King & Spalding

Things Are Looking (Loper) Bright!

Medicare reimbursement litigation in a post-Chevron world

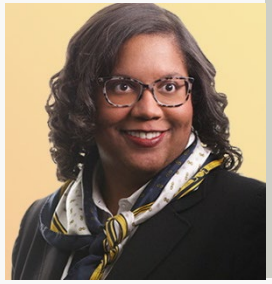
August 26, 2024

PRESENTED BY

Juliet McBride, *Partner*

Dan Hettich, *Partner*

Presenters

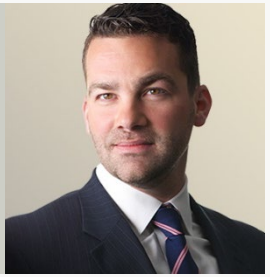


Juliet McBride
Partner
Healthcare

jmcbride@kslaw.com
+1 713 276 7448

Dan Hettich
Partner
Healthcare

dhettich@kslaw.com
+1 202 626 9128



Agenda

- Introduction
- What is (or was) *Chevron* deference?
- What *Loper* held
- How *Loper* might influence long-standing Medicare litigation
- How *Loper* could influence new Medicare appeals
- How CMS might regulate in a *Loper* world

What is (or was) *Chevron* Deference?

The *Chevron* Doctrine

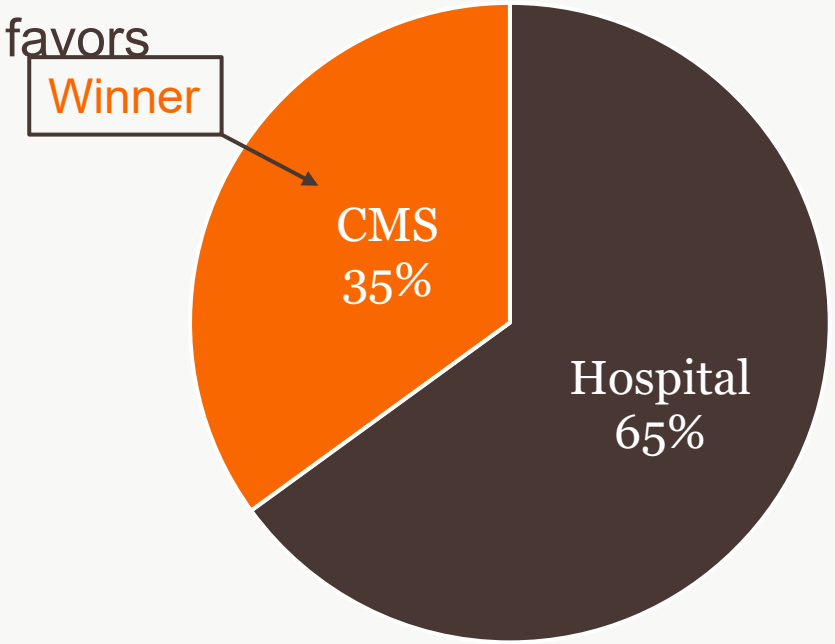
- Two-step test for determining whether an agency is acting within its statutory authority
- **Step 1**: Determine "whether Congress has directly spoken to the precise question at issue"
  - Does the statute have a clear, unambiguous meaning?
- "If the intent of Congress is clear, that is the end of the matter"

Chevron Hypothetical (cont.)

- If the statute was "silent or ambiguous" → Step 2
  - How much ambiguity is enough? What if statute likely favors hospitals but not definitively?

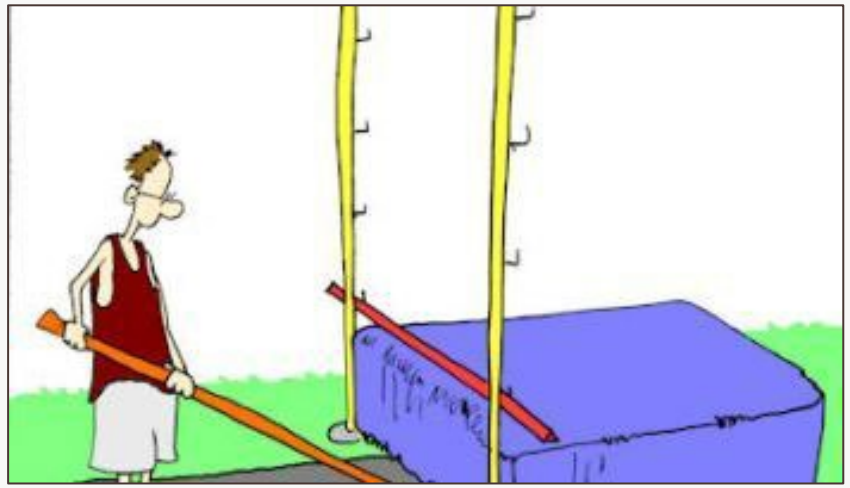
What if the court is 65% convinced the hospital's interpretation is better?

- Most courts would proceed to Step 2
  - The statute is susceptible to more than one interpretation



The *Chevron* Doctrine (cont.)

- **Step 2**: Is the agency's interpretation based on a permissible/ reasonable construction of the statute?
  - Yes? → defer to the agency's interpretation
  - Even if not the reading the court would have reached on its own
- "[A] court may not substitute its own construction of a statutory provision for a reasonable interpretation made by the administrator of an agency"



Chevron's Dissymmetry

- *Chevron* set a low bar for agencies to defend their regulations
- Courts would defer to CMS unless agency's interpretation was unreasonable
  - 70% of *Chevron* cases advanced to Step 2
  - ~94% of Step 2 cases were decided in favor of agencies

Southeast Alabama Medical Center v. Sebelius

- **Statute**: CMS must determine the portion of the standardized amount attributable to “wages and wage-related costs”
- **CMS**: This includes payments to independent contractors for nonmedical services (landscapers, accountants and lawyers)
- **Hospitals**: It should be limited to direct employees performing medical services
- **Holding**: HHS “did not act unreasonably” in interpreting “wages and wage-related costs” to include independent contractors and nonmedical costs
  - Hospital’s position “might have been a reasonable line to draw”
  - But “wages and wage-related costs” is ambiguous

Another Example: Site-Neutral Litigation

- Bipartisan Budget Act, § 603
  - No OPPS for new off-campus PBDs
  - Existing off-campus PBDs excepted
- CY 2019 OPPS rule
  - CMS cut OPPS e/m rates at off-campus PBDs to match physician offices
  - Without a BNA to offset decrease in OPPS payments
- Statutory predicate
  - CMS "shall develop a method for controlling unnecessary increases in the volume of covered OPD services"

Site Neutral Litigation (cont.)

Hospitals (*American Hospital Association v. Azar*):

- Statute does not authorize cuts targeting specific services
- Subparagraph (9)(C) says "method[s] for controlling increases in volume" must be implemented with an across-the-board adjustment to the conversion factor
  - And in a budget-neutral manner
- CMS's take reduces (9)(C) to redundancy

Site Neutral Litigation (cont.)

Holding (D.C. Circuit):

- Congress did not "unambiguously forbid" specific cuts
- "[E]ven if (9)(C) did amount to surplusage under HHS's reading…that would not necessarily compel rejecting the agency's interpretation"
- "Congress could have thought it desirable to confirm the agency's power to reduce the conversion factor in response to volume growth, as subparagraph (9)(C) does."

Deference → Aggressive Interpretations

- Courts presumed statutory ambiguities were implicit delegations for agencies to fill gaps left by Congress
- This gave agencies license to interpret their regulatory authority broadly

Loper Bright Enterprises v. Raimondo

Loper Bright Enterprises v. Raimondo

- Decided June 28, 2024
- Overturned *Chevron USA v. Natural Resources Defense Council* (1984)
- "[S]tatutory ambiguity…is not a reliable indicator of actual delegation of discretionary authority"
  - "[M]any or perhaps most ambiguities may be unintentional."

Loper Bright Enterprises v. Raimondo

- Fisheries challenged whether statute authorized agency rule requiring them to pay for an observer to monitor their harvest
- Relying on *Chevron*, lower court found that the statute is not "wholly unambiguous," and the agency's interpretation was reasonable

Chevron at the Supreme Court

Chevron deference violates the Constitution's separation of powers by making the agency both the interpreter and executioner of the law and by violating the Constitution's instruction that it is the judiciary's duty to interpret the law.

Chevron is at odds with APA Sec. 706 which states: "[T]he reviewing court *shall decide all* relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of the terms of an agency action."

Chevron has had negative consequences.

- Different judges have different conceptions of whether a particular statute is ambiguous, generating inconsistency (Judge Kethledge, *e.g.*, never found a case that required going past Step One while Judge Silberman has said in most cases the statute was ambiguous).
- Agencies can change interpretations at will and still be upheld as long as each interpretation is "reasonable".
- Congress can abdicate its responsibility to make law by knowing that an agency will be given wide-latitude in its interpretation of existing statutes.

Loper Bright Enterprises v. Raimondo (cont.)

Holding:

- *Chevron* deference violates the Administrative Procedure Act (APA)
  - APA says courts must "decide all relevant questions of law" in cases challenging agency action
- APA says courts must exercise "independent judgment" in deciding whether an agency has acted within its statutory authority
- This requires courts to use every tool at their disposal to determine the "best reading" of the statute

Loper Limitations

- The “informed judgment” of an agency is still be entitled to “great weight” if persuasive and based on agency expertise
- Only applies in cases concerning whether an agency is properly interpreting statutory language

Loper Limitations (cont.)

- Implicit v. Explicit delegations
  - "Some statutes '*expressly* delegate[]' to an agency the authority to give meaning to a particular statutory term" or "empower an agency to prescribe rules to 'fill up the details' of a statutory scheme. . . ." by using terms "such as 'appropriate' or 'reasonable.'"
  - In those instances, "the role of the reviewing court [is to] . . . effectuate the will of Congress subject to constitutional limits."

How *Loper* Might Influence Long-Standing Medicare Litigation

Volume Decrease Adjustment

- Statute requires CMS to "*fully* compensate" SCHs or MDHs for their "fixed costs" if they experience a 5% decline in discharges
- Hospitals challenged CMS policy of comparing a hospital's *total* DRG payments (which cover both fixed and variable costs) to just the hospital's fixed costs. (Only if a hospital's fixed costs exceeded its total payments would the hospital received a VDA payment.)
- In 2018, CMS agreed to adopt hospitals' methodology (comparing a hospital's fixed costs to *the portion* of its DRG estimated to be for fixed costs), but only prospectively; claimed prior methodology was still "reasonable."

VDA (cont.)

Lake Region Healthcare Corp. v Becerra

- The DC district court agreed w/ CMS holding that while the hospitals' interpretation "might be better…and the Secretary might have conceded that point by prospectively adopting that method…," the "Secretary's interpretation" was nonetheless "reasonable, even if it might not be the best."
- Before the DC Circuit, CMS argued in response to *Loper* that it *could* change policies where Congress had given CMS discretion

Does "Hospital Patient Days" Include only Acute Care Patients for Medicaid DSH Fraction?

Baptist Healthcare of Oklahoma v Becerra

The statute requires HHS to include a "hospital's patient days" in the DSH calculation.

Question Presented: Do long-term adolescent psychiatric care days count as patient days even if providing sub-acute care?

Hospitals:

> "[T]he Medicare statute mandates that the DSH payment calculation include the 'hospital's patient days,' and neither the statutory text nor its purpose leaves room to exclude these Hospitals' patient days based on the nature of care provided."

Does "Hospital Patient Days" Include only Acute Care Patients for Medicaid DSH Fraction? (cont.)

Baptist Healthcare of Oklahoma v Becerra

Judge Kelly (DDC):

- "[W]hen the parties submitted their briefing before this Court . . . *Chevron* was still good law, and the agency defends its interpretation of the statute merely as a 'permissible construction' of it."

- Ordered new briefing in light of *Loper's* "seismic change in the law, to allow the parties an opportunity to reframe their statutory interpretation arguments and how the Court should understand the case law provided by both parties."

Part C *Allina* Litigation

- In response to the Supreme Court 2019 decision in *Allina* that CMS's policy of treating Part C patients as still being "entitled to benefits under part A" for DSH purposes required notice and comment rulemaking, CMS, in 2023, retroactively adopted that same policy for all periods prior to 2013
- The Medicare statute generally prohibits retro-rulemaking unless it's 1) required by statute or 2) in the public interest. 42 U.S.C. § 1395hh(e)(1)(A)

Part C *Allina* Litigation (cont.)

CMS claims the statutory standard is met:

"Absent … retroactive rulemaking…the Secretary would be unable to calculate and confirm proper DSH payments for time periods before FY 2014, which would be contrary to the public interest of providing additional payments to hospitals that serve a significantly disproportionate number of low-income patients…"

– 88 Fed. Reg. 37772, 37774 (June 6, 2023).

Part C *Allina* Litigation (cont.)

- The court will have to analyze the statute under the *Loper* framework
- Is the rule "necessary to comply with statutory requirements"?
  - Is a regulation necessary to determine how part C days will be treated in calculating payments for FYs 2005 – 2013?
  - CMS had a policy that preceded 2005
- Would failure to apply the new regulation retroactively "be contrary to the public interest"?

How *Loper* Could Influence New Medicare Appeals

The Protest Requirement

- **Statute**: CMS can withhold payment from providers who haven't furnished information needed "to determine the amounts due to such provider"
- **Beginning CY 2016**: Hospitals must present all claims they intend to appeal to the PRRB in their as-filed Medicare cost reports
  - Even if the MAC has no authority to act on the claim
- Otherwise, CMS can refuse to pay on those claims
- Even if the hospital prevails before the PRRB

The Protest Requirement (cont.)

CMS will have to convince a court that:

- "[I]nformation" about nonallowable claims is necessary "to determine the amounts due to such provider"
- CMS can unilaterally strip the PRRB of its independent power "affirm, modify or reverse" a final payment determination
- There is daylight between the PRRB's jurisdiction and its power to compel payment
  - The Supreme Court has ruled that presentment cannot be a condition of PRRB jurisdiction

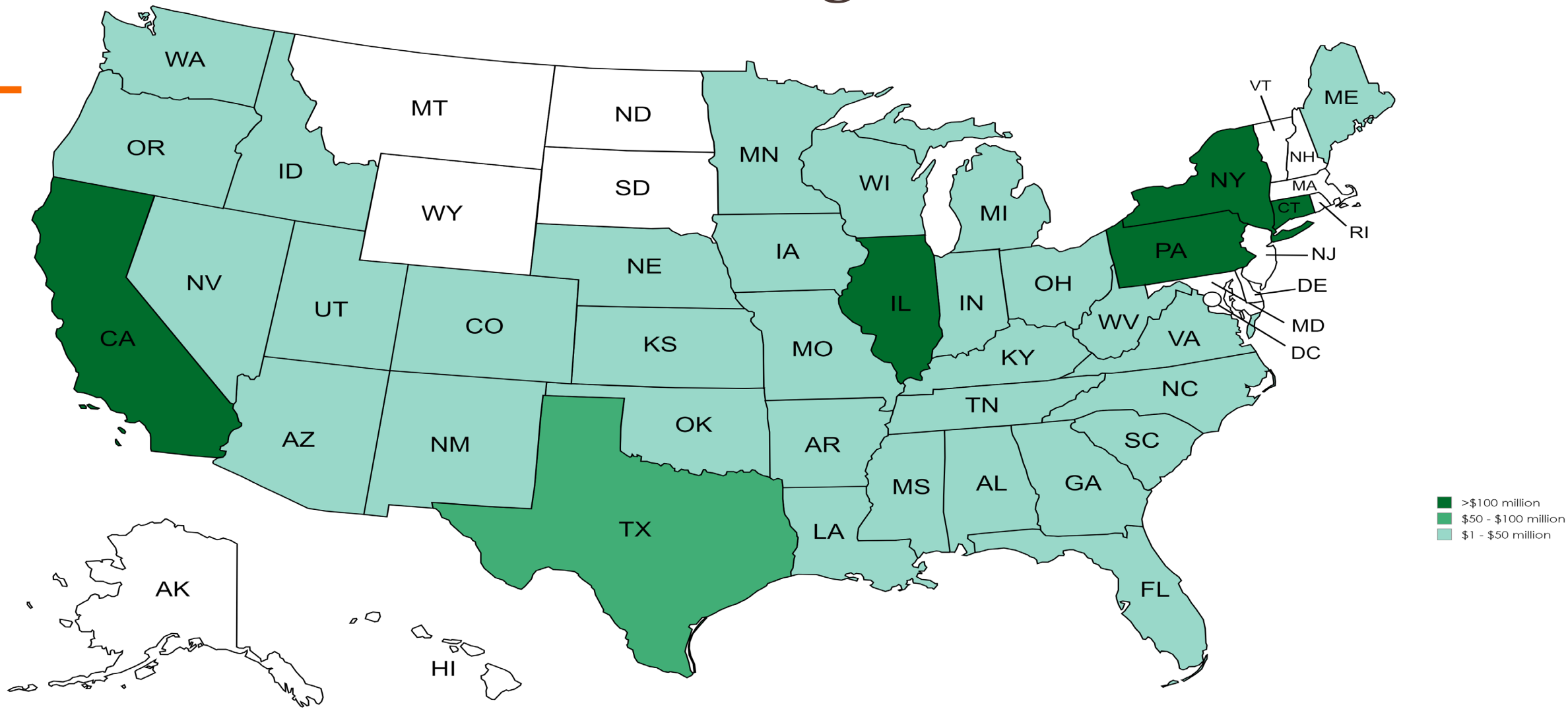
Retrospective Wage Index Appeals

- In FY 2024, CMS changed how it calculates the rural wage index
- "CMS now agrees that the best reading of [the statute] instructs CMS to treat [reclassified rural] hospitals the same as geographically rural hospitals for the wage index calculation"
- The average rural wage index has increased by 5%
- The number of hospitals receiving the rural floor has tripled

Retrospective Wage Index Appeals (cont.)

- What if CMS had adopted the “best reading” in an earlier year?
- Many hospitals getting higher wage index adjustments today would have received them in earlier years
- Should affected hospitals appeal their wage index values from prior years?
- Can CMS defend not using the best reading in past years?

The “Best Reading” in FY 2022



Created with mapchart.net

The “Best Reading” in FYs 2020 - 2023

Impact on Louisiana hospitals:

	2020	2021	2022	2023
Actual Rural WI	0.7055	0.744	0.7008	0.6989
Correct Rural WI	0.736	0.7477	0.7692	0.7773
LA Impact	$230 k	$896 k	$3.8 m	$5.1 m

“Rurban” Appeal Issues

Rural reclassification is good but could be better.

CMS is not giving the hospitals the full benefit of that status.

K&S’s group appeals challenging several CMS policies that adversely affect reclassified rural hospitals strengthened under *Loper*:

- Ineligibility for capital DSH payment.
- Implementation of three-year rolling average (developed by K&S).
- No 30% increase for FTE caps established after 1996 (developed by K&S).

Rurban Appeal Issues (cont.)

Capital DSH—Like with the VDA issue discussed above, CMS's prospective surrender on the capital DSH issue strengthens argument that CMS must provide capital DSH retroactively as well to those with valid appeals.

30% increase to post-1996 IME caps--Our statutory argument against CMS's policy that a reclassified rural hospital doesn't receive a 30% increase to its IME FTE caps established *after* 1996 is even stronger.

- Statute requires CMS to apply a 30% upward adjustment to FTE caps established as of 1996 but also requires CMS to establish similar rules for programs established *after* 1996.

Three-year Rolling Average

A hospital's reimbursable FTE count is calculated based on its 3-year rolling average (current year, prior year, penultimate year).

CMS applies a hospital's FTE cap to each of the **inputs** of the 3-yr rolling average, rather than simply capping the **output** (result) of the 3-yr rolling average.

For example, under CMS's policy, a hospital with a cap of 500 that trained 200 residents in year 1, 600 in year 2, and 1,800 in year 3 would have an "average" of just 400 (200+500+500/3=400).

Three-year Rolling Average (cont.)

K&S believes this violates the statute's command to use the "actual" FTEs and is otherwise arbitrary and capricious.

This issue primarily affects hospitals that have reclassified as rural by delaying the benefit of the 30% increase to their IME FTE caps.

Challenges to the Standardized Rate: ATRA 2.0 and the Standardized Amount

ATRA 2.0

Issue

Pursuant to ATRA and subsequent legislation, CMS enacted a 3.9% reduction to the standardized amount to recoup excess funding Congress believed hospitals received when converting to MS-DRGs.

CMS was only authorized to maintain the ATRA reductions “through fiscal year 2023”.

Nonetheless, CMS argued **in 2024** that it was justified in only restoring 3.0% of the 3.9%.

- CMS essentially enacted a permanent reduction to IPPS payments of almost 1%.

ATRA 2.0 (cont.)

Next Steps

K&S is representing hundreds of hospitals appealing that determination.

Current 2024 appeal is fundamentally different from an earlier unsuccessful appeal — *Fresno v. Azar* (2021) — brought by another firm challenging CMS's determination to leave prior year ATRA reductions in the FFY *2018* rates:

1. The adverse *Fresno* decision turned on a preclusion of review provision that doesn't apply in FFY 2024.
2. The statutory language requiring the restoration of prior year reductions is stronger in 2024 than it was in 2018.

Standardized Amount Appeals

Issue

Hospitals alleged the 1983 standardized amount is diluted because CMS erroneously treated transfers as discharges when it calculated the average cost per discharge.

The DC Circuit previously held the appeal was not barred by CMS's rule that "predicate facts" can't be reopened after 3 years.

On remand, the PRRB decided that the issue was precluded from review because, whatever the 1983 standardized amount happened to be, it would have been "budget neutralized" in 1985.

Standardized Amount Appeals (cont.)

Next Steps

We believe the PRRB is wrong that the issue is precluded from review and that the Board's reasoning may raise bigger issues.

Providers, therefore, should protest and appeal both ATRA 2.0 and the Standardized Amount issues pending final outcomes in those lead cases.

Multiple Other Issues As Well

- The above isn't a comprehensive list of new or ongoing appeals favorably impacted by *Loper, see, e.g.:*
  - RC to IPPS BNA issue

How CMS Might Regulate in a *Loper* World

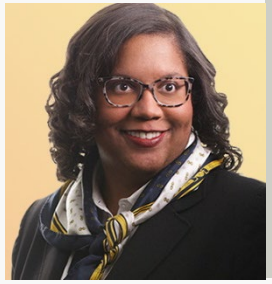
Regulating in the Age of *Chevron*

- Before adopting a regulation, CMS will have to consider whether a court would agree that its reading probably reflects the intent of Congress
- Will CMS promulgate regulations more conservatively?
- Will OMB play a more active role in reviewing proposed regulations?
- Might CMS be more reluctant to improve its interpretations prospectively knowing that will open them up to strong claims for retroactive correction as well?

Banking on Persuasive Power

- Courts will give “great weight” to the “informed judgment” of an agency but focus will shift to Subject to the agency’s “power to persuade”
  - The thoroughness evident in its consideration
  - The validity of its reasoning; and
  - Consistency with earlier pronouncements
- Commenters could influence an agency’s ability to persuade
  - Did the agency address all comments?
  - How thorough were its responses?

Questions?



Juliet McBride
Partner
Healthcare

jmcbride@kslaw.com
+1 713 276 7448

Dan Hettich
Partner
Healthcare

dhettich@kslaw.com
+1 202 626 9128