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Supreme Court strikes down CMS's changes to hospital reimbursements guaranteeing future notice and comment periods

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In a seven to one decision, the SCOTUS held that CMS's failure to provide public notice and a 60-day comment period for changes to the Medicare fraction calculations rendered such changes, and the resulting reduced payments to hospitals, invalid. *Azar v. Allina Health Services*, 587 U.S. ___ (2019). While the issue before the SCOTUS pertained only to the fiscal year 2012, CMS will need to pursue notice and comment before making substantive changes to hospital reimbursement. Hospitals now are assured that the notice and comment procedures will be available for similar changes to reductions in reimbursement.

Discussion

Medicare provides additional payments to health systems that serve a "disproportionate number" of low-income patients. 42 U.S.C. §§1395ww(d)(5)(F)(i)(I). These additional payments are derived from a qualified hospital's Medicare fraction. The fraction reflects the percentage of care that the health system provides to Medicare Part A patients who are also entitled to income support under the Social Security Act. The higher the percentage, the higher the additional payment.

Calculating this fraction became more complicated with the addition of Medicare Part C enrollees in 1997. Between 1997 and 2004, CMS did not include Part C enrollees in its Medicare fractions. In 2003, CMS proposed a regulation to formalize the exclusion of Part C enrollees from Medicare fraction calculations. However, in 2004, CMS dramatically changed direction and promulgated regulations that included Part C enrollees in the Medicare fractions. The D.C. Circuit later vacated the 2004 regulation after hospitals filed legal challenges. The D.C. Circuit held that the 2004 regulation was not a logical outgrowth of the 2003 proposal and thus had been improperly issued without notice and opportunity for comment. *Allina Health Services v. Sebelius,* 746 F.3d 1102, 1107-09 (D.C. Cir. 2014).

In 2013, CMS promulgated a new prospective rule that included Part C enrollees in its Medicare fractions. In 2014, CMS prepared the Medicare fractions for the 2012 fiscal year and included Part C enrollees. CMS published the Medicare fractions spreadsheet to its website despite having no clear regulatory authority from the vacated 2004 regulation or the prospective 2013 regulation.

A group of hospitals challenged the 2014 spreadsheet on many grounds, including that the inclusion of the Part C enrollees was a substantive change to the payment scheme and required a notice and comment period under the Medicare Act. CMS defended its position by arguing that no notice and comment period was necessary because the inclusion of Part C enrollees was merely an interpretive change.

The law requires that CMS provide the public with advance notice and a chance to comment on any "rule, requirement, or other statement of policy" that "establishes or changes a substantive legal standard governing…the payment for services." 42 U.S.C. §1395hh(a)(2). Thus, the question before the Court in *Azar v. Allina Health Services* was whether CMS's 2014 spreadsheet for the 2012 Medicare fractions established or changed a "substantive legal standard" that governed the "payment for services" and required a notice and comment period.

The hospitals argued that a substantive standard is one that "creates duties, rights and obligations." To the contrary, CMS argued that substantive rules are those that have the "force and effect of law" as defined in the Administrative Procedure Act (APA). Interpretive rules, like the one here "advise the public of the agency's construction of the statutes and rules which it administers" and therefore do not require a notice and comment period.

The Court held that the Medicare Act does not use the word "substantive" in the same way the APA does because the Medicare Act contemplates that "statements of policy" can establish or change a "substantive legal standard." 42 U.S.C. §1395hh(a)(2). The APA, on the other hand, treats statements of policy as interpretive rules and does not, by definition, consider changes to statements of policy or interpretive rules to be substantive. 5 U.S.C. § 553(b)(A). The Court reasoned that §1395hh(e)(1) would make no sense if it accepted CMS's position that the Medicare Act mirrors the APA's use of "substantive."

The Court ultimately found that the structure and language of the Medicare Act foreclose CMS's argument. The Court noted that Congress had the opportunity to incorporate two APA exemptions from the usual notice and comment obligations when it drafted the Medicare Act, but Congress did not make any reference to the interpretative rule exemption in §553(b)(A)(1) of the APA or the good cause exemption in §553(b)(B) of the APA. The Court reasoned that Congress chose to write a new, Medicare-specific statute that requires CMS to provide public notice and a 60-day comment period for "any rule, requirement, or other statement of policy that establishes or changes a substantive legal standard governing…the payment for services." 42 U.S.C. § 1395hh(a)(2). As such, the Court held that CMS failed to adhere to the notice and comment period when it changed the Medicare fraction calculations in 2014, and therefore, the calculations for the 2012 fiscal year are invalid.

Takeaways

Holding CMS to its statutory obligation to provide notice and a 60-day comment period to substantive changes to reimbursement schemes will be an important first line of defense for a hospital facing future cuts in reimbursement. Hospitals anticipating future cuts in reimbursement should actively review these changes and use the comment period to advocate for reasonable reimbursement schemes.

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