760 Alexander Road | PO Box 1 | Princeton, NJ 08543-0001 | 609-275-4000 | www.njha.com

October 5, 2020

Centers for Medicare and Medicaid Services
Attention: CMS-1739-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

VIA ELECTRONIC SUBMISSION (http://www.regulations.gov)

Re: Notice of Proposed Rulemaking CMS-1739-P; RIN: 0938-AU24 Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage

Dear Secretary Azar and Administrator Verma:

I. Introduction

On behalf of the New Jersey Hospital Association (NJHA) please accept these comments in response to the notice of proposed rulemaking regarding the establishment of a policy concerning the treatment of patient days associated with persons enrolled in a Medicare Part C plan for purposes of calculating a hospital's disproportionate patient percentage for cost reporting periods starting before federal fiscal year ("FFY") 2014, published in the Federal Register on August 5, 2020 (the "Proposed Rule").

NJHA strongly disagrees with the purportedly "new" policy as announced in the Proposed Rule and, for several reasons discussed below, strongly urges CMS to instead calculate DSH adjustments in accordance with the plain text of the DSH statute, consistent with the policy included in the "alternative model" proposed.

First, the governing Medicare Act provision, 42 U.S.C. 1395ww(d)(5)(F)(vi), unambiguously defines which hospital patient days are to be included in the "Medicare" or "SSI" fraction of each provider's disproportionate patient percentage ("DPP"), and which patient days are to be included in hospitals' "Medicaid" fraction of the DPP. The statute is therefore self-executing and clearly directs that only specific days on which patients are actually "entitled" to benefits under Part A of the Medicare program are to be included in hospitals' Medicare/SSI fractions for purposes of calculating the DPP.

Second, the Proposed Rule does not conform to the governing statutory provision. The claim that patients can be "entitled" to inpatient hospitalization benefits under both Part A and Part C on the same day is factually and legally incorrect. As noted by then-Judge Kavanaugh, beneficiaries "must choose between government-subsidized private insurance plans under Part C and government-administered insurance under Part A, and after they choose, they are obviously not entitled on the same 'patient day' to benefits from both kinds of plans." *Northeast Hosp. Corp. v. Sebelius,* 657 F.3d 1, at 18 (D.C. Cir. 2011) (Kavanaugh, J. concurring). This inconsistency dooms the Proposed Rule to legal failure.

Third, the Proposed Rule is substantively indistinguishable from policies purportedly adopted in 2004 and 2007. Each of those rules has been vacated by Federal appellate courts on the grounds that these policies were not supported by notice and comment, since there had been no articulation of any reason why CMS had changed its policy after FFY 2004 regarding treatment of Part C days for purposes of calculating hospitals' DPPs for fiscal periods ending in FFYs 2005 through 2013. This new attempt to articulate a retroactive Part C days policy is equally deficient, since there is no articulation of any valid or credible reason why the policy and practice changed from FFY 2004 to FFY 2005 and later years.

Fourth, the argument that it is necessary to adopt this Proposed Rule on a retroactive basis is unfounded. Retroactive rulemaking is neither permitted nor appropriate in this instance for the following reasons:

1. There is a clear statutory presumption against retroactive rulemaking under the governing sections of the Medicare Act, and such rulemaking is broadly prohibited except in extremely limited circumstances that are not present here. See, 42 U.S.C. 1395hh(e)(1)(A), *Azar v. Allina Health Services.*

2. There is no requirement in the governing statute requiring rulemaking (let alone <u>retroactive</u> rulemaking) to give effect to the statutory provisions defining the calculation of hospitals' DPPs. See, 42 U.S.C. 1395ww(d)(5)(F)(vi). The provision is self-executing, evidenced by the fact that CMS calculated hospitals' DPPs prior to the (now vacated) Part C days rule from roughly 1997 through 2004 without benefit of any adopted regulation.

3. There is no demonstrated any compelling "public interest" to support the need for adopting his policy on a retroactive basis. The argument that compliance with the governing statute is an important public interest is circular and presupposes that the DSH statute in Section 1395ww(d)(5)(F)(vi) cannot be given effect except through regulation, which is not the case. In addition, the suggestion that the public interest will not be served under the Alternative Model because it will add costs to the Medicare program is not a basis for demonstrating that a retroactive rule is needed to serve the public interest. The public interest would clearly be better served through hospitals being reimbursed consistent with the plain text of the DSH statute. Use of the "public interest" exception to permit retroactive rulemaking has

been narrowly defined, and this case does not fit within those narrow exceptions. Given the statutory bases for adoption of the DSH adjustment in the first place, the Proposed Rule, by incorrectly reducing payment to hospitals for services to low income patients, is actually contrary to the public interest.

4. If it is correct that there was no policy in place concerning calculation of the DPP (Medicare and Medicaid fractions) prior to 2014, retroactive rulemaking is unavailable. Section 1395hh(e)(1)(A) only provides limited authority to apply a "substantive ***change*** in regulations, manual instructions, interpretive rules, statements of policy, or guidelines of general applicability" on a retroactive basis. (emphasis added). Congress has not authorized CMS to retroactively ***establish*** rules for the first time. Rather, the prohibition on retroactive rulemaking articulated in *Bowen v. Georgetown University Hospital,* 488 U.S. 204 (1988) would apply if CMS, in fact, had no applicable policy in effect during the pre-2014 period.

5. If the Proposed Rule is actually a "change" in policy, and not establishment of a new policy, the Proposed Rule fails to discuss the clear alternative to retroactive rulemaking. CMS could instead comply with the language of the DSH statute by continuing to apply that statute's pre-2004 policy used by CMS to calculate the DPP Medicare and Medicaid fractions for all cost periods prior to FFY 2014.

Fifth, even if a "new policy" is needed, the Alternative Model (with a handful of data adjustments) exemplifies how this issue should be resolved. A policy of excluding Part C days from the Medicare fraction and including Medicaid eligible Part C hospital inpatient days in the numerator of providers' Medicaid fractions is both consistent with the plain dictate of the governing statute and, in most cases, with the practice and policy of CMS prior to FFY 2005.

Sixth, CMS has incorrectly accounted for the financial impact of the Proposed Rule.

II. Comments on the Proposed Rule

A. The Medicare Act is Self-Executing with Respect to Calculation of Providers' DSH Adjustments.

Despite claims in the Proposed Rule that rulemaking (retroactive or otherwise) is necessary at this juncture because there is no remaining authority (post-Azar *v. Allina Health Services)* under which to calculate or recalculate providers' DSH fractions for FFYs 2013 and earlier, there is no basis in the Medicare Act for this claim. The governing statute provides the full authority required by the Secretary and CMS to calculate and apply the DSH adjustment. See, 42 U.S.C. 1395ww(d)(5)(F). The statute also provides clear direction to the Secretary and CMS on how to calculate the additional (DSH) payment. See, 42 U.S.C. 1395ww(d)(5)(F)(ii). There is no requirement for any rule; the agency is simply directed to provide the DSH adjustment pursuant to statutorily dictated terms. Throughout these sections, paragraphs and subparagraphs, there is no

requirement or direction for rulemaking. The agency further is given no discretion by Congress to vary from the adjustments provided by the governing sections of the Medicare Act.

In its wisdom, however, Congress did not stop there – CMS is then provided explicit direction regarding calculation of the DPP fractions themselves in subparagraph (vi) of Section 1395ww(d)(5)(F):

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

See 42 U.S.C. 1395ww(d)(5)(F).

With or without a formal rule, and by statute, CMS is required to calculate the DPP for each qualifying hospital as the sum of two fractions. The first, the Medicare fraction, counts in the numerator, the number of hospital inpatient days on which patients were actually "entitled" to benefits (that is, to payment for services) under Part A of Medicare and to SSI benefits on the particular days of hospitalization (that is, "***for such days***"), and counts in the denominator, the total number of hospital inpatient days in a given year that were paid ("entitled to benefits") under Part A of the Medicare program. The second fraction, the Medicaid fraction, just as clearly directs the agency to calculate the ratio of patient days on which patients who are merely "eligible" for state Medicaid benefits (even if not paid) were in the hospital, so long as such patients did not receive Part A benefits on such days, divided by the total number of patient days for that hospital in a given year. The Medicaid fraction does not exclude Part C days. Under each of these fractions, CMS does not have any ability to vary from the specific directives of these calculation instructions, nor is any rulemaking required in order to effectuate such Congressional directives.

B. <u>The Proposed Rule Seeks to "Adopt" Policy that Actually Contravenes the Statute and Prior Agency Policy</u>.

As noted in the prior section, the plain language of the Medicare Act pertaining to DSH explicitly eliminates Part C days from any consideration under the Medicare fraction and just as clearly does not exclude from (and thereby include in) the Medicaid fraction, Medicaid eligible Part C patient days. The Proposed Rule in this manner ignores the plain text and meaning of the Medicare Act. Whereas the Proposed Rule includes Part C days in the Medicare fraction and excludes qualifying dual eligible Part C days from the Medicaid fraction, the plain language of the DSH statute (as explained above in Section II.A of these comments) contemplates precisely the opposite result. CMS has never explained how or why the (now twice vacated) 2004/2007 Rule, and newly Proposed Rule are consistent with the plain language of the DSH statute, particularly Section 1395ww(d)(5)(F)(vi).

Important to note is the fact that, prior to FFY 2005, CMS followed a different policy, one that was more consistent with the Alternative Model included in the Proposed Rule, not the policy proposed for adoption in the Proposed Rule. Before FFY 2005, CMS did not consider Part C patients to be "entitled to benefits under Part A" for DSH adjustment calculation purposes: "Before 2004, HHS had not treated Part C enrollees as entitled to benefits under Part A." *Allina II,* 863 F.3d at 939; see also, *Allina I,* 746 F.3d 1106, 1108 ("Prior to 2003, the Secretary treated Part C patients as not entitled to benefits under Part A . . . excluding Part C days from the Medicare fraction and including them in the Medicaid fraction."); *Northeast Hospitals, Inc.*, 657 F.3d at 16-17 ("[2004 rule] contradicts [the agency's] former practice of excluding [Part C] days from the Medicare fraction" and "longstanding" policy.")

Further, the Proposed Rule does not explain a related provision of the pre-2004 DSH regulation, which included as Medicare Part A-entitled only patient days that were <u>covered and paid</u> under the Part A fee-for-service system. See 42 C.F.R. 412.106(b)(2)(i) (2003) (defining the Medicare fraction to include only "the number of ***covered*** patient days"); see also, 42 C.F.R. 409.3 (2003) (defining "covered" as services for which payment is authorized).

Without a credible explanation of why such a "change" in policy is now required, or even authorized under the statute (now, CMS states, retroactively, no less,) for all years prior to FFY 2014 (including even pre-FFY 2005 years), the Proposed Rule cannot stand.

C. <u>The Proposed Rule Incorrectly Assumes Patients Can Remain "Entitled to Part A Benefits" Even if Such Patients' Hospital Services Cannot be Paid Under Part A for Specific Days of Care</u>.

The Proposed Rule states that when a patient elects Part C Medicare benefits, such patient is still somehow "entitled" to Part A benefits. The examples contained within the Proposed Rule of why Part C patients are still Part A benefit "entitled" patients do not explain how Part A benefits are still received on specific days of care.

No one disputes that Section 1852(a)(1)(B)(i) of the Medicare Act states that a patient cannot sign up for Part C benefits without first being entitled to Part A benefits. But CMS cannot explain how patients can simultaneously receive both benefits for the same services. They cannot. Once a patient elects to become a Medicare Advantage patient that election eliminates the patient's "entitlement" to all of the inpatient, outpatient and ancillary services covered under Part A. For example, if a patient receives benefits under Part A in year 1, but then enrolls in Part C at the start of year 2, and then is admitted for inpatient hospital care in year 2, the patient is in no way, shape or form "entitled" to Part A benefits for that hospitalization.

This is a critical distinction, since the governing DSH statute, as stated in Section II. A., above, states explicitly with respect to the numerator of the DSH Medicare/SSI fraction that the days include only those "patients who **(<u>for such days</u>) were <u>entitled</u> to benefits under Part A** of this subchapter. . ." See, 42 U.S.C. 1395ww(d)(5)(F)(vi) (Emphasis added.) It is not enough that a patient is "entitled" in some general sense or in the abstract to benefits under Part A, nor is it enough that a patient was entitled in the past, or that he/she can be again in the future. (The language covering the denominator of the Medicare/SSI fraction uses precisely the same terms, albeit a larger subset of days, as discussed in Section II.A., above.) **The Proposed Rule does not discuss the "for such days" requirement and thereby seeks impermissibly to eliminate a key clause of the statute through rulemaking.**

The other examples also do not support the Proposed Rule. There are identified services under Section 1812(d)(1) of the Act, whereby under certain circumstances Part C enrollees may have hospice services covered under Part A, and/or whereas under Section 1853(a)(4) of the Medicare Act a Part C enrollee might receive services paid for under Part A through a federally qualified health center under contract with a Part C plan. But none of these examples alter the fundamental truth here: These extremely limited examples of miniscule Part A benefits **do not constitute Part A benefits paid to Part C enrolled patients for hospital services "for such days"** as the patients are *actually hospitalized* in a particular hospital facility. As stated by then Judge (now Justice) Kavanaugh in his concurring opinion in *Northeast Hospitals* invalidating CMS's attempt to apply the 2004/2007 DSH Part C days policy retrospectively to pre-2004 hospital patient days*:* "[A] Part C beneficiary is not "entitled" to Part A benefits for a specific patient day." *Northeast Hospitals, supra,* at 657 F.3d 21.

Similarly, Part C days cannot be excluded from the Medicaid fraction pursuant to the plain language of section 42 U.S.C. 1395ww(d)(5)(F)(vi). The statutory language explicitly ties the eligibility and entitlement language to specific days, in this case, those very specific days during which a patient is receiving services in a particular inpatient hospital. *Id.* The Proposed Rule does not explain how or why Part C days that from all appearances should <u>not</u> be in the Medicare/SSI fraction, <u>are</u> in that fraction, and why the Medicaid eligible subset of those Part C days, that from all appearances, *should be* in the Medicaid fraction, are <u>not</u> in that fraction. As the D.C. Circuit Court held in the first *Allina* case, since prior to 2004 CMS treated Part C days as not entitled to Part A benefits, a change in this policy must be explained. *Allina Health Services v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014) ["*Allina I"*]. As summarized by then-Judge Kavanaugh in his concurring opinion in *Northeast Hospitals Corp., supra at 18:*

> "[Beneficiaries] must choose between government-subsidized private insurance plans under Part C and government-administered insurance under Part A, and after they choose, they are obviously not entitled on the same 'patient day' to benefits from both kinds of plans."

CMS should instead move forward with a new policy that is consistent with the DSH statute, such as is embodied in the Alternative Model, or simply revert back to pre-2004 rule policy,

D. <u>The Proposed Rule is Indistinguishable from Prior Proposed and Final Rules Previously Invalidated and Vacated by Multiple Federal Appellate Courts</u>.

As noted by CMS in the Proposed Rule, the new rule is indistinguishable from the 2004/2007 rule and essentially is identical (except for the years to which it applies) to the 2013 Part C days rule. In the Proposed Rule, CMS points out that if the Proposed Rule is adopted, ". . . there would not be any additional costs or benefits relative to the Medicare DSH payments that have already been made because those payments were made under the policy reflected in the proposal (prior to it having been vacated)." 85 Fed. Reg. at 4772. There would be no change in costs simply because the same policy that CMS has tried in vain to follow for 15 years, despite four federal appellate courts vacating and/or harshly criticizing it, despite many hundreds of hospitals challenging it in every year it has purportedly been in effect, and despite it being plainly contrary to the language of the governing statute, would be adopted once again.

The Proposed Rule would, in fact, have a substantial economic cost to hospital providers, in the billions of dollars, when properly compared to the **prior**, <u>judicially accepted</u>, pre-2004 practice of following the statute's plain text and excluding Part C days from the DSH Medicare/SSI fraction. The cost also would likely be borne, in health and welfare terms, by patients who cannot obtain sufficient access to quality health care due to artificially limited Medicare reimbursements paid to hospitals.

E. <u>Retroactive Rulemaking is Permitted Under the Medicare Act Only Under Narrow Exceptions None of Which are Applicable or Present Here</u>.

CMS, cognizant of the fact that each of its prior attempts to apply the policy of including Part C days in the Medicare/SSI fraction for DSH purposes has been vacated, now seeks to apply that same policy through this Proposed Rule on a retroactive basis to all years prior to FFY 2014. There are no circumstances with respect to this issue to justify retroactive rulemaking.

1. <u>There Is a Clear Statutory Presumption Against Retroactive Rulemaking</u>.

As a general rule, retroactive applications of a law are strongly disfavored, as they disrupt legitimate expectations and disturb settled transactions. *See E. Enters v. Apfel*, 524 U.S. 498, 532 (1998); *see also Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 208 (1988) ("[r]etroactivity is not favored in the law."). "Congressional enactments and administrative rules will not be construed

to have retroactive effect unless their language requires this result." *Bowen* at 208 (internal quotations omitted). But as discussed above and below, the DSH statute has no effective date or deadline language, and no requirement for rulemaking. The language of the DSH statute itself does not provide the required clear statement by Congress that retroactive rulemaking (indeed, ***any*** rulemaking) is required to comply with and implement the statute's terms.

A separate section of the Medicare Act, 42 U.S.C. 1395hh(a)(2), requires notice-and-comment rulemaking for any Medicare "rule, requirement, or other statement of policy" 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." In *Azar v. Allina Health Services*, 139 S.Ct. 1804 (June 3, 2019) ("*Allina II*"), the Supreme Court (as well as the *Allina II Circuit Court*) held that 42 U.S.C. § 1395hh(a)(2) required CMS to engage in notice-and-comment rulemaking **before** adopting and making effective its policy regarding the treatment of inpatient days for the purposes of calculating the DPP. Yet, CMS now seeks to impermissibly circumvent the Supreme Court's decision in *Allina II* to enact retroactively the same rule that was rejected by multiple courts, including by the Supreme Court, once again without notice and comment preceding application of the change or establishment of a rule.

2. <u>None of the Statutory Exceptions to Retroactive Rulemaking Apply in this Instance</u>.

The claim that this attempted retroactive Proposed Rule is authorized under 42 U.S.C. § 1395hh(e)(1)(A) is inaccurate. This statute does not provide a "blank check." Retroactive rulemaking clearly is prohibited except in narrowly prescribed circumstances— "where it is necessary to comply with statutory requirements" or "failure to apply the change retroactively would be contrary to the public interest." *See Azar v. Allina Health Svcs.*, 139 S.Ct. at 1812 (describing the authority to make retroactive "substantive change[s]" as "limited").

(i) *Not Necessary to Comply with Statutory Requirements.*

First, as explained above, the DSH statute is self-executing. There is no requirement in the governing statute that mandates rulemaking—let alone retroactive rulemaking—to give effect to the statutory provisions defining the calculation of hospitals' DPPs. *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi). There also is no missed deadline (the most common basis for determining that retroactive rulemaking is appropriate) by which a regulation is to be effective with respect to the DSH statute. Therefore, the DSH statute does not require retroactive rulemaking in any manner.

Second, CMS computed the Medicare and Medicaid fractions without any rulemaking for the years prior to 2004. It is ahistorical for the agency now to claim that a retroactive regulation is necessary to comply with the statutory requirements of the DSH statute when they were never required in the first place. In the Proposed Rule CMS asserts that Medicare DSH payments cannot be calculated without such a retroactive rule, but no such rule was needed from 1997 through 2004

to calculate the Medicare DSH payments. Arguing now that a retroactive rule is necessary to satisfy the statute is disingenuous. Indeed, the D.C. Circuit has already rejected an effort to apply the 2004-rule change retroactively to payments for services rendered by hospitals in prior years. *See Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 13-17 (D.C. Cir. 2011) (finding that the 2004 rule "change[d] the legal consequences of treating low-income patients" and therefore could not be applied retroactively).

Third, although *Allina II* vacated the 2014 publication of the FFY 2012 Medicare fractions, as many of the UNC Hospitals have experienced, the Medicare Administrative Contractors ("MACs") are still issuing NPRs that continue to apply the vacated methodology for calculating the DPP fractions. It is unjustifiable to claim that, as a result of *Allina II,* Medicare DSH payments cannot be calculated without a retroactive rule while simultaneously allowing MACs to issue NPRs for the Medicare DSH payments applying the vacated rule. The "required by statute" exception does not apply.

(ii) *Failure to Apply the Change Retroactively Is Not Contrary to the Public Interest.*

The Proposed Rule also has not demonstrated any compelling "public interest" to support the need for adopting the policy on a retroactive basis. The Proposed Rule articulates only two public interest bases (and arguably, a third can be inferred). However, none of the alleged public interest reasons for retroactive rulemaking could even remotely justify retroactive rulemaking under 42 U.S.C. § 1395hh(e)(1)(A).

First, the Proposed Rule alleges that it is in the public interest to pay providers and that without retroactive rulemaking CMS cannot do so. But the contention that without a rule the statute cannot be implemented and no provider can receive DSH payments is circular and blurs the public interest argument into the statutory requirements argument. Just as before, the DSH statute does not require a retroactive rulemaking in order to execute the formula and pay providers that care for low income patients. The agency was able to compute the Medicare fraction without the benefit of an applicable regulation when the Medicare fraction was calculated without including Part C days in the years prior to the subsequently vacated 2004 rulemaking. In addition, CMS has paid providers their DSH payments for years during 2005 through 2013, even during periods when the Part C days rules had been vacated. The appropriate practice now would be to revert to the pre-2004 policy, not to engage in retroactive rulemaking.

Second, the Proposed Rule contends that it is in the public interest to follow notice-and-comment rulemaking to permit interested stakeholders to comment on the proposed approach. However laudable an objective, this alone is not a sufficient rationale for why such rulemaking must be implemented retroactively as opposed to prospectively. Far from it – there was that chance, in 2004 and 2005, but notice and comment was never provided prior to the 2004 rule. That shortfall should not be remedied more than fifteen years later, in 2020.

Third, it is inferred that, because the Proposed Rule would pay providers no more than what they have been paid for years, implementing the Proposed Rule would have no negative financial impact and thus would be in the public interest. 85 Fed. Reg. at 47726. The problem with that position is that it equates paying more to providers as a negative financial impact that is contrary to the public interest. But the opposite is true; failing to pay the providers sums owed to compensate them for providing services to disadvantaged patients as called for under the plain dictate of the DSH statute is what is contrary to the public interest. The purpose of the DSH adjustment in the first place was to compensate hospitals for providing often undercompensated care to economically disadvantaged patients. It is hardly "in the public interest" to create an artificial rule to decrease such statutorily guaranteed reimbursement and increase barriers to the care of economically disadvantaged patients.

Based on the above, it is clear that applying the Proposed Rule retroactively would actually be contrary to the public interest.

3. Retroactive Rulemaking is Unavailable if No Policy Exists for the Calculation of the DSH Fractions Prior to 2014.

Even if it is correct there was no policy in place concerning calculation of the DPP (Medicare and Medicaid fraction) prior to 2014, retroactive rulemaking would be unavailable under 42 U.S.C. § 1395hh(e)(1)(A). Section 1395hh(e)(1)(A) only provides limited authority to apply a "substantive ***change*** in regulations, manual instructions, interpretive rules, statements of policy, or guidelines of general applicability" on a retroactive basis. 42 U.S.C. § 1395hh(e)(1)(A) (emphasis added). Congress has never authorized the agency to retroactively ***establish*** Medicare rules for the first time. If, as it appears, there is an assertion that there was no rule at all during the pre-2014 period, then the proposal does not seek to ***change*** a rule, rather it seeks to ***establish*** the rule. This means that 42 U.S.C. § 1395hh(e)(1)(A) is not applicable. Without a statutory basis that narrowly permits retroactive rulemaking, the prohibition on retroactive rulemaking articulated in *Bowen*, 488 U.S. at 204, applies.

If, on the other hand, the Proposed Rule actually seeks to ***change*** existing policy, then, as explained above, applying it retroactively is not necessary to comply with statutory requirements nor is it in the public interest, since instead the agency could comply with the language of the DSH statute by continuing to apply the pre-2004 policy to calculate the DPP Medicare and Medicaid fractions for all times prior to FFY 2014.

4. The Citation to Other Proposed Rules Contemplating Retroactive Rulemaking and Final Rules Purporting to Have Retroactive Application are Distinguishable, Inapposite and/or Immaterial.

Congress' grant of retroactive rulemaking under Section 1395hh(e)(1)(A) has been used sparingly in the past, in part, because it is very limited. Recently, there has been an enhanced reliance on retroactive rulemaking. But the citation to other proposed rules contemplating

retroactive rulemaking and final rules purporting to have retroactive application has no impact on this case.

Bad Debt Policy. In the FY 2021 IPPS/LTCH PPS proposed rule, the use of retroactive rulemaking to change bad debt policy is justified because of an important public interest such retroactive rulemaking would serve. Specifically, the lack of impact on prior transactions was cited, lack of adverse consequences or additional duties, lack of effect on providers' rights and the avoidance of confusion about which policy applies. 85 Fed. Reg. 32460, 32867 (May 29, 2020).

None of these public interest rationales is asserted for the DSH Part C Days' Proposed Rule, and for good reason. As such, the bad debt example is inapposite here. For example, it is without question that the DSH Part C Days policy change would impose adverse consequences upon providers (i.e., paying them less). Additionally, the DSH Part C Days' proposed retroactive rulemaking is either a change to the longstanding policy that was in place prior to the attempts to change the practice in 2004 or an attempt to create entirely new policy. The Courts in *Allina I, Allina II and Northeast Hospitals* have made this crystal clear.

Predicate Facts/Cost Reopening. In the CY 2014 OPPS rule, the use of retroactive rulemaking was explained as necessary both to comply with statutory requirements and because failure to do so would be contrary to the public interest. The statutory requirements assertions are not relevant here as they concern different statutory provisions than the DSH statute, which, as explained above, does not contain any statutory requirements that necessitate retroactive rulemaking. Nor does the Proposed Rule aid finality in this instance (which otherwise would be in the public interest), since avoidable long-term litigation will obviously ensue.

Low Volume Adjustment. The low-volume hospital adjustment instance is distinguishable and irrelevant because the retroactive rulemaking was necessitated by a **statutory** change that created a new deadline by which the rule was to apply. The retroactive rule was issued as it was necessary to comply with the statute. *See* 84 Fed. Reg. 42044, 42349 (Aug. 16, 2019). As stated earlier, there is no statutory requirement mandating or allowing retroactive rulemaking in the DSH statute.

The Proposed Rule fails to demonstrate how, under either Section 1395hh(e)(1)(A) exception, retroactive rulemaking would be proper here.

F. *Recommendation*: NJHA Urges CMS to Adopt the Policy Included in the "Alternative Model" Presented in the Proposed Rule and to Apply that Model at a Minimum to All Hospitals with Appeals/Lawsuits on File for FFYs 2013 and Prior, and to All Remaining Open Cost Reports in Those Years.

In the Proposed Rule, CMS proposes, as an "alternative model," the removal of all Part C days from each provider's numerator and denominator of the DSH Medicare/SSI fraction and then the inclusion of Medicaid-eligible Part C days in the DSH Medicaid fraction (the "Alternative Model"). NJHA urges CMS to adopt policy consistent with the DSH statute and the Alternative

Model in lieu of the Proposed Rule (with some tweaks to accommodate better and more accurate data discussed in the following section of these comments).

First, such a policy would be consistent with the governing statute. Removal of the Part C inpatient hospital days from the numerator and denominator of the DSH Medicare/SSI fraction of each Provider for all FFYs 2013 and prior would assure that only “for such days” on which patients actually were “entitled” to hospitalization benefits (payments) under Part A are counted in the Medicare/SSI fraction. See, 42 U.S.C. 1395ww(d)(5)(F)(I).

Likewise, if the Alternative Model’s policy is adopted, Medicaid-eligible Part C hospital days (whether based on State obtained data, or using an SSI benefit proxy) would, consistent with the governing statute, be included in the numerator of the DSH Medicaid fraction for each hospital for all FFYs 2013 and prior. As explained in Sections I and II.A through E., above, this would eliminate any conflict between the Proposed Rule and the requirement that the numerator of the DSH Medicaid fraction include all days on which a patient is “eligible” for State Medicaid benefits, but is “not entitled” to benefits under “Part A”. See, 42 U.S.C. 1395ww(d)(5)(F)(II).

Second, adoption of a policy that is consistent with the DSH statute would eliminate the need to adopt a new rule or change in policy “retroactively”. As noted earlier in Section II.E, adoption of the Proposed Rule retroactively for FFYs 2013 and prior is not required by statute, would be contrary to public interest, and would be facially inconsistent with the Medicare Act at 42 U.S.C. 1395hh(e). Adoption of a retroactive rule further would be inconsistent with the holdings not only of the Supreme Court in *Allina II,* but also with the D.C. Circuit Court’s holdings in *Allina I, Northeast Hospitals,* and *Allina II.*

It is incontrovertible that the Proposed Rule squarely contradicts and thus seeks either to “change” the agency’s prior (pre-FFY 2005) policy of excluding Part C days from the DSH Medicare/SSI fraction and including Medicaid-eligible Part C days in the DSH Medicaid fraction or establishes an entirely new rule to carry out the new policy. See, *Northeast Hospitals, supra, Allina II* (Supreme Court opinion), *supra*. Accordingly, adoption of a retroactive change without prior notice and comment is prohibited and would be vacated. The policy of the Alternative Model provides a path around any impermissible retroactive adoption of the Proposed Rule for FFYs 2013 and prior, since that model is essentially a reapplication of the policy followed by CMS in the absence of a formal rule prior to 2004.

Third, adoption of the Alternative Model approach would resolve the clear conflict between the Proposed Rule and prior judicial holdings. As noted above in Sections II. A. through E., the policy as embodied in the 2004/2007 Rule, and in this Proposed Rule, has been vacated three times, in relation to pre-FFY 2005 years, 2007 cost years and then again in relation to providers’ 2012 cost years. See, *Northeast Hospitals, supra, Allina I, supra,* and *Allina II, supra,* respectively. That policy has yet to withstand judicial scrutiny in any case, regardless of whether applied concurrently or retroactively. Moreover, in each of these cases, it has been made unambiguously clear that application of a change in policy retroactively to years prior to the

completion of meaningful notice and comment is invalid under the law. See, *Northeast Hospitals,* at 657 F.3d 13-17; *Allina II,* at 863 F.3d at 944-45; and *Allina II*, at 139 S.Ct. 1816.

To the contrary, adoption of a policy such as presented in the Alternative Model would be consistent with each of these judicial decisions. Adoption of that policy would reinstate the agency's prior practice as was in effect prior to FFY 2005. As such, there would be no retroactivity issue, and no conflict with either the statute or unanimous holdings of the courts that have to date reviewed the policy as first embodied in the 2004/2007 rule. NJHA urges CMS to adopt a policy consistent with the statute or to revert to pre-2004 policy.

G. The Proposed Rule's Public Use File Includes Numerous Inaccuracies and Unexplained Errors that Raise Substantial Issues Regarding CMS's Conclusions.

The Public Use File ("PUF") included with the Proposed Rule contains numerous errors and inaccuracies relating to the calculation of the impact of the Alternative Model. First, based on statistical and data analyses shared with this group by the Federation of American Hospitals (and its consultant, DeBrunner & Associates), whereas CMS's description of its methodology states that it subtracted all Part C days from the numerator and denominator of the Medicare/SSI fraction of all hospitals for the FFY 2013 year, the PUF actually shows an increase in days for 316 hospitals' numerators and/or denominators despite having numerous days removed from that fraction. This is statistically and practically impossible (*i.e.,* days cannot be removed yet the total number of days increases) and highlights the serious and adversely impactful errors built into CMS's reimbursement impact assumptions. This set of errors also improperly reduced the impact of the purported corrective modeling.

Second, despite CMS using an "SSI" day "proxy" to approximate the number of Part C Medicaid days added to the numerators of hospitals' Medicaid fractions (following removal of such days from the Medicare fraction), a large number of hospitals showed increases in their Medicaid fraction numerators that were far smaller than the decreases to the hospitals' Medicare fraction numerators. At least 295 hospitals had decreases of 100 days or more, and many had discrepancies of over 1,000 days. This makes no sense, given that CMS used an "SSI day proxy" to approximate the impact on hospitals' Medicaid fractions, and further reduces the actual impact shown under the Alternative Model. CMS also has better available data and methodologies to avoid these inaccuracies (for example, matching SSI eligibility files to the State Medicaid eligibility data that has been supplied to CMS since 2005 in the form of the "MMA" file) but chose not to use such better data, without explanation. Preliminary studies demonstrate that CMS's "SSI proxy"-derived percentage for 2013 may account for as little as fifty percent (50%) of the "dual eligible" Part C days that should properly be counted in the numerator of hospitals' Medicaid fractions. Whereas the SSI day proxy is a start, the Alternative Model grossly understates the Proposed Rule's adverse impact to hospitals and must be modified.

Third, CMS included only one year's data (FFY 2013) in its modeling. In addition to the other inaccuracies pointed out herein, and even limiting the impact to only the FFY 2005 through

FFY 2013, the likely adverse impact to hospitals of CMS's failure to follow an accurately calculated Alternative Model is (at a minimum) ten times larger than the $600 million impact identified by CMS in the Proposed Rule.

Therefore, NJHA respectfully requests that CMS correct its data and use accurate, consistent data in calculating the impact on a hospital-by-hospital basis in connection with adopting the Alternative Model.

III. Conclusion

For the reasons enumerated above, NJHA requests that 1) CMS first correct its data and use accurate, consistent data in its calculations and 2) adopt the Policy included in the "Alternative Model" presented in the Proposed Rule and apply that Model, at a minimum, to all hospitals with appeals/lawsuits on file for FFYs 2012 and prior, and to all remaining open cost reports in those years.

Thank you for the opportunity to submit these comments.

Respectfully submitted,

Neil Eicher, MPP
Vice President, Government Relations & Policy
New Jersey Hospital Association
Work: 609-275-4088
Cell: 732-221-2544
NEicher@njha.com