shalala v. Guernsey Mem'l Hosp.*, 514 U.S. 87, 99-100 (1995). In short, what an agency does by notice and comment can only be undone by notice and comment. *Nat'l Fam. Plan.*, 979 F.2d at 241 ("[O]nce a regulation is adopted by notice-and-comment rulemaking . . . its text may be changed only in that fashion.") (quoting *Homemakers N. Shore, Inc. v. Bowen*, 832 F.2d 408, 413 (7th Cir. 1987) (Easterbrook, J.)).

That fundamental principle is fully consistent with—and was reaffirmed by—the Supreme Court's decision in *Mortgage Bankers*. In *Mortgage Bankers*, the Supreme Court held that the APA did not require notice and comment "when an agency changes its interpretation of one of the regulations it enforces" from an earlier interpretation that it had issued without notice and comment. 135 S. Ct. at 1207. The Supreme Court reaffirmed, however, that notice and comment are required when an agency adopts a new position inconsistent with a regulation that was adopted with notice and comment. *Id*. at 1209. That latter holding governs here.

The district court erred by rejecting this doctrine on the ground that the 2014 issuance was an interpretative rule. Mem. Op. 24, JA___. But even a rule that might otherwise be deemed interpretative (which this is not) requires notice and

comment if it is inconsistent with a notice-and-comment regulation. *See Mortg. Bankers*, 135 S. Ct. at 1209 ("[A]n agency may only change its interpretation if the revised interpretation is consistent with the underlying regulations.") (internal quotation marks omitted); *Guernsey*, 514 U.S. at 100; *Nat'l Fam. Plan.*, 979 F.2d at 239 (finding that the Secretary issued a legislative rule modifying a regulation where, *inter alia*, "the agency has, through legislative rulemaking, already interpreted the statute, and is now changing that interpretation"). And—although the district court nowhere addressed the text of the regulation—the 2014 determination is flatly inconsistent with the restored, pre-2004 regulation limiting part-A days to those days covered and paid under part A.[15]

Furthermore, the agency's repeated past rulemaking on this exact issue shows the agency's understanding that notice-and-comment rulemaking is ordinarily required to change the kind of payment standard at issue. The agency has undertaken notice and comment no less than six times on this question. *See supra* at 11-12. Under the law of the Circuit, the agency's past practice bears on

[15] The district court correctly rejected the agency's position that the 2014 determination was a step in an adjudication rather than a rule. Mem. Op. 17, JA___. But the agency cannot depart from its regulations—without first amending them through notice and comment—in an adjudication, either. *See, e.g.*, *Rainbow Nav. Inc. v. Dep't of Navy*, 783 F.2d 1072, 1080 (D.C. Cir. 1986) (holding with respect to "the interpretation of the [statute] contained in the current regulations," "the government may not normally depart from it in an adjudicatory proceeding … without first amending the regulations").

the agency's intent, which is a factor in determining when notice-and-comment rulemaking is required under the APA. *See United States v. Picciotto*, 875 F.2d 345, 348 (D.C. Cir. 1989) (holding a rule regarding permit conditions at one park was legislative because, *inter alia*, "[w]hen the Park Service adopted a similarly site-specific, albeit stricter, regulation" for another location, the Park Service adopted it as a substantive rule requiring notice and comment, not as "an interpretive rule"). The district court erred by giving the past rulemakings no weight. *See* Mem. Op. 19-20, JA___.

2. ***The 2014 Issuance Conflicts with the Reinstated Pre-2004 DSH Regulation Excluding Part C Days from Part-A-Entitled Days***

The 2014 issuance squarely transgresses the prohibition on taking a "position inconsistent with any of the Secretary's existing regulations" without "APA rulemaking," *Guernsey*, 514 U.S. at 100, because it conflicts with the restored pre-2004 regulation.

The now-restored pre-2004 regulation dictates the exclusion of part C days from part-A-entitled days in the Medicare part A DSH calculation. It specifies that the part A/SSI fraction includes only "*covered patient days* that . . . [a]re furnished to patients who during that month were entitled to both Medicare Part A and SSI." 42 C.F.R. § 412.106(b)(2)(i) (2003) (emphasis added). "[C]overed" is a defined term in the regulations meaning paid. *Id.* § 409.3 (defining "covered" as services

for which payment is authorized). In short, this regulation text means that only "*covered* Medicare *Part A* inpatient days" may be included in the DSH calculation as Medicare part-A-entitled days. 51 Fed Reg. 16,772, 16,777 (May 6, 1986) (emphasis added); *see also Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914, 921 n.5 (D.C. Cir. 2013) (stating that the pre-2004 regulation limited the part A/SSI fraction to "covered Medicare Part A inpatient days").

Days are covered by part A only if part A was the "payor." *See* 51 Fed. Reg. 31,454, 31,460-61 (Sept. 3, 1986) (stating that limiting the Medicaid fraction to days where "the Medicaid program is the primary payor" was "consistent with" the part A/SSI fraction being limited to "covered days"). Part C days are not covered by part A because payment by private part C Medicare Advantage plans for services furnished to their part C patients is *not* payment by part A (the fee-for-service program). *See* 42 U.S.C. § 1395w-21(a)(1) & (i); *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 6 (D.C. Cir. 2011).[16] Therefore, the regulation prohibits part C days from being treated as part-A-entitled days.

[16] This Court in *Northeast Hospital* explained that the Secretary's (now-vacated) rule altered "the HHS regulation that governs calculation of DSH fractions, to state *expressly* that [part C] patient days should be counted in the Medicare fraction." 657 F.3d at 14 (emphasis added). In this context, the Court's follow-on statement that "[p]rior to 2004, the regulation did not specify where [part C] enrollees should be counted" means only that the pre-existing regulation did not "expressly" mention part C days. *See id.*

The established meaning of the pre-2004 regulation is reflected in the 2003 notice proposing to clarify "a then-existing policy, *i.e.*, one of excluding Part C days from the Medicare [part A/SSI] fraction and including them in the Medicaid fraction," *Allina I*, 746 F.3d at 1108. In that notice, the agency proposed no change to the regulatory text. 68 Fed. Reg. 27,154, 27,208 (May 19, 2003). It was only after the agency reversed course and announced that it was newly "adopting a policy" (in the now vacated rule) to begin treating part C days as part A days, 69 Fed. Reg. at 49,099, that the agency amended the regulation's text (i) first to delete the prior rule's limitation to "covered" days, *id.* at 49,246, and (ii) later to include in the part A/SSI fraction *all* days (not just covered days) for patients entitled to part A "*or* Medicare Advantage (Part C)," 72 Fed. Reg. 47,130, 47,411 (Aug. 22, 2007) (emphasis added). The amendment to delete "covered" and add "or . . . Part C" underscores that the prior regulation's covered part A days did *not* include part C days. The agency's prior policy likewise confirms that longstanding regulatory standard. Because days for patients enrolled under part C are not paid under part A, those days were not treated as part-A-entitled under the pre-2004 regulation. *See Allina I*, 746 F.3d at 1108; *Northeast Hosp.*, 657 F.3d at 15.

Similarly, under the pre-2004 regulation, many other categories of days for patients who met the enrollment criteria for part A were not treated as part A days, contrary to the government's current policy, because the days were not covered

(*i.e.*, paid) under part A. For example, the patient days for individuals who were enrolled in the Medicare part A fee-for-service program, but for whom part A benefits had been exhausted,[17] were not treated as part A days under the DSH regulation because "only covered patient days are included" in the part A/SSI fraction. *See, e.g.*, 69 Fed. Reg. at 49,098; *see also* 70 Fed. Reg. 47,278, 47,441 (Aug. 12, 2005) (adopting a "policy change" to prospectively include in the Medicare part A/SSI fraction days for patients enrolled in part A but "for which Medicare was not the primary payer.").

Notably, that regulation barred the inclusion even of days paid by *other parts of Medicare*, for patients who were eligible for enrollment in *part A*. For example, the Medicare statute provides that certain inpatient services can be reimbursed by Medicare part B after a beneficiary has exhausted his or her part A benefits. 42 U.S.C. § 1395*l*(t)(1)(B)(ii). Under the regulation, those inpatient days, which are partially paid under part B and relate to patients who are enrolled in the part A fee-for-service program, were not treated as part A days in the DSH calculation. *See* Pls.' Mem. re Mot. for Summ. J. Ex. A, *Allina II*, ECF No. 9-1 (D.D.C. Oct. 9, 2014). Those part B days were not expressly mentioned in the regulation, but they

[17] Part A covers the first 90 days of inpatient hospital services in a spell of illness, plus 60 lifetime reserve days. 42 U.S.C. § 1395d(a)(1).

were nonetheless excluded by definition because, like Part C days, they are not days covered and paid under part A.

It makes no difference that the part C program was enacted after the DSH regulation was adopted in 1986. The Secretary may not have contemplated all of the categories of patient days that would be excluded from coverage under part A when he adopted the regulation, but that does not change the fact that the regulation's terms excluded *all* days not covered and paid under part A, whether paid under part B or some other part of Medicare, even if the patient met the enrollment criteria for part A. A potential future application of a rule does not need to have been preemptively rejected for an agency's regulation to prohibit it. *See City of Idaho Falls v. FERC*, 629 F.3d 222, 229 (D.C. Cir. 2011) (holding that new methodology effectively amended regulation even though it had not been specifically rejected by the agency when the prior regulation was adopted). That is the case here.

In sum, the agency cannot take binding action doing what the reinstated pre-2004 regulation actually prohibited—treating patient days *not* covered and paid under part A as part-A-entitled days—unless and until the Secretary goes through proper notice and comment to amend the reinstated pre-2004 regulation.

II. The Secretary's Unexplained Rule Is Not The Product Of Reasoned Decision-Making

In addition to failing to comply with the notice-and-comment rulemaking provisions of the APA and the Medicare Act, the Secretary's 2014 determination to treat part C days as part A days is arbitrary and capricious because the agency has not "considered the matter in a detailed and reasoned fashion." *ITT Indus., Inc. v. NLRB*, 251 F.3d 995, 1004 (D.C. Cir. 2001) (internal quotation marks omitted). An agency's determination does not reflect reasoned decision-making, and constitutes arbitrary and capricious agency action, when the agency fails "to acknowledge and provide an adequate explanation for its departure from established precedent." *Dillmon v. Nat'l Transp. Safety Bd.*, 588 F.3d 1085, 1089-90 (D.C. Cir. 2009). The Secretary offered no explanation whatsoever for its 180-degree change in position. Earlier, defective pronouncements and later *post-hoc* litigation documents all denying that change and an important factor — its tremendous payment effect — cannot salvage the rule.

A. The Secretary Offered No Explanation For The 2014 Rule And Cannot Defend It With Extrinsic Rationalizations

The Secretary's 2014 issuance treating part C days as part A days does not even attempt to reflect reasoned decision-making. To the contrary, it announces the change, but provides *no explanation* for it at all. Mem. Op. 25-26, 28, JA ___. The agency's silence completely failed the requirement to "display awareness that

it *is* changing position." *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009) (emphasis in original).

The government's defense of the 2014 rule in the proceedings below did not rest on any explanation provided by the agency at that time. There was none. That rule therefore is "arbitrary and capricious because the agency has not . . . articulated any rationale for its choice." *Republican Nat'l Comm. v. FEC*, 76 F.3d 400, 407 (D.C. Cir. 1996) (quotation marks and citation omitted).

Below, the Secretary offered only a *post-hoc* rationalization that came 18 months later in another case on remand from this Court, *Allina I*. But that is not a valid reason for sustaining this agency action. "Agency decisions must generally be affirmed on the grounds stated in them," not *post-hoc* rationalizations. *Ass'n of Civilian Technicians v. Fed. Lab. Rels. Auth.*, 269 F.3d 1112, 1117 (D.C. Cir. 2001). Although an agency may be permitted to supply a "more detailed explanation of [its] action," it cannot "present a new basis for its action" after the fact. *Nat'l Oilseed Processors Ass'n v. Browner*, 924 F. Supp. 1193, 1204 (D.D.C. 1996). Given the complete lack of *any* basis offered in 2014, any reasoning offered after the fact is an impermissible "post-hoc rationalization," rather than a permissible "discussion of the previously-articulated rationale for the challenged action." *Id.*

The district court concluded that "[t]he Administrator's *Allina I* decision is precisely the type of post-hoc rationalization that . . . cannot be substituted on

appeal for contemporaneous, reasoned decision-making." Mem. Op. 27-28, JA ___. The court nonetheless also found that "the agency ha[d] supplied its reasons" on other prior occasions, including in the 2004 rulemaking that was vacated by this Court and in the 2013 rulemaking that readopted the vacated 2004 rule prospectively. *Id.* at 28, JA ___. The district court concluded that a contemporaneous explanation was not required, because the dangers of *post-hoc* rationalization—that the judiciary rather than the agency will supply reasons underlying the decision—are not present here, as the agency had already made its interpretation of the statute clear in the two other rulemakings. *Id.* at 28, JA ___.[18]

The dangers of *post-hoc* rationalizations, however, are front and center in this case. The Court should be especially wary of relying on the extrinsic rationales offered by the agency, in the context of ongoing litigation, due to the "danger that [the] agency, having reached a particular result, may become so committed to that result as to resist engaging in any genuine reconsideration of the issues." *See Food Mktg. Inst. v. Interstate Com. Comm'n*, 587 F.2d 1285, 1290

[18] The district court's reliance on *Women Involved in Farm Economics v. United States Department of Agriculture* in reaching this conclusion is misplaced. That case involved a set of "unusual circumstances" involving "the basis for a regulation issued nearly twenty years ago" where the agency was specifically exempt from providing any explanation at the time the rule was issued. 876 F.2d 994, 998 (D.C. Cir. 1989). Because the task was "essentially historical," this Court concluded that it was appropriate to accept justifications proffered by counsel. *Id.* That scenario is far afield from this case and provides no basis for accepting the non-contemporaneous explanations offered here.

(D.C. Cir. 1978). That danger is amplified here, where the issuance at stake applied the same policy reflected in the 2004 rule just sixteen days after this Court's vacatur of that rule, and the *Allina I* remand decision came after the hospitals had already filed a motion for summary judgment in this case. The agency's 2013 prospective-only "abundance of caution" rulemaking in response to *Allina I* makes it worse for the Secretary, not better. That *fait accompli* provided no rationale for the application of that prospective rule to prior years, including the 2012 year at issue. The agency's other rulemakings on part C days in the DSH calculation do not fill the void.

B. The Agency Has Never Explained Critical Aspects Of Its DSH Payment Standard Change

Even if reliance on non-contemporaneous explanations was proper (and it was not), the June 2014 rule was still arbitrary and capricious. An amalgamation of what the Secretary actually said in those extrinsic documents—the 2004 rule vacated by the district court for insufficient explanation, the preordained and prospective 2013 rulemaking, and the late 2015 separate *Allina I* remand decision subject to no public comment—does not demonstrate reasoned decision-making.

In the 2004 rule vacated by this Court, the Secretary's sole explanation for its new position was that part C enrollees "are still, in some sense, entitled to benefits under Medicare Part A." 69 Fed. Reg. at 49,099. The district court in *Allina I* rejected this "cursory explanation," finding that it "failed to meet the

requirements of the APA" because "the Secretary[] fail[ed] to acknowledge her 'about-face,'" and "her reasoning for the change was brief and unconvincing." *Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 93 (D.D.C. 2012) (quoting *Northeast Hosp.*, 657 F.3d at 15).[19]

In the 2013 rulemaking, undertaken "in an abundance of caution" given the *Allina I* litigation, the agency "readopt[ed] the policy of counting the days of patients enrolled in [part C] plans in the Medicare fraction," effective as of October 1, 2013 for "*FY 2014 and subsequent years*" only. 78 Fed. Reg. 50,496, 50,615, 50,619 (Aug. 19, 2013) (emphasis added). Thus, the prospective 2013 rule does not even purport to apply to the 2012 hospital cost years at issue here. Moreover, the 2013 rulemaking proceeded from the proposition that it was continuing pre-2004 policy, not changing it. *See id.* at 50,620 (stating that agency's new 2013 rule "is consistent with our longstanding policy" and "is not considered a change in our policy"). Consequently, the Secretary did "not believe that there will be additional savings or costs to the Medicare program, and by inference, to hospitals, as a result of this policy." *Id.* Nor does the Secretary's analysis of the financial impacts of the 2013 rulemaking, under the Regulatory Flexibility Act, contain any mention of

[19] This Court did not reach the question of whether the 2004 rule was arbitrary and capricious, holding that the Secretary had failed to provide proper notice to the Plaintiff hospitals. *Allina I*, 746 F.3d at 1111.

the effect of the renewed part C days policy change. *See id.* at 51,003-38. The Secretary's 2013 failure to address the impact does not cure the same failure in June 2014.

Nor does the later issued *Allina I* remand decision. That after-the-fact late 2015 decision is itself nothing more than "a barren exercise of supplying reasons to support a pre-ordained result," the one reached in 2014, that fails the APA's reasoned decision-making commands. *Food Mktg. Inst.*, 587 F.2d at 1290. "Post-hoc rationalizations by the agency on remand are no more permissible than are such arguments when raised by appellate counsel during judicial review." *Id.* This is especially true where, as here, the vacated agency action "itself departed drastically from" the agency's prior policy. *Id.*

Specifically, the *Allina I* remand decision repeats the same tired refrain *denying* that the agency was changing position or that there was ever a prior policy treating part C days as non-part A days prior to 2004. *See, e.g.*, Def.'s Mot. for Summ. J. Attach. No. 4 at 34-35, *Allina II*, ECF No. 29-4 (D.D.C. Dec. 15, 2015), JA ___ (stating that "the Providers are incorrect insofar as they suggested that including Part C days in the Medicare fraction, and excluding them from the Medicaid fraction, represents a reversal of prior policy"). This absence of a "conscious change of course," *Fox*, 556 U.S. at 515, fails what "the requirement of reasoned decisionmaking demands," *Am. Elec. Power Serv. Corp. v. FCC*, 708 F.3d

183, 186 (D.C. Cir. 2013). The agency has repeatedly tried—and failed—to disavow its prior position on part C days, and its effort should fare no better here. *See Allina I*, 746 F.3d at 1106; *Northeast Hosp.*, 657 F.3d at 14-17.

In addition to its refusal to acknowledge the agency's change in position on part C days, the later remand decision and earlier rulemakings also demonstrate that the agency has still "entirely failed to consider an important aspect of the problem." *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). One of the many things unexplained in the 2004 rule at issue in *Allina I* was "the financial impact" of the part C policy change. *Allina Health Servs.*, 904 F. Supp. 2d at 94. The agency has *never* grappled with the fact that its policy change reduces DSH payments to safety-net hospitals by hundreds of millions of dollars. *See Northeast Hosp.*, 657 F.3d at 5, 15 (noting that "the practical consequences of [the part C] dispute number in the hundreds of millions of dollars"); *Allina I*, 746 F.3d at 1107 (noting the "enormous financial consequences" of the policy change). At some point, the Secretary must reckon with the change and its financial consequences.

In addition, the agency has never adequately explained how its new position on part C days is consistent with its prior understanding of Congressional intent. Based on the legislative history of the DSH statute, the Secretary has historically confined the DSH measure to days paid under the part A inpatient hospital

prospective payment system.[20] *See* 68 Fed. Reg. at 45,419 ("[W]e believe that, based on a reading of the language in section 1886(d)(5)(F) of the Act, which implements the disproportionate share provision, we are in fact required to consider only those inpatient days to which the prospective payment system applies in determining a prospective payment hospital's eligibility for a disproportionate share adjustment.") (internal quotation marks and citation omitted). The purpose of the DSH adjustment, as previously recognized by the Secretary, is to provide additional payment under the part A prospective payment system for hospitals that incur higher than average costs in treating part A patients because they treat large numbers of low-income patients. *See* H.R. Rep. No. 99-

[20] The 2014 determination also fails the *Chevron* step two reasonableness test because the inclusion of part C days in the calculation of the part A Medicare DSH adjustment "conflict[s] with the policy judgments that undergird the statutory scheme." *Health Ins. Ass'n of Am., Inc. v. Shalala*, 23 F.3d 412, 416 (D.C. Cir. 1994). *See Goldstein v. SEC*, 451 F.3d 873, 883 (D.C. Cir. 2006) (rejecting policy under *Chevron* step two where it was not "rational when viewed in light of the policy goals underlying the" applicable statute); *Coal Emp't Project v. Dole*, 889 F.2d 1127, 1131 (D.C. Cir. 1989) (finding agency's interpretation impermissible where it was not "consistent with the statutory purpose"). The district court wholly rested its erroneous finding of consistency with the statutory intent on two cases decided by this Court, *Northeast Hospital* and *Catholic Health*, both of which plainly do *not* address the reasonableness of the Secretary's part C days policy. Mem. Op. 29, JA____. This Court explicitly declined to decide the reasonableness of the Secretary's new part C policy in *Northeast Hospital*. 657 F.3d at 13; *see also Allina I*, 746 F.3d at 1107. In light of the decision in *Catholic Health* rejecting similar arguments with respect to different days not paid by part A for patients actually enrolled in part A (because their part A benefits where exhausted), 718 F.3d at 918, 920, the hospitals reserve this argument for any *en banc* review by this Court.

241(I), at 16 (1985), *reprinted in* 1986 U.S.C.C.A.N 579, 594; 68 Fed. Reg. at 45,418 (citing legislative history of the DSH statute). Accordingly, the Secretary has never counted all Medicare beneficiaries' patient days in the part A/SSI fraction. The agency has, for example, excluded patient days paid under Medicare part B from the part A/SSI fraction, directing that they instead be included in the numerator of the Medicaid fraction (as "not entitled to benefits under part A") if Medicaid eligible. *See* Pls.' Mem. re Mot. for Summ. J. Ex. A, *Allina II*, ECF No. 9-1 (D.D.C. Oct. 9, 2014). And the Secretary *still* excludes patient days for Medicare part A enrollees in areas of a hospital that are not payable under the part A prospective payment system. 42 C.F.R. § 412.106(a)(1)(ii) (2010); 68 Fed. Reg. at 45,416-18 (including only patient days in units or ward providing services generally payable under the part A inpatient prospective payment system in DSH calculation). This further, unexplained inconsistency underlying the 2014 issuance also renders it arbitrary and capricious.

The Secretary's 2014 rule, devoid of any rationale and thus defended based on a mishmash of other deficient and litigation-posturing statements that themselves still deny the about-face and its impact on hospitals, epitomizes the need for notice and comment to change course in setting Medicare payment standards.

CONCLUSION

For the foregoing reasons, the judgment of the district court should be reversed.

Respectfully submitted,

/s/Stephanie A. Webster
Stephanie A. Webster
Pratik A. Shah
Christopher L. Keough
J. Harold Richards
AKIN GUMP STRAUSS HAUER & FELD LLP
1333 New Hampshire Ave., NW
Washington, D.C. 20036
202-887-4000
swebster@akingump.com

Counsel for Appellants

Hyland Hunt, *Of Counsel*
DEUTSCH HUNT PLLC
300 New Jersey Ave. NW, Ste. 900
Washington, D.C. 20001
202-868-6915

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CERTIFICATE OF COMPLIANCE

The foregoing brief is in 14-point Times New Roman proportional font and contains 12,933 words, and thus complies with the type-volume limitation set forth in Rule 32(a)(7)(B) of the Federal Rules of Appellate Procedure.

/s/Stephanie A. Webster
Stephanie A. Webster

January 23, 2017

CERTIFICATE OF SERVICE

I hereby certify that, on January 23, 2017, I served the foregoing brief upon the following counsel of record by filing a copy of the document with the Clerk through the Court's electronic docketing system:

Stephanie R. Marcus
U.S. Department of Justice
Civil Division
950 Pennsylvania Avenue, N.W., Room 7642
Washington, DC 20530
Phone: (202)-514-1633
Email: stephanie.marcus@usdoj.gov

Mark B. Stern
U.S. Department of Justice
Civil Division
950 Pennsylvania Avenue, N.W., Room 7642
Washington, DC 20530
Phone: (202)-514-5089
Email: mark.stern@usdoj.gov

/s/Stephanie A. Webster
Stephanie A. Webster

STATUTORY ADDENDUM

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United States Code

Title 5. Government Organization and Employees

Part I. The Agencies Generally

Chapter 5. Administrative Procedure

Subchapter II. Administrative Procedure

§ 551. Definitions

For the purpose of this subchapter—

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(4) "rule" means the whole or a part of an agency statement of general or particular applicability and future effect designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of an agency and includes the approval or prescription for the future of rates, wages, corporate or financial structures or reorganizations thereof, prices, facilities, appliances, services or allowances therefor or of valuations, costs, or accounting, or practices bearing on any of the foregoing;

(5) "rule making" means agency process for formulating, amending, or repealing a rule;

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United States Code

Title 5. Government Organization and Employees

Part I. The Agencies Generally

Chapter 5. Administrative Procedure

Subchapter II. Administrative Procedure

§ 553. Rule making

*****

(b) General notice of proposed rule making shall be published in the Federal Register, unless persons subject thereto are named and either personally served or otherwise have actual notice thereof in accordance with law. The notice shall include--

(1) a statement of the time, place, and nature of public rule making proceedings;

(2) reference to the legal authority under which the rule is proposed; and

(3) either the terms or substance of the proposed rule or a description of the subjects and issues involved.

Except when notice or hearing is required by statute, this subsection does not apply--

(A) to interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice; or

(B) when the agency for good cause finds (and incorporates the finding and a brief statement of reasons therefor in the rules issued) that notice and

public procedure thereon are impracticable, unnecessary, or contrary to the public interest.

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United States Code

Title 42. The Public Health and Welfare

Chapter 7. Social Security

Subchapter XVIII. Health Insurance for Aged and Disabled

Part E. Miscellaneous Provisions

§ 1395hh. Regulations

(a) Authority to prescribe regulations; ineffectiveness of substantive rules not promulgated by regulation

(1) The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter. When used in this subchapter, the term "regulations" means, unless the context otherwise requires, regulations prescribed by the Secretary.

(2) No rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this subchapter shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1).

(3)(A) The Secretary, in consultation with the Director of the Office of Management and Budget, shall establish and publish a regular timeline for the publication of final regulations based on the previous publication of a proposed regulation or an interim final regulation.

(B) Such timeline may vary among different regulations based on differences in the complexity of the regulation, the number and scope of comments received, and other relevant factors, but shall not be longer than 3 years except under exceptional circumstances. If the Secretary intends to vary such timeline with respect to the publication of a final regulation, the Secretary shall cause to have published in the Federal Register notice of the different timeline by not later than the timeline previously established with

respect to such regulation. Such notice shall include a brief explanation of the justification for such variation.

(C) In the case of interim final regulations, upon the expiration of the regular timeline established under this paragraph for the publication of a final regulation after opportunity for public comment, the interim final regulation shall not continue in effect unless the Secretary publishes (at the end of the regular timeline and, if applicable, at the end of each succeeding 1-year period) a notice of continuation of the regulation that includes an explanation of why the regular timeline (and any subsequent 1-year extension) was not complied with. If such a notice is published, the regular timeline (or such timeline as previously extended under this paragraph) for publication of the final regulation shall be treated as having been extended for 1 additional year.

(D) The Secretary shall annually submit to Congress a report that describes the instances in which the Secretary failed to publish a final regulation within the applicable regular timeline under this paragraph and that provides an explanation for such failures.

(4) If the Secretary publishes a final regulation that includes a provision that is not a logical outgrowth of a previously published notice of proposed rulemaking or interim final rule, such provision shall be treated as a proposed regulation and shall not take effect until there is the further opportunity for public comment and a publication of the provision again as a final regulation.

(b) Notice of proposed regulations; public comment

(1) Except as provided in paragraph (2), before issuing in final form any regulation under subsection (a) of this section, the Secretary shall provide for notice of the proposed regulation in the Federal Register and a period of not less than 60 days for public comment thereon.

(2) Paragraph (1) shall not apply where--

(A) a statute specifically permits a regulation to be issued in interim final form or otherwise with a shorter period for public comment,

(B) a statute establishes a specific deadline for the implementation of a

provision and the deadline is less than 150 days after the date of the enactment of the statute in which the deadline is contained, or

(C) subsection (b) of section 553 of Title 5 does not apply pursuant to subparagraph (B) of such subsection.

(c) Publication of certain rules; public inspection; changes in data collection and retrieval

(1) The Secretary shall publish in the Federal Register, not less frequently than every 3 months, a list of all manual instructions, interpretative rules, statements of policy, and guidelines of general applicability which--

(A) are promulgated to carry out this subchapter, but

(B) are not published pursuant to subsection (a)(1) of this section and have not been previously published in a list under this subsection.

(2) Effective June 1, 1988, each fiscal intermediary and carrier administering claims for extended care, post-hospital extended care, home health care, and durable medical equipment benefits under this subchapter shall make available to the public all interpretative materials, guidelines, and clarifications of policies which relate to payments for such benefits.

(3) The Secretary shall to the extent feasible make such changes in automated data collection and retrieval by the Secretary and fiscal intermediaries with agreements under section 1395h of this title as are necessary to make easily accessible for the Secretary and other appropriate parties a data base which fairly and accurately reflects the provision of extended care, post-hospital extended care and home health care benefits pursuant to this subchapter, including such categories as benefit denials, results of appeals, and other relevant factors, and selectable by such categories and by fiscal intermediary, service provider, and region.

[No subsection (d) has been enacted]

(e) Retroactivity of substantive changes; reliance upon written guidance

(1)(A) A substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this

subchapter shall not be applied (by extrapolation or otherwise) retroactively to items and services furnished before the effective date of the change, unless the Secretary determines that

(i) such retroactive application is necessary to comply with statutory requirements; or

(ii) failure to apply the change retroactively would be contrary to the public interest.

(B)

(i) Except as provided in clause (ii), a substantive change referred to in subparagraph (A) shall not become effective before the end of the 30-day period that begins on the date that the Secretary has issued or published, as the case may be, the substantive change.

(ii) The Secretary may provide for such a substantive change to take effect on a date that precedes the end of the 30-day period under clause (i) if the Secretary finds that waiver of such 30-day period is necessary to comply with statutory requirements or that the application of such 30-day period is contrary to the public interest. If the Secretary provides for an earlier effective date pursuant to this clause, the Secretary shall include in the issuance or publication of the substantive change a finding described in the first sentence, and a brief statement of the reasons for such finding.

* * * * *

United States Code

Title 42. The Public Health and Welfare

Chapter 7. Social Security Act

Subchapter XVIII. Health Insurance for Aged and Disabled

Part E. Miscellaneous Provisions

§ 1395ww. Payments to hospitals for inpatient hospital services

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

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(5)(F)

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(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 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.

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 of this chapter.

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2003 Code of Federal Regulations

Title 42. Public Health

Chapter IV. Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter B. Medicare Program

Part 412. Prospective Payment Systems for Inpatient Hospital Services.

Subpart G. Special Treatment of Certain Facilities Under the Prospective Payment System for Inpatient Costs

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

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(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

(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.

(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.

(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.

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2004 Code of Federal Regulations

Title 42. Public Health

Chapter IV. Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter B. Medicare Program

Part 412. Prospective Payment Systems for Inpatient Hospital Services.

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(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 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.

(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.

(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.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 400, 405, 412, and 489

[BERC-385-IFC]

Medicare Program; Fiscal Year 1986 Changes to the Inpatient Hospital Prospective Payment System

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule sets forth revisions to the Medicare inpatient hospital prospective payment system. This rule is needed to implement those portions of sections 9101 through 9105 and 9112 of the Consolidated Omnibus Budget Reconciliation Act of 1985 having an effective date of May 1, 1986 or earlier. The changes required by this legislation affect the fiscal year 1986 prospective payment rates; the rate-of-increase limits (target amounts) for hospitals excluded from the prospective payment system; the length of the transition period and the method of payment; application of the hospital wage index; payment for the indirect costs of medical education; and payments for hospitals that serve a disproportionate share of low-income patients.

DATES: Effective date: With certain exceptions, this interim final rule is effective on May 1, 1986. We refer the reader to section VII.B. of this preamble for a detailed discussion of effective dates.

Comment Date: To be considered, comments must be mailed or delivered to the appropriate address, as provided below, and must be received by 5:00 p.m. on June 5, 1986.

ADDRESS: Mail comments to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: BERC-385-IFC, P.O. Box 26676, Baltimore, Maryland 21207.

If you prefer, you may deliver your comments to one of the following addresses:

Room 309-G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC, or

Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland.

In commenting, please refer to file code BERC-285-IFC. Comments received timely will be available for public inspection as they are received, beginning approximately three weeks after publication of this document, in Room 309-G of the Department's offices at 200 Independence Avenue SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (phone: 202-245-7890).

FOR FURTHER INFORMATION CONTACT: Linda Magno, (301) 594-9343.

SUPPLEMENTARY INFORMATION:

I. Background

On September 3, 1985, we published a final rule in the **Federal Register** (50 FR 35646) that made the following changes to the Medicare inpatient hospital prospective payment system:

- We adjusted the diagnosis-related groups (DRG) classifications and weighting factors for discharges occurring on or after October 1, 1985.
- For cost reporting periods beginning on or after October 1, 1983, we adopted a new hospital wage index that was based on the HCFA survey of hospital wages.
- We made several changes to the regulations in 42 CFR Parts 405 and 412 concerning—

—The rate-of-increase limits for hospitals excluded from the prospective payment system;
—Payments for indirect costs of medical education;
—Limitations on charges to beneficiaries for hospitals paid under State reimbursement control systems or demonstration projects;
—The exclusion of alcohol/drug hospitals and units;
—Review of cost outliers; and
—Qualifying criteria for referral centers.

- We established the FY 1986 Federal rates by—

—Restandardizing the base year cost data to reflect the new wage index;
—Grouping the standardized costs per case for urban/rural averages for the nine census regions and the nation, reflecting the most recent geopgraphic designations;
—Updating the standardized amounts by zero percent; and
—Applying the same adjustment factors for nonphysician anesthetist costs and outlier payments as were used for FY 1985.

- We did not increase either the hospital-specific rates for hospitals under the prospective payment system or the rate-of-increase limits for hospitals excluded from the prospective payment system.

With certain exceptions, the September 3 final rule was to be effective on October 1, 1985.

On September 30, 1985, the Emergency Extension Act of 1985 (Pub. L. 99-107) was enacted. Section 5 of Pub. L. 99-107 extended through November 14, 1985 the Medicare payment rates for inpatient hospital services that were in effect on September 30, 1985. A result of this delay was that certain changes in the rules that govern Medicare payment for inpatient hospital services, which would have become effective on October 1, 1985, for FY 1986 as a result of the September 3, 1985 final rule, were postponed initially until November 15, 1985. The affected changes concerned the rules for determining payment rates for hospitals covered by the prospective payment system and the rate-of-increase limits for hospitals excluded from that system. In addition, the amendments to 42 CFR 412.118(f)(2) and (f)(3) concerning determination of indirect medical education costs that were scheduled to be effective on October 1, 1985 under the September 3, 1985 final rule were also postponed until November 15, 1985. We announced this postponement in a notice in the **Federal Register** published on November 12, 1985 (50 FR 46651).

Since publication of that notice, several more laws were enacted that further delayed the implementation of revised Medicare inpatient hospital services payment rules as follows:

- Pub. L. 99-155, enacted December 14, 1985, extended the delay through December 14, 1985.
- Pub. L. 99-181, enacted December 13, 1985, extended the delay through December 18, 1985.
- Pub. L. 99-189, enacted December 18, 1985, extended the delay through December 19, 1985.
- Pub. L. 99-201 enacted December 23, 1985, extended the delay through March 14, 1986.

To announce the first of these extensions of the delay, we published a notice in the **Federal Register**, on December 6, 1985 (50 FR 49930); the remaining extensions were described in a notice published February 3, 1986 (51 FR 4166). The result of these extensions is that, for the period of the extension, we continued to pay for hospital discharges under the rules that were in effect in FY 1985. Thus, we did not implement the following changes that were included in the September 3, 1985 final rule:

- Revised DRG classifications and weights.
- Revised wage index.
- Revised adjusted standardized amounts.
- Revised regulations concerning exclusions on the count of interns and

For purposes of determining a hospital's bed size, we are using the same definition that is currently used for determining number of beds for purposes of calculating the indirect medical education adjustment (§ 412.118(b)). That is, the number of beds in a hospital is determined by counting the number of available bed days during the hospital's cost reporting period, not including beds assigned to newborns, custodial care, and excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period.

Section 1886(d)(5)(F)(vi) states that the term "disproportionate patient percentage," which is used in the criterion implementing section 1886(d)(5)(F)(i)(I) and (v) of the Act, which is described above, means the sum of the following two fractions, which is expressed as a percentage:

1. Patient days of those patients entitled to both Medicare Part A and Supplemental Security Income (SSI) (excluding *those patients receiving State supplementation only*)

Patient days of those patients entitled to Medicare Part A

2. Patient days of those patients entitled to *Medicaid but not to Medicare Part A*

Total number of patient days

The number of patient days of those patients entitled to both Medicare Part A and SSI will be determined by matching data from the Medicare Part A Tape Bill (PATBILL) file with the Social Security Administration's (SSA's) SSI file. This match will be done at least annually and will involve a match of the individuals who are SSI recipients for each month during the Federal fiscal year in which the hospital's cost reporting period begins with the Medicare Part A beneficiaries who received inpatient hospital services during the same month. Thus, if a Medicare beneficiary is eligible for SSI benefits (excluding State supplementation only) during a month in which the beneficiary is a patient in the hospital, the covered Medicare Part A inpatient days of hospitalization in that month will be counted for the purpose of determining the hospital's disproportionate patient percentage. The match of SSI eligibility records to Medicare inpatient hospital days for a hospital will consist of counting the days in which Medicare inpatient hospital services are furnished during each month to patients entitled to both Medicare Part A and SSI, summing those days, and dividing by the total number of days for which Medicare inpatient hospital services are furnished to all Medicare Part A beneficiaries in the hospital.

Although section 1886(d)(5)(F)(vi)(I) of the Act specifies that the match is done on a cost reporting period basis, we believe that matching Social Security numbers on a Federal fiscal year basis is the most feasible approach. A monthly match of SSI eligibility files to Medicare hospital records would be administratively more cumbersome and costly and could not be accomplished in a timely manner. Relying on Medicare billing records for the Federal fiscal year rather than the hospital cost reporting period avoids the problem of billing lag at the end of the cost reporting period. We do not believe that there are likely to be significant fluctuations from one year to the next in the percentage of patients served by the hospital who are dually entitled to Medicare Part A and SSI. Consequently, the percentage for a hospital's own experience during the Federal fiscal year should be reasonably close to the percentage specific to the hospital's cost reporting period.

However, we are affording all hospitals the option to determine their number of patient days of those dually entitled to Medicare Part A and SSI for their own cost reporting periods. A hospital that avails itself of this option must furnish to its fiscal intermediary, in a manner and format to be prescribed by HCFA, data on its Medicare patients for its cost reporting period. These data will then be matched by SSA to determine those patients dually entitled to Medicare and SSI for the hospital's cost reporting period. The full cost of this process, including the cost of verification by SSA, will be borne by the hospital.

The number of patient days of those patients entitled to Medicaid but not to Medicare Part A will be determined by the hospital's Medicare fiscal intermediary based on Medicaid statistical data reported on the hospital's Medicare cost report. Total Medicaid inpatient days will include all covered days attributable to Medicaid patients including any inpatient days for Medicaid patients who are members of a health maintenance organization.

Section 1886(d)(5)(F)(vi)(II) of the Act describes Medicaid patient days at those". . . which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under title XIX . . . ." Therefore, Medicaid covered days will include only those days for which benefits are payable under title XIX. Any day of a Medicaid patient's hospital stay that is not payable by the Medicaid program will not be counted as a Medicaid patient day since the patient is not considered eligible for Medicaid coverage on those days. For example, if a patient is hospitalized for 15 days and is eligible for Medicaid benefits for 10 of those days, only the 10 covered days will be considered Medicaid patient days for purposes of determining a hospital's disproportionate patient percentage.

The process we will use for making payments to hospitals that serve a disporprotionate share of low-income patients will be similar to the process we use to make the additional payment for the indirect medical education costs; that is, we will make interim payments based on the latest available data subject to a year-end settlement on a cost reporting period basis. For purposes of making these interim payments, the initial determination of a hospital's eligibility for this payment will be made by the hospital's Medicare fiscal intermediary based on Medicaid statistical data as reported on the hospital's most recent cost report and the SSI and Medicare data to be supplied by HCFA central office. If a hospital disagrees with the intermediary's determination of its Medicaid patient days, it will be the hospital's responsibility to demonstrate to the intermediary that the Medicaid statistics reported on its cost report are incorrect or were improperly applied. Medicaid data submitted by the hospital, whether on the cost report or furnished subsequently, are subject to intermediary audit to ensure their accuracy.

Sections 1886(d)(5)(f) (ii) and (iv) of the Act specify that the additional payment adjustment for hospitals that meet the disproportionate patient percentage criterion (section 1886(d)(5)(F)(i)(I) of the Act) is determined as follows:

- For urban hospitals with 100 or more beds, the hospital's total DRG revenue (as defined below) is increased by 2.5 percent plus one-half the difference between the hospital's percentage of low-income patients and 15 percent, up to a maximum of 15 percent; that is, the disproportionate share adjustment factor is the lesser of 15 percent or (P−.15)(.5)+.025, where P equals the hospital's disproportionate patient percentage expressed as a decimal.
- For urban hospitals with fewer than 100 beds, the hospital's total DRG revenue is increased by five percent.

G. Subpart G is amended as follows:

Subpart G—Special Treatment of Certain Facilities

1. In § 412.90, a new paragraph (h) is added to read as follows:

§ 412.90 General rules.

* * * * *

(h) *Hospitals that serve a disproportionate share of low-income patients.* For discharges occurring on or after May 1, 1986 and before October 1, 1988, HCFA makes an additional payment to hospitals that serve a disproportionate share of low-income patients. The criteria for this additional payment are set forth in § 412.106.

2. A new § 412.106 is added to read as follows:

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

(a) *Basic rule.* (1) Unless a hospital elects the option concerning the period of time used for counting the number of patient days (that is, the hospital's cost reporting period rather than the Federal fiscal year), as described in paragraph (a)(2) of this section, a hospital's disproportionate patient percentage is the sum of the following, expressed as a percentage:

(i) Number of covered patient days during each month of the Federal fiscal year in which the hospital's cost reporting period begins of those patients who are entitled during that month to both Medicare Part A and Supplemental Security Income benefits under title XVI of the Act (excluding those patients receiving State supplementation only), summed for the months of the Federal fiscal year, and divided by the number of patient days during that same Federal fiscal year of those patients entitled to Medicare Part A.

(ii) Number of patient days during the hospital's cost reporting period of those patients who are entitled to Medicaid but not to Medicare Part A divided by the total number of patient days in that same period.

(2) For purposes of making the calculation in paragraph (a)(1)(i) of this section, a hospital may elect to have the count of the number of patient days made on the basis of its cost reporting period, rather than by Federal fiscal year, if the following conditions are met:

(i) The hospital furnishes to its intermediary, in a manner and format prescribed by HCFA, data on its Medicare Part A patients for its cost reporting period.

(ii) The hospital bears the full cost of preparing its submittal as described in paragraph (a)(2)(i) of this paragraph and the cost incurred by SSA in determining the number of beneficiaries entitled to both Medicare Part A and Supplemental Security Income benefits for each month of the cost reporting period.

(3) The number of beds in a hospital is determined as specified in § 412.118(b).

(4) The definitions for urban and rural areas are the same as those set forth in § 412.62(f).

(b) *Criteria for classification.* For discharges occurring on or after May 1, 1986 and before October 1, 1988, a payment adjustment (as described in paragraph (c) of this section) is made for each hospital that meets one of the following criteria:

(1) During the hospital's cost reporting period, the hospital has a disproportionate patient percentage that is at least equal to—

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

(ii) 40 percent, if the hospital is located in an urban area and has fewer than 100 beds; or

(iii) 45 percent, if the hospital is located in a rural area.

(2) The hospital is located in an urban area, has 100 or more beds, and can demonstrate that, during its cost reporting period, more than 30 percent of its total inpatient care revenues are derived from State and local government payments for indigent care furnished to patients who are not covered by Medicare or Medicaid.

(c) *Payment adjustment.* If a hospital meets one of the criteria in paragraph (b) of this section, the hospital's total DRG revenue based on DRG-adjusted prospective payment rates (for transition period payments, the Federal portion of the hospital's payment rates), including outlier payments determined under Subpart F of this part but excluding additional payments made under the provisions of this subpart or § 412.118, is increased by the disproportionate share payment adjustment factor, determined as follows:

(1) If the hospital meets the criteria of paragraph (b)(1) (i) of this section, the disproportionate share payment adjustment factor is the lesser of—

(i) 15 percent; or

(ii) 2.5 percent plus one-half the difference between the hospital's disproportionate patient percentage and 15 percent.

(2) If the hospital meets the criteria of paragraph (b)(1)(ii) of this section, the disproportionate share payment adjustment factor is five percent.

(3) If the hospital meets the criteria of paragraph (b)(1)(iii) of this section, the disproportionate share payment adjustment factor is four percent.

(4) If the hospital meets the criteria of paragraph (b)(2) of this section, the disproportionate share payment adjustment factor is 15 percent.

F. Subpart H is amended as follows:

Subpart H—Payments to Hospitals under the Prospective Payment System

§ 412.113 [Amended]

1. In § 412.113, paragraph (b) is amended by revising the date in the third sentence from "Ootober 1, 1986" to "October 1, 1987".

2. Section 412.118 is amended by revising the introductory language; revising paragraphs (a) and (c); redesignating current paragraphs (d), (e), (f), and (g) as paragraphs (e), (f), (g), and (h), respectively; adding a new paragraph (d); and revising newly redesignated paragraphs (e) and (g) to read as follows:

§ 412.118 Determination of indirect medical education costs.

To determine the indirect medical education costs, HCFA uses the following procedures:

(a) *Basic data.* HCFA determines the following for each hospital:

(1) The hospital's ratio of full-time equivalent interns and residents, except as limited under paragraph (g) of this section, to number of beds (as determined in paragraph (b) of this section).

(2) The hospital's total DRG revenue based on DRG-adjusted prospective payment rates (for transition period payments, the Federal portion of the hospital's payment rates), including outlier payments determined under Subpart F of this part but excluding additional payments made under the provisions of Subpart G of this Part. For cost reporting periods beginning on or after January 1, 1986, for purposes of this section, the total DRG revenue is not offset for payments made to outside suppliers under § 489.23 of this chapter for nonphysician services furnished to beneficiaries entitled to Medicare Part A.

* * * * *

(c) *Measurement for teaching activity.* The factor representing the effect of teaching activity on inpatient operating costs is equal to the following:

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 405 and 412

[BERC-353-F]

Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1987 Rates

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule.

SUMMARY: We are amending the Medicare regulations governing the inpatient hospital prospective payment system to implement necessary changes arising from legislation and our continuing experience with the system.

In addition, we are describing changes in the methods, amounts, and factors necessary to determine prospective payment rates for Medicare inpatient hospital services. In general, these changes are applicable to discharges occurring on or after October 1, 1986. We are also setting forth the update factor for determining the rate-of-increase limits (target amounts) for hospitals excluded from the prospective payment system.

EFFECTIVE DATE: This final rule is effective on October 1, 1986. We refer the reader to section VI.A. of this preamble for a discussion of specific provisions that apply to specific periods.

FOR FURTHER INFORMATION CONTACT: Linda Magno, (301) 594-9343.

SUPPLEMENTARY INFORMATION:

I. Background

A. Summary of the Implementation of the Prospective Payment System

Under section 1886(d) of the Social Security Act (the Act), enacted by the Social Security Amendments of 1983 (Pub. L. 98-21) on April 20, 1983, a prospective payment system for Medicare payment of inpatient hospital services was established effective with hospital cost reporting periods beginning on or after October 1, 1983. Under this system, Medicare payment is made at a predetermined, specific rate for each discharge. All discharges are classified according to a list of diagnosis-related groups (DRGs).

We published an interim final rule in the **Federal Register** (48 FR 39752) on September 1, 1983 to implement the prospective payment system effective with hospital cost reporting periods beginning on or after October 1, 1983. Technical corrections for that rule were issued on October 19, 1983 (48 FR 48467).

On January 3, 1984, we issued a final rule (49 FR 234) to make changes resulting from our consideration of public comments that were received in response to the interim final rule. Technical corrections for that rule were issued on June 1, 1984 (49 FR 23010).

As a result of our first year of experience with the prospective payment system and to accommodate changes resulting from the enactment of the Deficit Reduction Act of 1984 (Pub. L. 98-369) on July 18, 1984, we published a final rule on August 31, 1984 (49 FR 34728) that further revised the prospective payment regulations. In addition, we made changes in the methods, amounts, and factors necessary to implement the second year of the transition period. Technical corrections for that final rule were issued on October 15, 1984 (49 FR 40167).

On March 29, 1985, we published a final rule (50 FR 12740) that redesignated the prospective payment regulations under a new 42 CFR Part 412. These regulations were previously located in 42 CFR 405.470 through 405.477.

Taking into consideration the recommendations made by the Prospective Payment Assessment Commission (PROPAC) under the authority of section 1886(d)(4)(D) of the Act, we published a final rule on September 3, 1985 (50 FR 35646) to implement the third year of the transition period. Technical corrections for that final rule were issued on October 28, 1985 (50 FR 43570). However, beginning on September 30, 1985, Congress enacted a series of statutory extensions of the hospital payment rates that were in effect on September 30, 1985. The effect was to delay implementation of the September 3, 1985 final rule with the result that the revised payment rates for hospitals covered by the prospective payment system and the rate-of-increase limits for hospitals excluded from that system, which were originally scheduled to be effective on October 1, 1985, were postponed through April 30, 1986. We notified the public about these extensions (50 FR 46651 and 49930, and 51 FR 4166) and, after the President signed the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. 99-272) into law on April 7, 1986, we issued an interim final rule with comment period on May 6, 1986 (51 FR 16772). That rule implemented new Federal fiscal year (FY) 1986 hospital payment rates effective for discharges occurring on or after May 1, 1986 for prospective payment hospitals and for cost reporting periods beginning on or after October 1, 1985 for hospitals excluded from the prospective payment system.

The comment period for the interim final rule ended on June 5, 1986. We are responding to the comments received on that rule in section II of this preamble. Certain clarifying changes to the regulations, in response to the comments received on the interim final rule, are set forth in this document.

B. Summary of June 3, 1986 Proposed Rule

On June 3, 1986, we published a notice of proposed rulemaking (NPRM or proposed rule) in the **Federal Register** (51 FR 19970) to further amend the prospective payment system. We proposed to make the following changes:

- Under section 1886(a)(4) of the Act, we proposed to incorporate capital-related costs into the prospective payment system effective with cost reporting periods beginning in FY 1987. However, on July 2, 1986, Pub. L. 99-349 was enacted and included a provision (section 206) that amended section 1886(a)(4) of the Act to extend the period (through cost reporting periods beginning prior to October 1, 1987) during which capital-related costs must be treated separately from other inpatient hospital operating costs. Therefore, we are not incorporating capital-related costs into the prospective payment system in this final rule. Accordingly, we are not addressing in this final rule the comments we received concerning that proposal. However, we will consider the comments as we deliberate this matter further.
- We proposed to recompute the hospital market basket using data from a more recent base year (that is, "rebasing" the market basket) and to recalculate the weights of each of the components of the hospital market basket (that is, "reweighting" the market basket cost categories).
- We discussed several decisions and current provisions of the regulations in 42 CFR Parts 405 and 412, and set forth proposed changes concerning—

—Establishment of a base period for hospitals newly subject to the rate-of-increase ceiling;

—Extension of the exclusion for excluded alcohol/drug hospitals and units from the prospective payment system;

—Hospitals in redesignated rural counties which are surrounded on all sides by urban counties;

—Changes to referral center criteria; and

—Changes to the DRG classification system.

These results indicate a high degree of correlation between SSI/Medicare percentages computed based on the Federal fiscal year and those computed by hospital cost reporting period. (A coefficient of 1.0 equals a perfect correlation.)

In addition, we also point out that for a significant proportion of hospitals within each of these groups, the SSI/Medicare ratio computed for Federal FY 1984 was within 2.3 percentage points (approximately one standard deviation of the mean difference) of the actual value derived from the hospital's own cost reporting period that began in Federal FY 1984, as shown below:

Disproportionate share groups	Percentage [1]
Urban—100 or more beds	95.5
Urban—less than 100 beds	81.4
Rural	90.5
Overall	86.9

[1] Percentage of hospitals whose SSI/Medicare ratio for Federal fiscal year 1984 is within .023 of the SSI/Medicare ratio for its cost reporting period beginning in Federal fiscal year 1984.

While the variability in the percentages is somewhat higher for the small urban hospital and rural hospital groups, generally only those hospitals in these two groups with overall disproportionate patient percentages that fall short by a small margin of meeting the necessary thresholds to qualify for an adjustment (that is, 40 percent and 45 percent, respectively) could be impacted. This is because the amount of the disproportionate share adjustment for qualifying hospitals in these two groups is not dependent on the amount of their disproportionate patient percentages.

We do not believe Congress intended to impose such a cumbersome and costly administrative burden as that described above in implementing this provision. The Secretary has general rulemaking authority under section 1102 and 1871 of the Act to deal with problems of implementing and administering the Act in an efficient manner. Based on the above discussion, we believe that using the Federal fiscal year instead of a hospital's own cost reporting period is the most feasible approach to implementing this provision in terms of accuracy, timeliness and cost efficiency. In addition, we believe we have complied with the law by affording hospitals the option of having their SSI/Medicare percentage computed based on its own cost reporting period.

Comment: Several commenters objected to our definition of Medicaid patient days for purposes of computing a hospital's disproportionate patient percentage. These commenters stated that all inpatient days associated with a Medicaid recipient should be counted whether or not the patient was actually covered by Medicaid for those days. These commenters focused on the term "patients who . . . were eligible for medical assistance . . ." in section 1886(d)(5)(F)(vi)(II) of the Act and argued that, since a patient would still be "eligible" for Medicaid benefits even though part or all of the patient's care may not be covered by Medicaid for a certain day, all patient days for which care was actually provided to a Medicaid eligible individual should be counted.

Response: We believe that the parenthetical phrase "for such days" in section 1886(d)(5)(F)(vi)(II) of the Act was intended to modify the phrase "eligible for medical assistance" and that Congress intended to include only such patient days for which the Medicaid patient was eligible to have his or her care paid for by the Medicaid program. We believe evidence of Congressional intent in this regard may be found in the legislative history of section 1886(d)(5)(F)(vi) of the Act.

The Conference Report described the House bill on section 9105 of Pub. L. 99-272 as defining low income patients as follows:

> The proxy measure for low income would be the percentage of a hospital's total inpatient days attributable to medicaid patients (including medicaid-eligible medicare beneficiaries—medicare/medicaid crossovers).

(See H.R. Rep. No. 99–453, 99th Cong., 1st Sess. 459 (1985).) The phrase "inpatient days attributable to medicaid patients" supports the commenters' interpretation that all days that are attributable to Medicaid patients (that is, for which the patient is Medicaid-eligible) must be included in the numerator of the definition. However, the House bill's definition was not ultimately accepted by the Conference Committee. The Conference Report states that:

> The percentage of low income patients will be defined as the total number of inpatient days attributable to Federal Supplemental Security Income beneficiaries divided by the total number of medicare patient days, plus the number of *medicaid patient days* divided by total patient days. (Emphasis added.)

(See H.R. Rep. No. 99–453, 99th Cong., 1st Sess. 461 (1985).) The substitution of the term "number of medicaid patient days" in the Conference agreement for the previous term "attributable to medicaid patients" suggests that Congress intended to adopt the definition as we currently understand it (that is, only hospital days covered by Medicaid should be included in the numerator.) We believe that Congress consciously changed the focus of the Medicaid definition from the number of days that may be attributable to individuals eligible for Medicaid to the actual "number of Medicaid patient days" (that is, days that were paid for by the State's Medicaid program).

We believe this interpretation, that only Medicaid covered days should be counted, is not inconsistent with the statutory scheme as a whole, since the formula in section 1886(d)(5)(F)(vi) of the Act does not purport to identify all indigent patients. Rather, it refers to certain Medicare and Medicaid patients as an easily and objectively determined proxy for the indigent. Thus, under any reading of the statute, not all indigent patients are included in the formula. A Medicaid eligible recipient who has exhausted his or her benefits is thus situated similarly to the indigent patient who is not eligible for Medicaid at all, and so it is logical to treat them the same for purposes of determining the disproportionate patient percentage.

In addition, given the relatively short timeframe for implementing section 1886(d)(5)(F)(vi) of the Act, we believe it is reasonable to assume that Congress anticipated that the Medicare cost report would serve as the primary source for Medicaid patient day statistics. Our definition of Medicaid patient days is consistent with the way we require Medicaid days to be reported on the Medicare cost report. On that form, a day of care is designated a Medicaid patient day only if the Medicaid program is the primary payor. There is no provision on the form for a patient day being counted as more than one type for payment purposes. We do not believe that Congress intended that an additional reporting mechanism, possibly tied to State eligibility records, be developed to obtain Medicaid statistics on noncovered patient days.

Therefore, since Congress clearly intended that the disproportionate share adjustment be implemented promptly with the data currently available, we believe the definition of Medicaid patient days published in the interim final rule is the one that Congress intended that we adopt.

We should also point out that our interpretation that the Medicaid portion of the definition of the disproportionate share percentage under section 1886(d)(5)(F)(vi)(II) of the Act refers only to Medicaid covered days is consistent with our interpretation of the Medicare portion under section 1886(d)(5)(F)(vi)(I) of the Act, (which uses similar language)

to refer only to Medicare covered days. In the preamble to the interim final rule, we indicated that we would count "covered" Medicare days in determining the Medicare portion of a hospital's disproportionate patient percentage. However, we received no comments on this issue.

D. Other Comments

Comment: One commenter believes that a 30-day comment period does not provide enough time for the public to comment on rule changes to a program as important as the prospective payment system. The commenter would prefer a 60-day comment period. In addition, the commenter is concerned that comments are considered only if they are received by HCFA by the end of the indicated comment period. Since commenters have no control over the date a comment is received, HCFA should consider all comments postmarked by the end of the comment period.

Response: It was important that we move quickly to inform the public as soon as possible about the provisions of Pub. L. 99-272 that affected implementation of the prospective payment system during FY 1986. Congress authorized issuance of an interim final rule (section 9115(b) of Pub. L. 99-272), and mandated the effective date of the provisions dealt with in the interim final rule. In addition, under section 1886(e)(5)(B) of the Act, we were required to issue the proposed update for the prospective payment system for FY 1987 by June 1, 1986 and the final rule by September 1, 1986.

As indicated in section I of this preamble, this leaves no time for a comment period of longer than 30 days on the proposed updates. Therefore, in order to deal with the comments on the Pub. L. 99-272 interim final rule and the proposed FY 1987 update in an organized sequential manner, we established the 30-day comment period for the interim final rule. A 60-day comment period would have meant that the comment periods for both the interim final rule and the proposed FY 1987 update would have ended virtually simultaneously. This in turn would have meant that we would have been required to address comments on both documents at the same time, thereby complicating the process of meeting the September 1, 1986 statutory deadline for publication of the FY 1987 final rule.

As discussed above, we normally provide a 60-day comment period if circumstances permit it. However, given the need to issue regulations to implement Pub. L. 99-272 quickly combined with the imminent publication of the FY 1987 prospective payment proposal, we determined that a 30-day comment period was necessary. We also point out that, for the most part, those provisions in Pub. L. 99-272 affecting the prospective payment system in FY 1986 were ones about which we had little administrative discretion concerning their substance or implementation. Therefore, a longer public comment period for those provisions would have been unnecessary. In addition, although there is no specified minimum time for the length of a public comment period, the courts have consistently held that a 30-day comment period is sufficient.

With regard to how the comment period date is applied, we consider to be timely only those comments that are received by the last day of the comment period rather than those postmarked by the last day of the comment period because postmarks are not always a reliable indicator of when a comment was sent. In many cases, the postmark is illegible and thus cannot be used to prove when a comment was sent. Also, for those commenters who use a postal meter outside the post office, a meter may be changed to reflect a date other than the one on which the comment was actually sent, or a predated envelope may be used to send a late comment. Expedited mail services are available from the post office and from private carriers to help ensure that comments are delivered timely. We believe that our policy is not only reliable but equitable since it imposes the same constraints on all commenters.

Comment: One commenter requested that in all future documents concerning the prospective payment system that are published in the **Federal Register**, we should present a table of outlier criteria and thresholds that includes the labor portion percentage, national ratio of cost to charges, the fixed dollar minimum, and the minimum multiple of the Federal DRG rate.

Response: The outlier criteria and thresholds are routinely published in the **Federal Register** as a part of the proposed and final rules concerning the annual update to the prospective payment rates. This information was not published in the May 6, 1986 interim final rule implementing sections 9101 through 9105 and 9112 of Pub. L. 99-272 since the outlier criteria and thresholds for FY 1986 published in the **Federal Register** on September 3, 1985, were not changed as a result of this legislation. We did not see the necessity of republishing this information since we believe it was clearly understood that absent any specific changes made by Pub. L. 99-272, the changes to the prospective payment system that were published in the **Federal Register** on September 3, 1985 would become effective May 1, 1986.

III. Rebasing and Reweighting of the Hospital Market Basket

A. Background

For cost reporting periods beginning on or after July 1, 1979, we developed and adopted a hospital input price index (that is, the hospital "market basket") for use in establishing the limits on hospitals' routine operating costs (44 FR 31802). The percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient care. Traditionally, we used the market basket to adjust hospitals' cost limits by an amount that reflects the average increase in the prices of the goods and services used to furnish inpatient care. This approach linked the increase in the cost limits to the efficient utilization of resources.

With the inception of the prospective payment system on October 1, 1983, we continued to use the market basket to update each hospital's 1981 inpatient operating cost per discharge used in establishing the standardized payment amounts. In addition, the projected change in the market basket is one of the integral components of the update factor by which the prospective payment rates were updated for FY 1985. An explanation of the market basket used to develop the prospective payment rates was published in the **Federal Register** on September 1, 1983 (48 FR 39764). For additional background information on the market basket index, we refer the reader to the article by Freeland, Anderson, and Schendler, "National Hospital Input Price Index," *Health Care Financing Review*, Summer 1979, pp. 37-61.

The market basket is a Laspeyres or fixed-weight price index constructed in two steps. First, a base period is selected and the proportion of total expenditures accounted for by designated spending categories is calculated. These proportions are called cost or expenditure weights. In the second step, a rate of increase for each spending category is multiplied by the expenditure weight for that category. The sum of these products for all cost categories yields the percentage change in the market basket, an estimate of price change for a fixed quantity of purchased goods and services.

The market basket is described as a fixed-weight index because it answers the question of how much more or less it would cost at a later time to purchase the same mix of goods and services that