Are Notice and Comment Rule Making Required Before the Center for Medicare and Medicaid Services Can Adopt Policies Determining How It Will Compute a Component of a Hospital's Disproportionate Share Reimbursement?

CASE AT A GLANCE

When adopting "substantive legal standards" governing payment for Medicare services, the Center for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services (HHS) is required to pursue notice and comment rule making. Allina Health Services operates a number of hospitals that serve a large cohort of low-income patients. In the process of adopting policies instructing its third-party contractors with regard to reimbursing hospitals serving this demographic, CMS computed a component of that reimbursement known as the Disproportionate Share Hospital adjustment without rule making for nine years from 2004 to 2013. (HHS adopted a new prospective rule in 2013, thus cabining the impact of this litigation to the stated period.) Allina asserts that formal rule making with notice and comment by affected entities and the public is required. The district court disagreed, but the D.C. Circuit Court of Appeals reversed. The question for the Supreme Court is whether this policy is a "substantive legal standard."

Azar v. Allina Health Services
Docket No. 17-1484

Argument Date: January 15, 2019
From: The D.C. Circuit

by Elliott B. Pollack
Pullman & Comley, LLC, Hartford, CT

ISSUE

Is notice and comment rule making required before the Center for Medicare and Medicaid Services (CMS) can adopt policies determining how it will compute a component of the disproportionate share reimbursement for hospitals that treat many low-income patients?

FACTS

After challenging the calculations by Health and Human Services (HHS), Allina Health Services unsuccessfully sought review by the Provider Reimbursement Review Board (PRRB). That board decided that it did not have the legal authority to deal with the issue and allowed Allina to seek prompt review in the district court.

The district court held that notice and comment rule making was *not* required for CMS to base its calculations on its policy statement and that provisions of the Social Security Act and the Administrative Procedures Act deemed to require this action were not applicable. CMS was merely interpreting existing statutes, the lower court ruled, rather than adopting a new rule, requirement, or other statement of policy that establishes or changes a substantive legal standard.

In reversing the district court, the D.C. Court of Appeals held that CMS had adopted a substantive legal standard within the meaning of both applicable statutes because, paraphrasing the statute, its rule created, defined, and regulated the rights, duties, and powers of parties. That was the case because hospitals' rights to payment for treating a large number of low-income patients was being decided.

CASE ANALYSIS

While rather turgid on the surface, this litigation focusing on the intricacies of Medicare law and the federal Administrative Procedure Act is clearly very important to all hospitals as they seek to maximize their federal reimbursements consistent with law and regulation. This is especially important in this case given that these patients tend to present with more significant medical problems than those more fortunate, and therefore, their treatment is more costly.

Adding some spice here is that 1) HHS claims the District of Columbia Court of Appeals's decision conflicts with decisions dealing with similar issues from the First, Eighth, and Ninth Circuits in *Warder v. Shalala,* 149 F.3rd 73 (1998), *Baptist Health v. Thompson,* 458 Fed.3rd 768 (2006), and *Erringer v. Thompson,* 371 Fed.3rd 625 (2004), respectively; and 2) Associate Justice Brett

Kavanaugh, the Supreme Court's most junior member, wrote the court of appeals's decision and is recused.

Because discussion of the legal issues embedded in this extremely technical litigation requires a large allotment of Sominex and Red Bull, we focus here on the larger policy issue of whether significant reimbursement shifts by CMS can be pushed through without being first commented upon and vetted in public.

Lest some readers may think otherwise, the question of mandatory rule making for CMS actions is not a one-off issue. Only recently, the CMS administrator issued a pronunciamento about the use of waivers under Section 1332 of the Social Security Act to create new insurance options for health-care savings accounts, which was preceded by "guidance" issued in November. A Fellow at the Brookings Institution observed in the December 3, 2018, issue of *Modern Health Care* that this guidance/interpretive rule is not exempt from notice and comment rule making and that the proposed CMS changes, if implemented, may prompt sanctions against states to whom such new waivers would be extended as they rely on the "guidance."

There are a variety of issues before the Court, including whether a series of lower court cases, *Warder, Erringer,* and *Baptist Health,* all rule that requirements declared by CMS in its interpretive manual do not require notice and comment rule making because they are not substantive legal standards. Second, the Court will be asked to determine what "substantive legal standards" means in this context. The parties are expected to ask the Court to determine whether an existing legal standard has to be changed in order for that change to be a substantive legal rule. Finally, the Court may consider whether the financial administration of the Medicare system may be jeopardized by the court of appeals's rulings.

The Allina petitioners note that even if the court of appeals's decision interpreting one section of the Social Security Act as requiring rule making was overturned, the lower court's decision also rests on an alternative statutory section that was not included within the certification of these proceedings by the Supreme Court. They maintain that there is no conflict among the circuits because the court of appeals's alternative holding is not within the questions certified and has not been addressed by any other court of appeals.

Citing previous HHS statements in Court filings, the respondents maintain that neither increased cost nor excessive administrative effort will be required if the court of appeals's decision is upheld.

The impact of any new changed payment policy by CMS requires public hearing, respondents maintain, particularly in light of the $120 billion of annual payments for Medicare inpatient hospital services around the country.

While characterizing its policies merely as "instructions" to its third-party contractors, respondents assert that CMS did not simply adopt an interpretive rule to "guide" its contractors or to address "ambiguities" in calculating Disproportionate Share Hospital (DSH) payment reimbursements. There appears to be no question that CMS is attempting to defend rules that have nationwide application to payment determinations notwithstanding how they are styled. Moreover, the respondents trenchantly observe that the Medicare system "repeatedly used notice-and-comment rule making in new or revised standards on different components of the DSH payment formula." How can petitioner argue now, respondents ask, that the same procedures are not required for the action that is contested here?

SIGNIFICANCE

The Medicare system accounts for something totaling three-quarters of a *trillion* dollars of health-care payments to hospitals and other providers around the country. While it makes no sense to hamstring CMS when it deals with the intricacies of an individual hospital's reimbursement, adoption of standards that apply to all hospitals treating a significant number of low-income folks appears to meet the definition of a "substantive legal standard," which requires notice and comment rule making before it becomes effective. It is perhaps the general and sweeping nature of CMS's instructions to its contractors as to how to pay hospitals entitled to DSH payments that suggest the general applicability of the announcement that is challenged here. Thus, unless the Supreme Court is willing to risk a major crack in the wall of mandatory notice and comment rule making, it would appear that the court of appeals's decision, even though limited to a defined calendar period, is properly supported.

Elliott B. Pollack is a member of Pullman & Comley, LLC, in Hartford, CT. He represents health-care providers and commercial property valuation clients. He frequently represents physicians in their regulatory, transactional, reimbursement, managed care, and medical/legal affairs. He can be reached at ebpollack@pullcom.com.

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ATTORNEYS FOR THE PARTIES

For Petitioner Alex M. Azar II, Secretary of Health and Human Services (Noel J. Francisco, Solicitor General, 202.514.2217)

For Respondents Allina Health Services, et al. (Stephanie A. Webster, 202.887.4000)