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SCOTUS Rejects CMS DSH Policy, Calls CMS Guidance Practices Into Question

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Earlier this week, the Supreme Court upheld a D.C. Circuit Court decision vacating a policy of the Centers for Medicare and Medicaid Services ("CMS") that would have "dramatically – and retroactively – reduced payments to hospitals serving low-income patients." *Azar v. Allina Health Services*, 587 U.S. __ at 1 (2019). The Supreme Court's *Allina* opinion ("Op." or the "Decision") is critically important for hospitals that rely on Medicare disproportionate share ("DSH") payments and has broader implications for the way that CMS issues the voluminous guidance that the agency applies to Medicare-participating providers and suppliers and other CMS-contracted entities.

Disproportionate Share Payments

Medicare provides DSH payments to eligible hospitals as additional reimbursement to cover the higher operating costs commonly experienced by hospitals that serve a significantly disproportionate number of low-income patients. DSH payments are calculated as a percentage add-on to the basic DRG payment for inpatient hospital services provided by a DSH-eligible hospital. Eligibility for DSH payments and the amount of DSH payments that an eligible hospital receives is determined by a complex formula and each hospital's "disproportionate patient percentage" ("DPP"). Currently, the DPP is derived from the sum of two ratios – (i) the percentage of Medicare inpatient days (including Medicare Advantage (Medicare Part C) inpatient days) attributable to patients entitled to both Medicare Part A and Supplemental Security Income ("SSI") benefits, and (ii) the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A.

As noted above, the current DPP calculation includes Medicare Advantage inpatient days when adding up the total number of Medicare inpatients days used in the first ratio. However, as shown in the timeline below, Medicare Advantage inpatient days were not always included in that calculation.

1. **2003**. CMS issued a proposed rule that sought "to clarify" that Medicare Advantage days are excluded from DSH calculations because they are not considered covered and paid under Medicare Part A.
2. **2004**. CMS changed course and issued a final rule providing that Medicare Advantage days are to be counted in the calculation of Medicare inpatient days for purposes of calculating the

DPP.

3. **2013**. CMS issued a new rule formally including Medicare Advantage beneficiaries in the DSH calculation and applying the practice prospectively. At the same time, the D.C. Circuit, in the *Allina* case, was considering whether the 2004 final rule – a reversal of the 2003 proposed rule – could stand or whether it differed so much from the proposed rule that it constituted new rulemaking that required its own notice and comment period before it could be enforced.
4. **2014**. Sixteen days after the D.C. Circuit's mandate vacating the 2004 rule, CMS issued its DPPs for 2012, noting that they included Medicare Advantage days ("2014 DSH Guidance"), consistent with the vacated 2004 rule. By issuing the 2014 DSH Guidance as policy rather than regulation, CMS avoided the notice and comment period required under the Medicare Act, as discussed further below. As a result, the 2014 DSH Guidance was issued without notice to the public, without any explanation of CMS' departure from the prevailing pre-2004 standard reinstated by the D.C. Circuit in its 2014 mandate, and without an opportunity for public comment on the substance of the 2014 DSH Guidance.

Azar v. Allina Health Services

In response to CMS's 2014 DSH Guidance, a group of hospitals challenged CMS' retroactive policy change, arguing that the government had failed to meet the Medicare Act's requirement to provide public notice and a 60-day comment period for any "rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under [Medicare]." 42 U.S.C. § 1395hh(a)(2). Over a five year period, the *Allina* case moved through the courts until it finally reached the Supreme Court.

In the Decision, the Court agreed with the hospitals and held that the statutory language did not track the APA's distinction between "substantive" and "interpretive" rules, but instead was broad enough to include CMS' 2014 policy change.

The Supreme Court's Analysis

The APA – and its notice and comment requirements – does not apply to public benefit programs like Medicare. *See* 5 U.S.C. § 553(a)(2). The Medicare Act, however, separately imposes a notice and comment requirement with respect to the establishment of or change to certain substantive legal standards. The Court's decision turned on the interpretation of the phrase "substantive legal standard." The parties proposed fundamentally different definitions of the phrase. The hospitals argued that the statute distinguishes between substantive legal standards that create duties, rights, and obligations, and procedural legal standards, that specify how duties, rights, and obligations should be enforced. Meanwhile, the government argued that the statute should track the APA's distinction between "substantive rules" that have the force and effect of law, and interpretive rules that advise the public of an agency's construction of statutes and rules.

Justice Gorsuch, writing for the Court, found the government's interpretation untenable for several reasons. First, Justice Gorsuch pointed out that the Medicare Act's notice and comment requirement explicitly applied to statements of policy, which are – by definition – not substantive rules under the APA. Second, Justice Gorsuch looked to a subsequent provision in the Medicare Act, which gives the government limited authority to make "substantive change[s]" to certain pronouncements, including "interpretive rules" and "statements of policy," implying again that "substantive" as used in the Medicare Act does not have the same meaning as in the APA. Third, Justice Gorsuch noted that if

Congress intended to incorporate the APA standard, Congress could simply have done so via cross-reference, as it did with the APA's good cause exemption; Congress' cross-reference to one exemption but not the other strongly implied that the exclusion of the "interpretive rules" exemption was intentional.

Based on this analysis, Justice Gorsuch concluded that "the government's arguments for reversal fail to withstand scrutiny." Op. at 12. Therefore, while the Court noted that it "need not…go so far as to say that the hospitals' interpretation, adopted by the court of appeals, is correct in every particular," it affirmed the D.C. Circuit's 2014 mandate vacating CMS' rule.

Implications

The Court's decision is a triumph for hospitals, in the face of a CMS policy change that was promulgated retroactively and with no notice, cutting millions of dollars of payments that hospitals had reasonably expected to receive and could ill afford to lose. While CMS may certainly shift its policy on disproportionate share payment calculation going forward, it will at least be clearly required to give affected stakeholders at least a minimal heads-up.

Stepping back from these unambiguously positive practical consequences, the decision raises a great many questions about how CMS will be required to establish its subregulatory guidance going forward. For an agency – and the entities it regulates – that publishes tens of thousands of pages of subregulatory guidance, all of which is subject to regular amendment, this question could not be more fundamental. Justice Gorsuch contended that his opinion will not impose substantial burden on the agency, noting that "the dissent points to only *eight* manual provisions that courts have deemed interpretive over the last four decades." However, there is no reason to think that courts would have considered whether the vast majority of manual provisions were interpretive.

Moreover, as Justice Breyer's dissent points out, the Court provides no clear standard for distinguishing between the types of CMS guidance that would and would not be subject to the Medicare Act's notice and comment requirement, since the Court did not adopt the substantive/procedural distinction suggested by the hospitals or propose an alternative. Potentially, a significant volume of manual provisions could at least arguably establish or change "substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under [Medicare]." The status of such manual provisions and any future revisions thereto is uncertain.

Finally, as Justice Gorsuch noted, "[n]otice and comment gives affected parties fair warning of potential changes in the law and an opportunity to be heard on these changes – and it affords the agency a chance to avoid errors and make a more informed decision." Op. at 15-16. These benefits cannot be overstated, and CMS would no doubt be well-served to be more transparent and communicative in its development of subregulatory guidance, even at the cost of a slower rate of change required by a more contemplative process. Nevertheless, it would be valuable to both CMS and its regulated entities to better understand the scope of Justice Gorsuch's opinion and the extent to which CMS' volumes of subregulatory guidance may be called into question.

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