DSH – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Pay or Days, and No-Pay Part A Days)

**Description of Issue:** Whether patient days associated with Medicare Part A and Title XIX eligible patients should be included in the Medicaid fraction of the Medicare Disproportionate Share Hospital (“DSH”) calculation. Further, whether the MACs should have included in the Medicaid fraction of the DSH calculation patient days applicable to patients who were eligible for both Medicare and Medicaid where Medicare Part A did not make a payment.

**Adjustment Numbers:** Various[[1]](#footnote-1)

**Adjustment Amount:** Various[[2]](#footnote-2)

**Estimated Reimbursement Amount:** $986,511[[3]](#footnote-3)

1. **BACKGROUND FACTS AND LAW**

**Statutory and Regulatory: Medicare DSH Payment**

Section 1886(d)(5)(F) of the Medicare Act provides for a DSH payment to hospitals that serve a significantly disproportionate number of low-income patients. 42 U.S.C. § 1395ww(d)(5)(F). A hospital typically qualifies for a DSH payment adjustment through a complex statutory formula under which the DSH payment adjustment is based on the hospital’s geographic designation, the number of beds in the hospital and the level of the hospital’s disproportionate patient percentage (“DPP”). A hospital’s DPP is the sum of two fractions: The “Supplemental Security Income (“SSI or Medicare”) fraction” and the “Medicaid fraction.” The statue, 42 U.S.C. §1395ww(d)(5)(F)(vi)(I), defines the Medicare fraction as:

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…(Emphasis added.)

The statue, 42 U.S.C. §1395ww(d)(5)(F)(vi)(II), defines the Medicaid fraction as:

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

In *Empire Health Foundation v. Alex M. Azar, II,* Case No. 16-209 (9th Cir., May 5, 2020), the Court provided a visual chart describing the calculation of these two fractions:

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

This appeal relates to cost reporting periods with discharges beginning on or after October 1, 2004. The providers included in this group had the FYE of December 31, 2014. The statute authorizes the Secretary to outline the regulations to create methods to determine reasonable costs and the items to be eligible for reimbursement services. The Secretary implemented the statutory provisions for the hospital’s DPP at 42 C.F.R. § 412.106 (10-1-2013) which states:

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

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

(i) Determines the number of patient days that—

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

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

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

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

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

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

For the second computation, 42 C.F.R. § 412.106(d)(4) set forth, in the relevant part:

(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… (Emphasis added.)

The regulation clearly states that only patients who were eligible for Medicaid but not entitled to Medicare Part A can be included in the Medicaid fraction.

**Dual-Eligible Exhausted Benefit Days and Medicare Secondary Payer (“MSP”)**

A patient who is a Medicare beneficiary and also eligible for Medicaid is known as dual-eligible patient. (69 FR 49098, August 11, 2004) In *Metropolitan[[4]](#footnote-4),* the court explains dual-eligible exhausted benefit days as follows:

All Medicare beneficiaries — not just dual-eligible patients — are entitled to have Medicare pay for inpatient hospital services for up to 90 days during any spell of illness (the period from when a person enters a hospital for an injury or illness until he or she has been out of the hospital for 60 consecutive days). *Id.*; *see also id.* §1395x(a) (defining the term “spell of illness”). They also receive an additional 60 days of such coverage that can be spread across all spells of illness during a beneficiary's lifetime. *Id.* §1395d. In other words, Medicare will cover: (1) hospital services for any spell of illness lasting up to 90 days; and (2) an additional lifetime cap of 60 days for hospital services for care in excess of 90 days per spell of illness.

This means that a Medicare patient who receives 150 days of Medicare-paid inpatient care for a single spell of illness (90 + 60) is limited to 90 days of such care for every subsequent spell of illness. The same is true of a patient who uses, for example, 110 Medicare-covered days during one spell of illness (90 + 20) and 130 such days during another spell (90 + 40). Once a patient reaches the 90th day of a spell of illness and has exhausted his or her 60-day supply of post-90th day coverage, Medicare will no longer pay for the patient's hospital services during that same spell of illness. *See id.* §1395d(b)(1).

Both parties refer to such patients as having “exhausted their Medicare Part A coverage” for inpatient hospital services. If a dual-eligible patient exhausts his or her coverage for a particular spell of illness, then the subsequent patient days are called **“dual-eligible exhausted benefit days”** and are generally paid by Medicaid as the payor of last resort. *See* 42 U.S.C. §1396a(a)(25) (mandating that state Medicaid plans identify any third parties liable to pay for medical care available under the plan and to seek reimbursement from such parties if the Medicaid program has already paid for such care); *see also* State Plan Requirement and Other Provisions Relating to State Third Party Liability Programs, 55 Fed. Reg. 1423-02, 1429 (Jan. 16, 1990) (“[W]hen an individual is entitled to Medicare and eligible for Medicaid, Medicare, like any other third party, is the primary payor.”).[[5]](#footnote-5)

As promulgated in 42 C.F.R. § 412.106(b), the Secretary's regulation applicable to this appeal that implements the DPP statute interprets the language **“entitled to benefits under [Medicare] part A”** as including the patient days of all Medicare beneficiaries, regardless of whether a beneficiary has exhausted Medicare coverage for any particular patient day. As a result, all exhausted benefit days (including dual-eligible exhausted benefit days and MSP) are included in the Medicare fraction — either in the denominator only, or in the numerator as well if the Medicare beneficiary is also entitled to SSI.

In this case, the Providers appeal the Medicare exhausted benefit days and MSP days. The Providers contend that: “the Secretary's construction of the statute is invalid, and that MSP and Exhausted days should be included in the Medicaid fraction of the DSH calculation. *See* 42 C.F.R. § 412.106(b)(2)(i)(B); *see also* 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004) (IPPS Final Rule for Federal Fiscal Year 2005) and 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007). The Providers contend that the FY 2005 IPPS Final Rule is procedurally and substantively invalid; that MSP and Exhausted days must be excluded from the Medicare fraction and instead counted in the Medicaid fraction.”[[6]](#footnote-6) (Emphasis added).

1. **ARUMENTS**

**The 2005 Final Rule is Procedurally Valid**

The 2005 Final Rule began as a proposed rule issued in May of 2003[[7]](#footnote-7) to be effective beginning in Fiscal Year (“FY”) 2004. The proposed rule misstated that the current policy counted dual-eligible exhausted covered days in the Medicare fraction. Several commenters responded by pointing out the misstatement of the then-applicable handling of the dual-eligible exhausted covered days and MSP days. The Secretary deferred promulgating a final rule for FY 2004. During the proposed rulemaking period for FY 2005[[8]](#footnote-8) the Secretary stated he would address comments received in response to the previously proposed rule as part of the FY 2005 final rule. At that time, the Secretary did not address the misstatement made during the previous rulemaking period. Then, days before the close of the comment period for the 2005 final rule, a Health and Human Services website posting acknowledged the previous misstatement of the then-applicable rule. The 2005 Final Rule[[9]](#footnote-9) included dual-eligible exhausted benefit days and MSP days in the Medicare Fraction, in effect enacting what in 2003 the Secretary (mistakenly) stated was the then-applicable rule.

In its preliminary position paper, the Provider citing *Allina* cases including a D.C. District Court in *Allina Health Services, et al. v. Sebelius* (Case No. 1:10-cv-01463 (RMC)) *("Allina I")* and *Allina Health Servs. v. Burwell,* 201 F. Supp. 3d 94 (D.D.C. 2016) (*Allina II)*, argues:

The D.C. District Court in *Allina I* also found in that the 2004 Final Rule, which applies to the fiscal year under appeal, was procedurally defective and, therefore, infirm *ab initio. Allina I* was appealed to the Court of Appeals, which decided that CMS did not use proper notice and comment rulemaking to include MA Days in the Medicare fraction, but the Court did not rule that the days had to be included in the Medicaid fraction. However, the Court did say that MA days must be in one or the other of the fractions. The Providers request the Board incorporate the entire administrative and judicial records of *Northeast* and *Allina I* into the record of this appeal, which is PRRB Case Number 18-0930GC.[[10]](#footnote-10)

The Providers’ argument that the 2005 Final Rule was procedurally invalid fails for three reasons. First, the D.C. court decisions in *Allina I* and *Allina II [[11]](#footnote-11)* are for Managed Care days which do not address the Exhausted Dual Eligible days and MSP days appealed in this case.

Second, the Court of Appeals for the Ninth Circuit reversed the district court’s decision, and held:

While HHS’s notice-and comment procedure for the 2005 Rule was not without flaws, it met the APA’s requirements.[[12]](#footnote-12)

Third, and more important, the very issue raised by these Providers, the procedural validity of the 2005 Final Rule, was addressed by the D.C. District Court in *Stringfellow Mem’l Hosp v. Azar*. After an analysis of the “logical outgrowth test”, the court held:

[**T]he Secretary was “proposing to change” a policy and identified the two possible choices**: dual-eligible exhausted days would be included in either the Medicare fraction, or the Medicaid fraction. The 2005 Final Rule then adopted one of those two stated options. Accordingly, because **the 2005 Final Rule is a logical outgrowth of the 2004 Proposed Rule**, the 2005 Final Rule was promulgated with adequate notice and comment procedures and is not procedurally defective.[[13]](#footnote-13) (Emphasis added.)

Therefore, the Providers’ argument that the 2005 Final Rule at issue is procedurally invalid is not supported by any judicial decision, and in fact, has been procedurally upheld by the Ninth Circuit (cited by the Providers) and the Sixth Circuit (the circuit the Providers are located within).

**The 2005 Final Rule is Substantively Valid**

The Providers contends that dual eligible MSP and Exhausted day patients are not “entitled to benefits under Part A” which should be excluded from the Providers’ Medicare fractions, and included in the Providers’ Medicaid fractions to the extent that such days are Medicaid eligible.[[14]](#footnote-14)

Much litigation has surrounded the phrase “entitled to benefits under [Medicare] Part A.” In the Sixth Circuit appellate court decision in *Metropolitan*, the court addressed the precise issue raised by the Providers in this this appeal; whether dual-eligible exhausted benefit days should be included in the Medicaid fraction. The hospital, just like the Providers in this appeal, argued that:

[T]he plain language of the DPP statute unambiguously provides that a dual-eligible exhausted benefit day must be counted in the Medicaid fraction and that no exhausted benefit day (whether dual-eligible or not) may be counted in the Medicare fraction.[[15]](#footnote-15)

The Secretary argued that:

[T]he phrase “entitled to benefits under [Medicare] part A” has a clear, consistent meaning throughout the Medicare statute; i.e., covering any individual who meets the statutory criteria set out in 42 U.S.C. § 426.[[16]](#footnote-16)

The Court concluded that:

[T]he statue’s plain language does not unambiguously endorse either party’s interpretation.

No definition of the phrases “entitled to benefits under [Medicare] part A” or “eligible for [Medicaid]” is provided in the DPP provision or elsewhere in the statutory section in which the DPP appears.[[17]](#footnote-17)

The *Metropolitan* court concludes by stating:

In sum, we conclude that the rulemaking process was not arbitrary and that the resulting regulation is a permissible construction of the DPP provision that warrants judicial deference under *Chevron*.[[18]](#footnote-18)

The D.C. Circuit Court in *Stringfellow* reached the same conclusion when considering whether the 2005 Final Rule was the product of reasoned decision making, stating:

**The 2005 Final Rule provides adequate explanations for the Secretary’s decision to begin counting dual-eligible exhausted days in the Medicare fraction.** In the Final Rule, the Secretary detailed several themes of the comments received on the proposed rule, and he explained that the agency “agree[d] with” a comment that “including the days in the Medicare fraction has a greater impact on a hospital’s DSH patient percentage than including the days in the Medicaid fraction.” The Secretary also acknowledged another commenter’s argument that “beneficiaries who have exhausted their Medicare Part A inpatient coverage may still be entitled to other Part A benefits.” **These two observations help explain the Secretary’s decision to count dual-eligible exhausted days in the Medicare fraction**: the days would have “a greater impact” when included in the Medicare fraction, and patients who were entitled to other Part A benefits beyond inpatient hospital stays would logically be treated as still being “entitled to benefits under [Medicare] part A,” as the statutory definition of the Medicare fraction states. Indeed, the DSH adjustment aims to compensate hospitals for treating sick, low-income patients—in other words, individuals who are likely to exhaust their Part A coverage but who remain in the hospital for treatment. Including patient days for these individuals in the Medicare fraction, where the days will often have a greater impact, furthers the purpose of the DSH adjustment.[[19]](#footnote-19) (Citations omitted.) (Emphasis added.)

The *Stringfellow* court acknowledged the Sixth Circuit’s decision in *Metropolitan*, stating:

Notably, the Sixth Circuit has examined this same rule and concluded that the 2005 Final Rule “appears to be the result of a reasoned deliberative process, reflecting HHS’s experience in case-by-case administrative adjudications and in federal-court litigation, and its benefitting from stakeholder input through notice-and-comment rulemaking. In *Metropolitan Hospital*, the Sixth Circuit addressed whether the interpretation set forth in the 2005 Final Rule was entitled to *Chevron* deference, concluding that “the rulemaking process was not arbitrary and that the resulting regulation is a permissible construction of the DPP provision that warrants judicial deference under *Chevron*.” The Sixth Circuit noted that the Secretary had “appropriately considered the [ ] comments” without “blindly accept[ing] them as true,” had “recognized th[e] inconsistency” in his prior interpretations of the phrase “entitled to benefits under [Medicare] part A,” and had adopted the interpretation that would “facilitate consistent handling of these days across all hospitals.” The court thus concluded that the 2005 Final Rule was “the product of a reasoned analysis” rather than “an ad hoc determination meant to unduly restrict DSH adjustments.” Although not binding on this Court, the Sixth Circuit’s reasoning is persuasive, lending strength to the defendant’s argument that the 2005 Final Rule was the product of reasoned decision making.[[20]](#footnote-20) (Citations omitted.)

Taken together, the D.C. Circuit’s decision in *Stringfellow* and the Sixth Circuit’s decision in *Metropolitan* clearly show that the Secretary’s 2005 Final Rule was substantively valid.

The *Metropolitan* court addressed the Provider’s argument that the Secretary implemented inconsistent interpretation of the phrase “entitled to benefits under part A, stating:

**[N]othing in the language or structure of § 1395ww suggests that the use of the phrase in the DPP provision should dictate the meaning of that same phrase elsewhere in the statute.** Indeed, the DPP provision is not the first place that the phrase appears, nor does the DPP provision purport to define the phrase. And applying Metro’s construction of the phrase elsewhere in § 1395ww makes little sense substantively.

For instance, part of the statute’s definition of a “sole community hospital” is that such a hospital be the only source of inpatient services reasonably available to individuals “who are entitled to benefits under [Medicare] part A.” *Id.* § 1395ww(d)(5)(D)(iii)(II). **We can perceive of no reason why Congress would intend that a hospital’s status as a sole community hospital depend on that hospital’s accessibility only to those Medicare beneficiaries who have not exhausted their benefit days for a particular spell of illness, as opposed to all Medicare beneficiaries generally.** But that is precisely what Metro argues is the import of Congress’s choice to use the phrase “entitled to benefits under [Medicare] part A.” Metro’s interpretation of this phrase as employed in the DPP provision similarly does not make sense in other § 1395ww contexts in which the phrase appears.[[21]](#footnote-21) (Emphasis added.)

Similar to the *Metropolitan* court’s analysis and application of “entitled to benefits under Part A” to sole community hospitals, there is no perceived reason to apply these Providers’ interpretation of “entitled to benefits under Part A” to Medicare dependent hospitals. As the *Metropolitan* court stated, “[N]othing in the language or structure of § 1395ww suggests that the use of the phrase in the DPP provision should dictate the meaning of that same phrase elsewhere in the statute.” In fact, the Metropolitan court specifically addressed the Secretary’s interpretation of the phrase “entitled to benefits under Part A” to Medicare dependent hospitals, stating:

Metro's potentially stronger point is that, as explained above in Part V.B.1., the Secretary previously interpreted the phrase “entitled to benefits under [Medicare] part A” elsewhere in §1395ww as excluding exhausted benefit days. *See* 42 U.S.C. §1395ww(d)(5)(G)(iv) (using the phrase as part of the definition for the term “medicare-dependent, small rural hospital”); *see also* Changes to the Hospital Inpatient PPS and FY 1991 Rates, 55 Fed. Reg. 35990, 35996 (Sept. 4, 1990) (explaining HHS's view that “entitlement to payment under part A ceases” upon exhaustion of benefit days). But the Secretary recognized this inconsistency and, rather than change her interpretation of that phrase in the DPP provision and everywhere else in the Medicaid statutes, instead amended her interpretation of the phrase as used in §1395ww(d)(5)(G)(iv). **This correction further demonstrates that the Secretary's interpretation of this statutory phrase is the product of a reasoned analysis of its terms, not an ad hoc determination meant to unduly restrict DSH adjustments.**[[22]](#footnote-22)(Emphasis added.)

The Sixth Circuit, the circuit in which these Providers are located, has already dismissed this same “arbitrary and capricious” argument by finding that “the Secretary's interpretation of this statutory phrase is the product of a reasoned analysis”. Therefore, the Secretary’s current interpretation is not arbitrary and capricious.

In *Becerra v. Empire Health Foundation, for Valley Hospital Medical Center*, 20-1312, (U.S. Supreme Court, June 24, 2022), the Court ruled that:

In calculating the Medicare fraction, individuals “entitled to [Med­icare Part A] benefits” are all those qualifying for the program, regard­less of whether they receive Medicare payments for part or all of a hos­pital stay. Pp. 7–19.

HHS’s regulation is consistent with the text, context, and structure of the DSH provisions. The agency has interpreted the phrase “enti­tled to benefits” in those provisions to mean just what it means throughout the Medicare statute: qualifying for benefits. And count­ing everyone who qualifies for Medicare benefits in the Medicare frac­tion—and no one who qualifies for those benefits in the Medicaid frac­tion—accords with the statute’s attempt to capture, through two separate measurements, two different segments of a hospital’s low-in­come patient population[[23]](#footnote-23).

**CMS Has Produced the Data That It is Required to Produce to the Providers**

The Providers complain “CMS is now releasing the MEDPAR data, but the Providers have not yet been able to fully reconcile their records with that of CMS, and specifically identify patients believed to be Medicare and Medicaid crossover patients where Medicare Part A did not make a payment. Accordingly, the Providers have also been unable to determine which of these patients also have Medicaid coverage for their inclusion in the Medicaid fractions of their DSH calculations.[[24]](#footnote-24)” The Providers have not analyzed Medicare Part A data at the time that they filed their hearing request and preliminary position paper to identify specific EB and MSP days. The statutory basis for the Providers to obtain the data is the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 108-173) (the “MMA”). Section 951 of the MMA directed the Secretary to begin providing hospitals the information necessary to “compute the number of patient days used in computing the disproportionate patient percentage” no later than December 8, 2004.

The Secretary published her method for complying with the MMA in the August 12, 2005 Federal Register. CMS explained that:

We interpret section 951 to require the Secretary to arrange to furnish to hospitals the data necessary to calculate both the Medicare and Medicaid fractions. With respect to both the Medicare and Medicaid fractions, we interpret section 951 to require CMS to arrange to furnish the personally identifiable information that would enable a hospital to compare and verify its records, in the case of the Medicare fraction, against the [sic] CMS’ records, and in the case of the Medicaid fraction, against the State Medicaid agency’s records.[[25]](#footnote-25)

Specifically, CMS stated that it calculated the Medicare fraction using data from the “MedPAR LDS,” which was established in a notice published in the August 18, 2000 Federal Register (65 FR 50,548).[[26]](#footnote-26) The notice explained that “MedPAR LDS contains a summary of all services furnished to a Medicare beneficiary, from the time of admission through discharge, for a stay in an inpatient hospital or skilled nursing facility, or both; SSI eligibility information; and enrollment data on Medicare beneficiaries.”[[27]](#footnote-27) CMS determined that it would comply with Section 951 of the MMA by releasing the MedPAR LDS data to providers:

Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108-173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital’s patients eligible for both SSI and Medicare at the hospital’s request, regardless of whether there is a properly pending appeal relating to DSH payments. We will make the information available for either the Federal fiscal year or, if the hospital’s fiscal year differs from the Federal fiscal year, for the months included in the Federal fiscal years that encompass the hospital’s cost reporting period. Under this provision, the hospital will be able to use these [this] data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year. The data set made available to hospitals will be the same data set CMS uses to calculate the Medicare fractions for the Federal fiscal year.[[28]](#footnote-28)

The Providers in this group have requested and received the MedPAR LDS data from CMS.[[29]](#footnote-29) CMS has therefore complied with the statutory and regulatory requirements compelling it to provide the data necessary for the Providers to confirm that the Medicaid fraction was properly computed. Although CMS has complied with its statutory obligations, the Providers claim that the data received is insufficient to identify any patients who also have Medicaid coverage.

The Providers have failed to identify any discrepancies in the MedPAR data and have failed to carry their burden of proof and persuasion. The Providers here have not shown that errors still remain in the Medicaid fraction. Therefore, the burden of proof remains on the Providers. They cannot recover in their appeal when they failed to take the actions available to them that would allow them to potentially identify remaining errors to comply with the jurisdictional requirements.

**CONCLUSION**

The MAC contends that it was proper to treat exhausted benefit days, including dual-eligible exhausted benefit days, as entitled to benefits under Part A, and properly excluded those days from the numerator Medicaid fraction of the Providers’ DPP. The MAC’s DPP and DSH calculations are supported by the judicial decisions in the Sixth Circuit, D.C. Circuit and Supreme Court. Thus, the Board should uphold the MAC’s calculations of the Providers’ DPPs and DSH payments.

IV. LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS

Other Sources:

**United States Statutes**

42 U.S.C. § 426(a)

42 U.S.C. § 1395ww(d)(5)(F)

Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 108-173, § 951)

**Regulations**

42 C.F.R. § 412.106 (10-01-13)

**Federal Register Notices**

68 Fed. Reg. 27154, 27207-208 (May 19, 2003)

68 Fed. Reg. 45421-45422 (August 1, 2003)

69 Fed. Reg. 28196, 28286 (May 18, 2004)

69 Fed. Reg. 49093, 49099 (Aug. 11, 2004)

70 Fed. Reg. 47438-47439 (Aug. 12, 2005)

65 Fed. Reg. 50548 (Aug. 18, 2000)

**Court Decisions**

*Becerra v. Empire Health Foundation*, , No. 20-1312, U.S. Supreme Court (June 24, 2022)

*Empire Health Foundation v. Alex M. Azar, II,* Case No. 16-209 (9th Cir., May 5, 2020)

*Metropolitan Hospital v. HHS, US Court of Appeals, Sixth Circuit* (March 27, 2013)

*Stringfellow Mem’l Hosp v. Azar*, 317 F. Supp. 3d 168 (D.D.C. 2018)

V. EXHIBITS

Exhibit C-1: SOP

Exhibit C-2: *Metropolitan Hospital v. HHS, U.S. Court of Appeals*

Exhibit C-3: *Empire Health Foundation v. Alex M. Azar, II*

Exhibit C-4: 68 Fed. Reg. 27154, 27207-208 (May 19, 2003)

Exhibit C-5: *Stringfellow Mem’l Hosp v. Azar*

Exhibit C-6: 70 FR 47438

Exhibit C-7: MedPAR Data

Exhibit C-8 *Becerra v. Empire Health Foundation 06-24-2022*

1. *Id.* [↑](#footnote-ref-1)
2. *Id.* [↑](#footnote-ref-2)
3. *Id.* [↑](#footnote-ref-3)
4. *Metropolitan Hospital v. HHS, US Court of Appeals, Sixth Circuit* (March 27, 2013) (Exhibit C-2). [↑](#footnote-ref-4)
5. *Id*., at C000009-C000010. [↑](#footnote-ref-5)
6. Provider’s Preliminary Position Paper at 00007. [↑](#footnote-ref-6)
7. 68 Fed. Reg. 27154, 27207-208 (May 19, 2003). (Exhibit C-4). [↑](#footnote-ref-7)
8. 69 Fed. Reg. 28196, 28286 (May 18, 2004). [↑](#footnote-ref-8)
9. 69 Fed. Reg. at 49098 (August 11, 2004). [↑](#footnote-ref-9)
10. Provider’s Preliminary Position Paper at 000015. [↑](#footnote-ref-10)
11. Allina II, 863 F.3d at 942 (D.C.C. 2017) and *Alex M. Azar,II, Secretary of Health and Human Services, Applicant v. Allina Health Services et al.,*Supreme Court Docket No. 17A770. [↑](#footnote-ref-11)
12. *Empire Health Foundation v. Alex M. Azar, II,* Case No. 16-209 (9th Cir., May 5, 2020) (Exhibit C-3 at C000070.) [↑](#footnote-ref-12)
13. *Stringfellow Mem’l Hosp v. Azar*, 317 F. Supp. 3d 168 (D.D.C. 2018) (Exhibit C-5 at C-000108.) [↑](#footnote-ref-13)
14. See Provider’s Preliminary Position Paper at 000015. [↑](#footnote-ref-14)
15. Exhibit C-2 at C000013. [↑](#footnote-ref-15)
16. *Id.* [↑](#footnote-ref-16)
17. *Id.,* at C000013-C000014. [↑](#footnote-ref-17)
18. *Id.,* at C000036. [↑](#footnote-ref-18)
19. Exhibit C-5 at C000110. [↑](#footnote-ref-19)
20. Id., at C00110-C000111. [↑](#footnote-ref-20)
21. Exhibit C-2 at C000020-C000021. [↑](#footnote-ref-21)
22. *Id.,*at C000035. [↑](#footnote-ref-22)
23. See Exhibit C-8, at C000127. [↑](#footnote-ref-23)
24. Provider’s Preliminary Position Paper at 000018. [↑](#footnote-ref-24)
25. Exhibit C-6 at C000119. [↑](#footnote-ref-25)
26. *Id.,* at C000120. [↑](#footnote-ref-26)
27. *Id.* [↑](#footnote-ref-27)
28. *Id.* [↑](#footnote-ref-28)
29. Exhibit C-7 [↑](#footnote-ref-29)