NOW + NEXT

HEALTH CARE ALERT | NIXON PEABODY LLP

MARCH 13, 2017

Nixon Peabody Litigation team helps clients enjoin CMS policies: New Hampshire District Court holds Medicaid disproportionate share hospital limit not reducible by dual-eligible payments

By Anthony J. Galdieri and W. Scott O'Connell

On March 2, 2017, United States District Court for the District of New Hampshire granted summary judgment on behalf of Nixon Peabody's clients, the New Hampshire Hospital Association (NHHA) and four New Hampshire hospitals, in the case of *New Hampshire Hospital Association v. Burwell*.[1] The court permanently enjoined CMS from reducing the hospital-specific disproportionate share hospital (DSH) limit through enforcement of "policy clarifications" contained in two Frequently Asked Questions (FAQs) that reduced DSH payments nationwide. This decision marks the first case in which CMS's policies regarding the inclusion of both private health insurance and Medicare payments in the calculation of the hospital-specific DSH limit were challenged. This decision will likely have a far reaching effect in states around the country with DSH programs.

Background

42 U.S.C. § 1396r-4(g)(1)(A) sets forth the formula to determine a provider's hospital-specific DSH limit. Under the statute, a DSH payment to a hospital may not exceed "the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this subchapter, other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year."

In 2008, CMS promulgated a final rule interpreting a reporting and annual auditing statute related to DSH payments. The rule restated the formula set forth in 42 U.S.C. § 1396r-4(g)(1)(A) to calculate the hospital-specific DSH limit. In FAQs 33 and 34, CMS added new variables to hospital-specific DSH limit calculation that were not contained in 42 U.S.C. § 1396r-4(g)(1)(A) or in the final 2008 rule. Specifically, FAQs 33 and 34 provided that in calculating the hospital specific DSH

[1] *New Hampshire Hosp. Assn. v. Burwell*, 15-CV-460-LM, 2016 DNH 040 (D.N.H. March 2, 2017).

limit, a state must subtract payments received from private health insurance and Medicare for dual-eligible Medicaid patients from the costs incurred in providing hospital services.

The District Court for the District of Columbia had previously addressed the validity of FAQ 33 in December 2014, and preliminarily enjoined CMS from enforcing that FAQ pending further order of the court.[2] The order prompted the plaintiffs to petition CMS directly for relief from FAQs 33 and 34. CMS denied the petition and limited the effect of the District Court for the District of Columbia's ruling to Texas and Washington only, forcing the plaintiffs to file its lawsuit.

The plaintiffs sued CMS under the Administrative Procedure Act (APA), alleging that FAQs 33 and 34 substantively altered the calculation used to determine the hospital-specific DSH limit and therefore violated 42 U.S.C. § 1396r-4(g)(1)(A) and constituted substantive rules that had to be promulgated using notice-and-comment rulemaking. The plaintiffs also argued that the enforcement of those policies violates the Medicaid Act and the APA because they effectively amended the State Plan without meeting the rulemaking notice-and-comment requirements.

Analysis

After considering cross motions for summary judgment, the Court (McCafferty, J.), agreed with the plaintiffs that FAQs 33 and 34 represented actions in excess of statutory authority under the Medicaid Act and the lack of rulemaking procedure rendered the FAQs "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." The Court analyzed the language of the Medicaid Act as well as CMS's final rule on Disproportionate Share Hospital Payments, 73 Fed. Reg. 77904 (Dec. 19, 2008) (the "2008 Rule"), for any evidence that private health insurance or Medicare payments were part of the Medicaid Shortfall calculation for DSH payments. Finding no such references, the Court concluded that FAQs 33 and 34 constituted substantive rules rather than interpretative guidance. The distinction was material as no agency deference under either *Chevron* or *Skidmore* was appropriate. The failure to issue the FAQs utilizing traditional rule-making procedures was fatal.

As a consequence of these rulings, the Court permanently enjoined CMS from enforcing FAQs 33 and 34 and ordered that the policies and procedures in effect prior to these FAQs be followed. The Court completely rejected any effort by CMS to include private health insurance or Medicare payments in the Medicaid Shortfall calculation for determining a provider's hospital-specific DSH limit. The Court did not decide, and left for another day, whether CMS could promulgate a new rule consistent with the Medicaid Act for the policies embedded in FAQs 33 and 34, as well as whether such a new rule might be entitled to any deference.

Conclusion

CMS is enjoined from enforcing FAQs 33 and 34, which required inclusion of private health insurance and Medicare payments in the hospital-specific DSH limit calculation set forth in 42 U.S.C. § 1396r-4(g)(1)(A).

---

[2] *See Texas Children's Hosp. v. Burwell*, 76 F. Supp. 3d 224, 246-47 (D.D.C. 2014).

For more information on the content of this alert, please contact your regular Nixon Peabody attorney or:

- Anthony J. Galdieri at **agaldieri@nixonpeabody.com** or (603) 628-4046
- W. Scott O'Connell at **soconnell@nixonpeabody.com** or (617) 345-1150