Supreme Court Victory for Hospitals in Medicare Billing Dispute

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On June 3, 2019, the United States Supreme Court issued its decision in *Azar v. Allina Health Services*, delivering a multi-billion dollar victory for hospitals that serve a disproportionate share of low-income patients by invalidating the Centers for Medicare and Medicaid Services' (CMS) changes to how Medicare payments for such hospitals are calculated. The decision also has larger implications concerning the way that CMS issues the guidance and manuals that govern Medicare providers and suppliers and other CMS-contracted entities.

Under Medicare Part A (the original Medicare), the federal government pays hospitals directly for providing covered patient care and also offers additional payments to institutions that serve a disproportionate share of indigent patients—so-called Disproportionate Share Hospital (DSH) payments. These payments are calculated in part using a hospital's "Medicare Fraction," where the fraction's denominator is the time the hospital spent caring for patients who were "entitled to benefits under" Medicare Part A and the numerator is the time the hospital spent caring for Part-A-entitled patients who were *also* entitled to income support payments under the Social Security Act. The bigger the fraction, the bigger the payment to hospitals.

In 1997, Congress created Medicare Part C (Medicare Advantage). Historically, Part C patients had not been considered in the calculation of a hospital's Medicare Fraction for reimbursement purposes. However, Part C patients tend to be wealthier than Part A patients, so if Part C patients were counted as "entitled to benefits under" Part A when calculating a hospital's Medicare fraction, then the fraction would be smaller and hospitals' payments would be reduced by between $3 and $4 billion over a nine-year period.

In 2014, CMS posted on its website the Medicare Fractions for fiscal year 2012, noting for the first time that they included Part C patients. A group of hospitals sued, claiming that the government violated the Medicare Act's requirement 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." The Supreme Court agreed and held that CMS' new reimbursement policy must be vacated.

The case turned on whether the government's 2014 announcement established or changed a "substantive legal standard" for purposes of the Medicare Act, which requires notice-and-comment rulemaking. The Court rejected the government's analogy to the Administrative Procedure Act (APA) and its argument that the 2014 announcement merely changed an "interpretive legal standard," which does not require notice-and-comment rulemaking under the APA. Here, notice-and-comment rulemaking was necessary because, under the Medicare Act, "statements of policy" can establish or change a "substantive legal standard," which means any legal standard or determination that creates rights and obligations.

What This Means Going Forward

Going forward, CMS will have to take steps to implement the decision and to recalculate the relevant Medicare Fractions and related DSH payments. In addition, at least some Medicare Administrative Contractors (MAC) have notified hospitals that the MAC would unilaterally reopen the hospital's cost report if there was a final decision in *Allina* that would change the hospital's DSH payments. Now that the Supreme Court has made its decision, hospitals and MACs should prepare for this process.

This case also has clear implications for many other CMS policies that substantively effect reimbursement but have never been subject to notice-and-comment rulemaking. For example, many of CMS' policies are found only in CMS manuals. *Allina* provides ammunition to healthcare entities that have contracted with CMS in situations where CMS may have created or changed substantive legal standards governing the scope of benefits, payment for services, or eligibility of individuals, entities or organizations to furnish or receive services or benefits under Medicare. If CMS made any such changes without notice and opportunity to submit comments to CMS, then the policies may be open to attack under the Supreme Court's decision in *Allina*. The decision will also affect how CMS issues policies going forward, clarifying that any changes to substantive legal standards under the Medicare Act will require notice-and-comment rulemaking.

If you have questions or need more information, contact Dana Petrillo (215.864.7017; petrillod@whiteandwilliams.com) or another member of the Healthcare Group.

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