

# FY 2018 IPPS LEGISLATIVE AND REGULATORY UPDATE

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Presented by: Robert L. Roth, Esq.  
Hooper, Lundy & Bookman, P.C.  
202.580.7701 | rroth@health-law.com



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## FYs 2017 and 2018 IPPS Final Rules

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- A. FY 2017 Final Rule Released August 2, 2016 (printed in Federal Register August 22, 2016)**
- B. FY 2018 Final Rule Released August 2, 2017 (printed in Federal Register August 14, 2017)**
- C. Highlights covered today:**
  - 1. Inpatient payment update
  - 2. ATRA Adjustment/MACRA Restoration
  - 3. Two Midnight Payment Adjustment
  - 4. Outlier Threshold
  - 5. Disproportionate Share Hospital (DSH) and UC-DSH
  - 6. Use of Worksheet S-10 for UC-DSH
  - 7. Payment Consequences of Quality Metrics

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## Market Basket Updates

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- A. Latest market basket updates can be found on CMS website**
- B. CMS rebases the market basket and labor share every four years and proposed to rebase in 2018:**
  - Labor share 68.3 percent (down from 69.6 percent) for hospitals with a wage index value greater than 1.0000; and
  - Labor share 62 percent for hospitals with a wage index value less than or equal to 1.0000.
- C. FY 2017 Final Rule used a market basket update of 2.7 percent**
- D. FY 2018 Final Rule market basket update also 2.7 percent**
- E. Quality reporting and meaningful use reductions to market basket rate will be discussed later.**

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## ACA Productivity Cuts

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Fiscal Year	Cut
2012	- 1.0%
2013	- 0.7%
2014	- 0.5%
2015	- 0.5%
2016	- 0.5%
2017	-0.3%
2018	-0.6%

1. Applies beginning in FY 2012
2. 10-year moving average of changes in annual non-farm productivity, as determined by the Secretary
3. Can result in a market basket increase of less than zero
4. Payments in a current year may be less than the prior year
5. Applies to other provider types

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## Additional ACA-Mandated Reduction

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- Market basket adjustment FYS 2012-2019

Fiscal Year	Cut
2012	.1%
2013	.1%
2014	.3%
2015	.2%
2016	.2%
2017	.75%
2018	.75%
2019	.75%

- Similar, if not identical, market basket adjustments apply for long-term care hospitals, inpatient rehabilitation facilities, psychiatric hospitals, and outpatient hospital services

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## ATRA Recoupment and MACRA Restoration

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### A. ATRA imposed an aggregate estimated \$11 billion recoupment of asserted coding overpayments in FYS 2010-2012

1. Recoupment to take place over four years (FYS 2014 – 2017),
2. Secretary has discretion on timing and level of the recoupment,
3. Adjustments are to be based on estimated discharges,
4. CMS used a level 0.8% reduction per year, for FYS 2014 – 2016,
5. CMS finalized a -1.5% adjustment to complete the recoupment in FY 2017.

### B. MACRA Restoration

1. To generate savings to pay for the physician SGR fix, Congress prohibited CMS from restoring the aggregate ATRA adjustment to the IPPS rate in FY 2018,
2. Congress, anticipating a 3.2% ATRA adjustment in FY 2017 (4 X 0.8%), allows CMS to ramp up the IPPS rate by 0.5% per year between FYS 2018 and 2023 to restore part of the adjustment,
3. Unfortunately, CMS imposed an aggregate -3.9% ATRA adjustment, potentially leaving -0.9% permanent. HLB is forming a Group Appeal on the 0.7% differential.

### C. Cures Act Modification – limits increase in FY 2018 to 0.4588%.

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## Two Midnight Policy and Payment Reduction

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### A. Original two-midnight policy FYs 2014 and 2015

1. CMS will generally consider hospital admissions spanning two midnights as appropriate for inpatient Part A payment
2. In contrast, hospital stays of less than two midnights will generally be considered outpatient cases, regardless of clinical severity
3. CMS imposed a -0.2% payment reduction under the assumption the policy would increase claims inpatient stays

### B. Modifications to the two-midnight policy CY 2016

CY 2016 OPPS Final Rule - Stays less than two midnights may be appropriate for inpatient admission based on "the clinical judgement of the admitting physician and medical record support for that determination."

### C. Litigation Update

1. Pending motions, including on interest due, to be heard by District Court on October 26, 2017.
2. As part of FY 2017 IPPS Final Rule CMS provided a permanent 0.2% adjustment and restores prior period adjustments by providing additional increase of 0.6% only in FY 2017, for an aggregate increase of 0.8% in FY 2017.
3. FY 2018 IPPS Final Rule – one time reduction of 0.6% to eliminate effect of one-time 0.6% increase in FY 2017

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## Basic IPPS Rates for FYs 2017 and 2018

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	FY 2017 IPPS Final Rule	FY 2018 IPPS Final Rule
Market Basket	2.7%	2.7%
<b>ACA Reductions</b>		
Market Basket	-0.75%	-0.75%
Productivity	-0.3%	-0.6%
<b>Subtotal = Applicable Percentage Increase</b>	<b>1.65%</b>	<b>1.75%</b>
ATRA Reduction (additive) or Cures Act Restoration	-1.5%	0.4588%
<b>TWO-MIDNIGHT ADJUSTMENT</b>	<b>0.8%</b> (only 0.2% permanent)	<b>-0.6%</b>
<b>Total General Adjustment before Sequester</b>	<b>0.95%</b>	<b>1.2088%</b>

Note: This update does not include hospital-specific payment changes due to readmissions, value-based purchasing, hospital acquired conditions, meaningful use, etc.

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## Hospital-Dependent Adjustments for FY 2018

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FY 2018 Summary by HPA	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital did NOT Submit Quality Data and is a Meaningful EHR User	Hospital did NOT Submit Quality Data and is NOT a Meaningful EHR User
Market Basket Increase	2.7	2.7	2.7	2.7
Adjustment for Failure to Submit Quality Data	0.0	0.0	-0.675	-0.675
Adjustment for Failure to be a Meaningful EHR User	0.0	-2.025	0.0	-2.025
MFP Adjustment	-0.6	-0.6	-0.6	-0.6
Statutory Adjustment SSA section 1886(b)(3)(B)(xii)	-0.75	-0.75	-0.75	-0.75
Applicable % Increase Applied to Standardized Amounts	1.35	-0.675	.0675	-1.35

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## Outlier Payment Adjustment

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### A. FY 2017

1. CMS proposed a \$23,681 fixed loss threshold for FY 2017, and finalized a \$23,573 threshold.
2. CMS now estimates FY 2016 outlier payments at 5.41% of MS-DRG payments.

### B. FY 2018

1. CMS proposed a \$26,713 fixed loss threshold, a surprisingly large increase from FY 2017, and finalized a \$26,601 threshold. We think this is driven in part by an increasing number of cases with charges over \$1.5 million, which CMS refused to exclude from the calculation.
2. While CMS does not provide specific information on its estimated outlier payments as a percentage of total DRG payment, a percentage of 4.9% can be inferred from an unexplained difference between the FY 2017 and 2018 modeled payments.
3. CMS did not provide an estimate of FY 2017 outlier payments, but said it would do so in the FY 2019 Proposed Rule, by when CMS will have the full year of FY 2017 claims data.

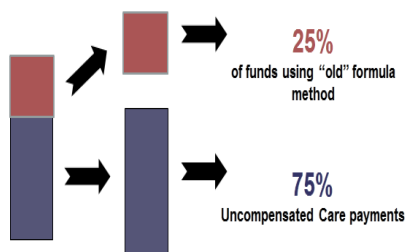
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## DSH and UC-DSH Payment Policy

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### □ ACA changed Medicare DSH payments starting in FY 2014

- New statute codified at 42 U.S.C. §1395ww(r)
- CMS adds new 42 C.F.R. §412.106(f)-(h) effective with discharges on and after 10/1/13



Total Uncompensated Care fund pool reduced as uninsured rate declines; hospital share of fund pool based on the relative uncompensated care each DSH Hospital provides relative to all DSH hospitals, but CMS uses a proxy for uncompensated care costs.

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## UC – DSH Basics

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### □ Affected Hospitals

- 2427 Hospitals projected to be eligible, including Puerto Rico
- Excludes Maryland and CAHs
- Sole Community Hospitals – consider all DSH when assessing eligibility for a hospital specific rate

### □ Total Uncompensated Care payments subject to three factors:

- One – Estimate 75% of traditional DSH payments and reduce traditional DSH payments to hospitals by that amount
- Two – Establish Uncompensated Care DSH Fund by taking 75% of Estimated traditional DSH payments reduced by improvement in insured rates (an additional statutory factor included in FY 2017 does not apply to FY 2018)
- Three – Distribute Uncompensated Care DSH Fund based on the ratio of each hospital's 3 year average of Medicaid and SSI days to all DSH hospitals' Medicaid and SSI days through FY 2017. The FY 2018 Final Rule starts transition to calculating uncompensated care costs using W/S S-10 data.

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## UC- DSH Factor One Calculation

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- **Initial size of the 75-percent aggregate uncompensated care payments**
- **Difference between CMS estimates of**
  1. The amount of DSH payments that would be made to all hospitals in the absence of the ACA payment provision; and
  2. The amount of the empirically justified Medicare DSH payments actually made in that year
- **75 percent of DSH payments that would be made to all hospitals in the absence of the ACA payment provision.**
- **Set prospectively and not based on (or revised for) actual data**
- **Historical Factor One:**
  1. FY 2017 - \$10.797 billion
  2. FY 2016 - \$10.058 billion
  3. FY 2015 - \$10.037 billion
  4. FY 2014 - \$9.579 billion
- **Final FY 2018 Factor One amount is \$11.664 billion; proposed was \$12.002 billion**

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## Factor Two Calculation for Final FY 2017

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- A. Change in the percentage of uninsured from 2013 baseline of 18%**
  - Congressional Budget Office (CBO) data
  - Estimate of individuals under the age of 65 with insurance in CY 2016 was 89 percent (uninsurance rate of 11 percent)
  - Estimate of individuals under the age of 65 with insurance in CY 2017 was 90 percent (uninsurance rate of 10 percent)
  - These figures are then weighted to determine the uninsurance rate for FY 2017
  - Percent change from 2013 uninsurance rate minus an additional statutory factor (0.2 percentage points or .002)
  - Proposed FY 2017 Factor Two was 0.5536
- B. CMS retains 55.36 percent – or \$5.977 billion – of the original aggregate uncompensated care payments (75-percent) in FY 2017 Final Rule**
- C. This caused a reduction of approximately \$400 million in Medicare DSH payments in FY 2017 compared to FY 2016**

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## Factor Two Calculation for FY 2018

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- A.** Prior to FY 2018, the statute focused on the change in the uninsured population under 65. Beginning in FY 2018 the measure must focus on the change in the total uninsured population between the base year of FY 2013 and each year beginning on and after FY 2018.
- B.** The statute allows CMS more data source flexibility in assessing that change in the uninsured population starting in FY 2018. CMS determined that uninsured estimates produced by CMS' OACT as part of the development of the National Health Expenditure Accounts (NHEA) best meet that goal.
- C.** CMS calculated Factor 2 for the FY 2018 Proposed Rule at 58.01 percent, which was left unchanged in the Final Rule.
- D.** The final uncompensated care amount for FY 2018 is \$11.664 billion x 0.5801 = \$6.767 billion.
- E.** This is about \$800 million more than FY 2017 available to distribute to hospitals using Factor 3 (a 13.2% increase).

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## Factor Three Calculation for FYs 2016 and 2017

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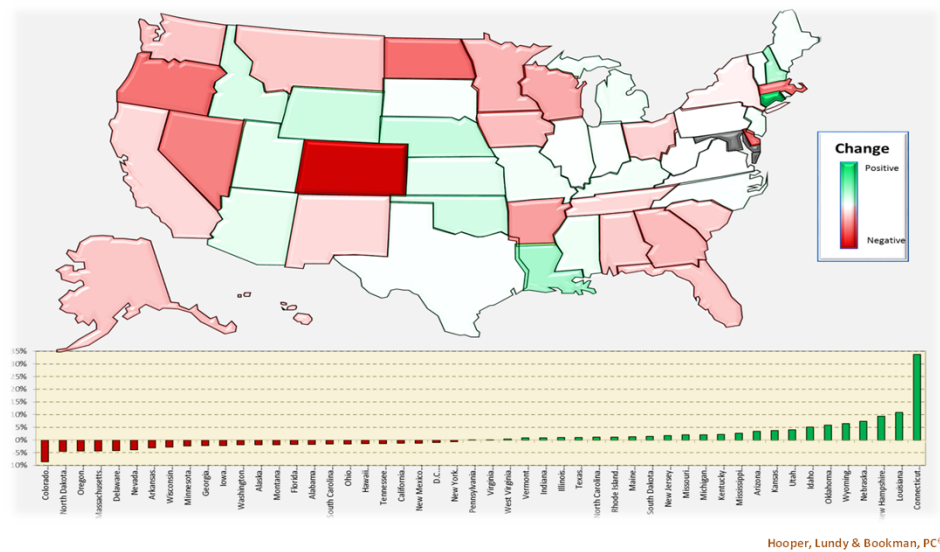
- A.** Based on uncompensated care costs for all UC-DSH hospitals
- B.** Allocates Factor 2 pool based on relative uncompensated care costs among all UC-DSH hospitals
- C.** Proportion of each hospital's measure to aggregate hospitals' total measure for all DSH eligible hospitals:
  - 1. Through FY 2017, CMS used inpatient days of Medicaid beneficiaries plus inpatient days of Medicare supplemental security income (Medicare SSI) beneficiaries as a proxy for measuring uncompensated care costs.
  - 2. For FY 2016 CMS used March 2015 update of the 2011/2012 Medicare cost reports for the Medicaid days and the FY 2013 SSI ratios for the Medicare SSI days.
  - 3. For FY 2017 CMS used a 3 year average for Medicaid and Medicare with SSI days (Puerto Rico hospitals are given a proxy for this factor) from March 2016 update for FYs 2011-13 (but is not annualizing partial periods) and the FY 2014 SSI ratios for the Medicare SSI days.
  - 4. CMS published on its website a table listing Factor 3 for all IPPS hospitals it estimates would receive uncompensated care payments.

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## DSH: Effect of 3-Year Averaging of Factor Three for FY 2017 vs. FY 2016 Single Year

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## FY 2018 IPPS Final Rule Methodology for Factor Three – Move to W/S S-10

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### FY 2018 IPPS Final Rule adopts proposal to begin using W/S S-10 data in FY 2018, with transition to full use by FY 2020.

1. For FY 2018, CMS calculated Factor 3 based on an average of Factor 3 calculated using low-income insured days (proxy data) determined using Medicaid days from FY 2012 and FY 2013 cost reports and FY 2014 and FY 2015 SSI ratios, and uncompensated care data based on FY 2014 Worksheet S-10, as amended.
2. For FY 2019, CMS would calculate Factor 3 based on an average of Factor 3 calculated using low-income insured days (proxy data) determined using Medicaid days from the FY 2013 cost report and the FY 2015 SSI ratios, and Factor 3 calculated using uncompensated care data based Worksheet S-10 from the FYs 2014 and 2015 cost reports.
3. For FY 2020, CMS would calculate Factor 3 using uncompensated care data based solely on Worksheet S-10 data from FYs 2014, 2015 and 2016 cost reports.
4. Indian Health Service and Puerto Rico hospitals' FY 2018 Factor 3 calculation not based on S-10 data (uses FY 2013 data twice and FY 2012 data once). Will revisit in FY 2019 rulemaking.
5. For "no charge" structure hospitals, CMS will continue to use low-income patient day data.
6. Because S-10 data is still unaudited, CMS will assign statewide average CCR for all hospitals with a CCR > 3 standard deviations above national corresponding geometric mean.
7. CMS adopted proposal to annualize short and long period cost report data.

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## Other FY 2017 Final Rule UC-DSH Changes

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### Timing of reporting charity care and non-Medicare bad debt:

1. CMS revises Worksheet S-10 cost report instructions for Line 20 concerning the timing of reporting charity care, such that charity care will be reported based on date of write-off, and not based on date of service (See CMS Pub. 15-2, Chapter 40, Section 4012),
2. This is consistent with charity write-offs that hospitals report in accordance with GAAP,
3. Hospitals currently report non-Medicare bad debt without regard when the services were provided, and
4. CMS advised contractors to allow W/S S-10 amendments to the FY 2014 reported data to accommodate this change and other corrections hospitals may offer, so long as received by Sept. 30, 2016. A similar offer has been made for FY 2015 reported data.

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## Other FY 2018 Final Rule UC-DSH Changes

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1. Uncompensated care costs exceeding 50% of a hospital's total operating expenses will be considered aberrant and not used.
2. Final Rule states that CMS "expect cost reports beginning in FY 2014, FY 2015, and FY 2016 to be subject to further scrutiny after submission."
3. Hospitals have until September 30, 2017 to resubmit FYs 2014 and 2015 cost reports containing W/S S-10 amendments to their MAC.

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## Example: California DSH Breakout

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### Estimated Impacts of CMS' Proposals Related to Distribution of the DSH Uncompensated Care Pool

	Est. UCC Revenue	Est. Total Revenue	Impact (\$)	Impact (%)
FFY 2017 Calculation Maintained at Single Year of Data (Current)	\$767,106,300	\$10,887,038,200		
FFY 2017 Calculation Based on Proposed Three Year Data Average	\$756,857,200	\$10,876,832,300	(\$10,205,900)	-0.09%

- CMS is proposing to utilize Medicaid Days from FFY 2011, 2012, and 2013 Medicare Cost Reports; and Medicare SSI Days from FFYs 2012, 2013, and 2014 in the calculation of the FFY 2017 DSH UCC distribution factors. As FFY 2014 Medicare SSI Days are not yet available, the proposed rule uses FFY 2013 as a proxy. The "Single Year" calculation is based a sum of FFY 2013 Medicaid Days and FFY 2013 Medicare SSI Days.

CCR Methodology	Transition Year	Factor 3 Data Mix	Est. UCC Revenue	Est. Total Revenue	Impact (\$) vs Current Proxy Distribution	Impact (%)
FFY 2014 S-10 Using Current CCR Calculation	1st	2 Proxy, 1 S-10	\$617,744,600	\$10,738,030,000	(\$149,008,200)	-1.37%
	2nd	1 Proxy, 2 S-10	\$481,605,900	\$10,602,186,500	(\$284,851,700)	-2.62%
	3rd	3 S-10	\$338,855,700	\$10,459,760,400	(\$427,277,800)	-3.92%
FFY 2014 S-10 After Applying Proposed Double-Trim Methodology to Hospital CCR	1st	2 Proxy, 1 S-10	\$598,473,100	\$10,718,741,300	(\$168,296,900)	-1.55%
	2nd	1 Proxy, 2 S-10	\$443,062,800	\$10,563,609,200	(\$323,429,000)	-2.97%
	3rd	3 S-10	\$281,041,000	\$10,401,892,400	(\$485,145,800)	-4.46%

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## Problems with Reliability of W/S S-10 Data

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- **Many errors obvious in filed S-10 data that strongly suggests data is unreliable as a basis to determine relative share of uncompensated care costs**
  - Many hospitals did not report S-10 data at all, about 5%
  - 14% had no total bad debt data, but 90% of that group reported Medicare bad debt data
  - Some had a CCR of 1, many had CCRs above .6, a few had more gross charges on S-10 than on C
  - Some reported unreimbursed costs of Medicaid as uncompensated care.
- **Definitional problems**
  - Uninsured vs. Charity – non-means tested uninsured discounts, or discounted care that is not charity care likely not included in charity
  - Charity must be determined during the cost reporting period
- **Converting Charges to Costs**
  - Problem particularly acute with bad debt
  - Hospitals may be grossing up charges to address copayment shortfalls – should a hospital be allowed to claim a cost for a copayment that exceeds the actual copayment obligation? If the answer is yes, how do you standardize how that cost will be measured?
- **FY 2018 Final Rule indicates that CMS will continue to work with stakeholders to address concerns with W/S S-10.**

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## Payment Formula for Value-Based Purchasing and Readmissions

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### What is the “base operating DRG amount” subject to reduction?

- No changes to the penalty formula
- Excludes Indirect Medical Education (IME), DSH, outliers, low-volume adjustment, and additional payments made due to status as an Sole Community Hospital (SCH), but
- Includes new technology payments, and will be,
- Adjusted to account for transfer cases, and then equals,
- $((\text{Labor Share} * \text{Wage Index}) + (\text{Non Labor Share} * \text{COLA}) * \text{DRG Weight}) + \text{New Technology Add On Payment}) * (\text{Adjustment Factor}-1)$

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## Hospital Value-Based Purchasing Program

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- **ACA-mandated; applies to discharges on and after 10/1/2012**
- **Funded through base operating DRG reductions: 1 percent in FY 2013, 1.25 percent in FY 2014, 1.5 percent in FY 2015, 1.75 percent in FY 2016 and 2 percent for FY 2017 and thereafter**
- **Budget neutral – all funds withheld are redistributed as incentive payments to applicable hospitals**
- **The available pool for FY 2018 is estimated to be \$1.9 billion**
- **Other details**
  - CMS increases from two to three the number of surveys for which a hospital must be cited for immediate jeopardy before its exclusion from the VBP Program. A hospital must be cited on Form CMS-2567, Statement of Deficiencies and Plan of Correction, for immediate jeopardy on at least three surveys during the performance period in order to meet the standard for exclusion from the VBP Program.
  - CMS to remove PSI 90 composite patient safety measure beginning in FY 2019 and use instead AHRQ Patient Safety and Adverse Events composite measure starting in FY 2023.
  - Beginning with FY 2022 payment, CMS finalized proposal to add a hospital-level, risk standardized 30-day pneumonia episode of care payment measure to the VBP Program.

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## Hospital Readmissions Reduction Program (HRRP)

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- A. ACA-mandated and assesses penalties on hospitals for having “excess” readmission rates when compared to expected rates for 6 measures that are unchanged for FY 2018.
- B. The applicable period for purposes of the FY 2018 comparison is July 1, 2013 – June 30, 2016.
- C. Maximum penalty topped out at 3.0 percent of Medicare base operating payments in FY 2015, and remains at 3.0 percent in FY 2016 and thereafter.
- D. CMS is considering socio-economic demographic data in the risk adjustment and submitted a report to Congress in December 2016: <https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs>. CMS is soliciting comments on such factors.
- E. 21st Century Cures Act mandates changes to the HRRP program beginning in FY 2019:
  1. Requires hospital be assigned to peer groups (5 proposed) stratified on the proportion of full Medicare to Dual Eligible patients at the hospital, and includes MA patients in the comparison,
  2. Must be budget neutral,
  3. No additional reporting requirements for hospitals,
  4. Finalized proposed payment formula that compares excess readmission ratio (ERR) to the median ERR for the peer group.

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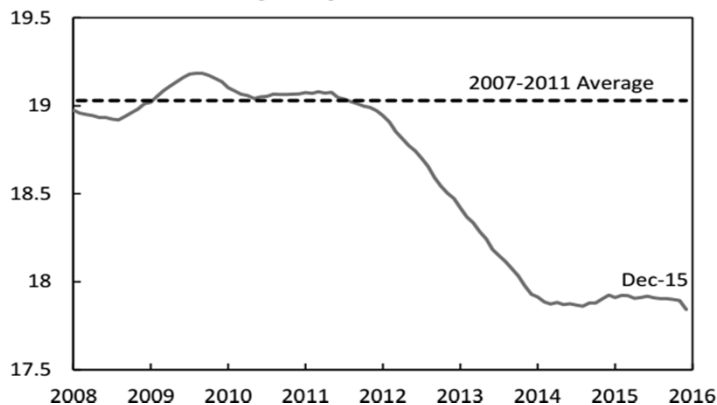
## Hospital Readmissions Reduction Program

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### Economic Report of the President

#### Medicare 30-Day, All-Condition Hospital Readmission Rate

Percent, 12-month moving average



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## HAC Reduction Program

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- A.** Hospital-Acquired Condition Reduction Program (HACRP) is an ACA-mandated program that imposes a 1 percent reduction to all Medicare inpatient payments for hospitals in the top (worst performing) quartile of risk-adjusted national HAC rates
- B.** Therefore, for discharges on and after Oct. 1, 2014, hospitals in top quartile of risk adjusted HAC measures receive only 99% of total PPS payments
- C.** Adjustment is applied after VBP and HRRP adjustments
- D.** FY 2018 IPPS Final Rule adopts a new 2-year measurement window and changes to the “extraordinary circumstances exception,” but will continue to consider new measures.

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## Impact of Medicare Access and CHIP Reauthorization Act on Inpatient PPS

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**EXTENDS ENHANCED LOW VOLUME HOSPITAL PAYMENTS AND THE MEDICARE-DEPENDENT HOSPITAL PROGRAMS UNTIL OCTOBER 1, 2017, BUT SUNSETS AFTER THAT ABSENT ADDITIONAL CONGRESSIONAL ACTION.**

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## Important Recent Court Decisions

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- A. *Allina Health Services v. Price*, No. 16-5255 (D.C. Cir. July 25, 2017) (“*Allina I*”)– Medicare DSH – Part C Days - Court reiterates that 2004 rule was invalid and suggests that CMS and the HHS Secretary can not repair and apply the rule to include Part C days in hospitals’ SSI fractions, regardless of any adjudicatory attempts to validate that rule.
- B. *Allina Health Services v. Price*, No. 16-0150 (RC) (D.D.C. August 4, 2017) (“*Allina I*”) – Medicare DSH – Part C Days – After remand, Court denies the Secretary motion to dismiss challenge to Medicaid fraction.
- C. *American Hospital Association v. Price*, No. 17-5018 (D.C. Cir. August 11, 2017) – Medicare Appeals Backlog – Circuit Court vacates mandamus order issued by District Court and remands for further proceedings.

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# Questions?

