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ALLINA NOTICE & COMMENT REQUIREMENT TRUMPS BAR TO REVIEW OF UNCOMPENSATED CARE PAYMENTS

A federal district court in Connecticut recently applied the Supreme Court's favorable opinion in the *Allina* case (which we previously wrote about **here**), compelling the Secretary to adhere to notice-and-comment rulemaking of Medicare policy when it affects providers' eligibility, benefits or payment. Additionally, CMS cannot use a preclusion statute to avoid challenges for which it did not follow notice-and-comment rulemaking. This case brings hope to an issue that has plagued health care providers: CMS's broad discretion to use "estimates" when calculating hospitals' Uncompensated Care ("UC") payments.

BACKGROUND

In *Yale New Haven Hospital v. Azar*,[1] the plaintiff Hospital appealed CMS's decision to disallow certain days when calculating its 2014 UC payments.[2] CMS asked the Court to dismiss the Hospital's case because under the applicable statute there is a bar to judicial and administrative review. While the Court sided with CMS on most of the arguments raised by the Hospital, it ruled in the Hospital's favor on an important issue: that CMS must satisfy *Allina* notice-and-comment requirements in spite of the bar to judicial review.

In 2012, Congress changed how 75 percent of hospitals' Disproportionate Share Hospital ("DSH") payments were calculated under the Affordable Care Act ("ACA"). Congress established a new mechanism accounting for hospitals' UC costs (also referred to as "UC DSH"). These UC DSH payments included a preclusion statute stating that there "shall be no judicial or administrative review" of "any estimate of the Secretary" for purposes of determining the three UC factors or "any period selected by the Secretary for such purposes."[3]

The main question before the Court was whether the preclusion provision encompasses procedural aspects involved in the adoption of a rule that governed the Secretary's determination of estimates. The Hospital argued the Court had jurisdiction to hear its case despite the judicial bar because the Secretary calculated the UC DSH payment using a policy not properly adopted under the Medicare Act and the Administrative and Procedure Act ("APA"). The Court agreed.

ANALYSIS

The District Court ruled it had jurisdiction to hear the Hospital's claim that the Secretary's merger policy it was challenging violated the procedural requirements of the APA and Medicare Act: "the change in FFY 2014 Merged Hospital Policy as alleged in the Complaint 'changed a substantive legal standard governing the scope of benefits [or] the payment for services' under the Medicare Act, because it changed the standard governing the size of UC DSH payments to eligible hospitals." [4]

The Court found this challenge to be one to CMS's notice-and-comment authority—not a challenge to the Secretary's estimate or use of underlying data which have been unsuccessfully challenged in other cases. Relying on the *Allina* decision, the Court agreed that "the procedure by which the Secretary established" a FFY 2014 policy is "separate from the substance of any such rules or policies or the determination of its estimates based on the substance of those rules or policies" and is thus not barred from judicial review.[5,6]

PRACTICAL TAKEAWAYS

Health care providers routinely struggle with CMS's decisions and often seek help from courts to reverse poorly conceived or improperly implemented agency determinations. This case is a reminder that experienced counsel can help providers navigate the morass of federal health care statutes and regulations and successfully challenge CMS determinations. CMS's attempt to protect improper rulemaking behind a narrow judicial review bar was unsuccessful. This decision will arm future plaintiffs with a means to obtain judicial review of improperly promulgated Medicare policies affecting eligibility, benefits and payments.

If you have any questions about the effect of this decision on your UC DSH payments, please contact:

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[references]

[1] No. 3:18-CV-1230, 2019 WL 3387041.

[2] The Hospital had merged with another hospital, and both hospitals were reporting under Plaintiff's Medicare Provider Number. Previously, both hospitals' data could be included post-merger, but CMS's Medicare Administrative Contractor ("MAC") disallowed data associated with the hospital that merged into Plaintiff.

[3] *See* 42 U.S.C. § 1395ww(r)(3).

[4] No. 3:18-CV-1230, 2019 WL 3387041 at *6.

[5] *Id*. at *9.

[6] The Hospital also raised an ultra vires claim stating that the agency's actions were beyond its statutory authority. But because the Court noted that this claim is duplicative of the Hospital's procedural argument, it dismissed the ultra vires claim. In making that decision, the Court highlighted that "ultra vires claims may not be brought unless 'there is no alternative procedure for review of the statutory claim.'" *Id*. at *10.

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