

PREVIEW

OF UNITED STATES SUPREME COURT CASES



AMERICAN **BAR** ASSOCIATION

Division for Public Education

www.supremecourtpreview.org

**Previewing the Court's Entire
December Calendar of Cases, including...**

*Dobbs v. Jackson Women's
Health Organization
and
Carson v. Makin*



HEALTH-CARE LAW

Did the Secretary Permissibly Include in a Hospital's Medicare Fraction All of the Hospital's Patient Days, for Individuals Who Satisfy the Requirements to Be Entitled to Medicare Part A Benefits, Regardless of Whether Medicare Paid the Hospital for Those Particular Days?

CASE AT A GLANCE

There is a circuit split on the issue of whether the Secretary of the U.S. Department of Health and Human Services appropriately interpreted the Medicare statute when he included, for the purposes of calculating a hospital's disproportionate share hospital percentage, inpatient hospital days attributable to individuals otherwise entitled to Medicare Part A benefits even when Medicare does not pay the hospital for those specific days because the beneficiary exhausted their maximum allotment for inpatient coverage. The D.C. and Sixth Circuits have upheld the secretary's interpretation as a reasonable reading of the statute subject to *Chevron* deference. The Ninth Circuit in *Empire*, on the other hand, ruled against the secretary, holding that the unambiguous statute precluded the secretary's interpretation. The secretary appealed and asks the Supreme Court to uphold his interpretation as the best reading of the statute or, in the alternative, as a reasonable interpretation subject to *Chevron* deference.

Becerra v. Empire Health Foundation

Docket No. 20-1312

Argument Date: **November 29, 2021** From: **The Ninth Circuit**

by Thomas R. Barker and Haider Andazola

Foley Hoag LLP, Washington, D.C.

Introduction

In 1983, Congress adopted a major policy shift governing Medicare payments for inpatient hospital services that moved away from payment on a reasonable cost basis to payment on a prospective payment basis. The new inpatient prospective payment system, or IPPS, relied on a classification of hospital services into diagnostic-related groupings (DRG) under the theory that services provided for a specific diagnosis have relatively predictable costs. Within two years of enacting IPPS, Congress heard that hospitals that treated a disproportionate share of low-income individuals were disadvantaged by the new

system because a flat payment rate subject to adjustments only for labor, medical education, and outlier costs did not recognize the higher costs incurred by hospitals treating low-income patients. The "disproportionate share hospital" (DSH) adjustment is available to hospitals that treat a "disproportionate share of low-income patients," determined to be at least 15 percent of their patient population.

The particular DSH percentage applicable to a hospital is determined based on a proxy measure of the hospital's low-income patient load. Although the broad parameters of the DSH formula is codified in the statute, the precise

details of what is included and excluded under the formula has been subject to extensive litigation since the DSH adjustment was established by Congress. On the last day of the 2020 Term, the Supreme Court granted the government's petition for *certiorari* in *Becerra v. Empire Health Foundation*, 958 F.3d 873 (9th Cir. 2020). The *Empire* case challenges the Department of Health and Human Services' (HHS) policy regarding calculation of the DSH percentage; the Ninth Circuit held that HHS's position was inconsistent with the statute. Although the issue in question involves an arcane Medicare payment methodology, the *Empire* case could have broad implications on the federal courts' deference to agency interpretations of the statutes they administer.

Issues

Did the secretary permissibly include in a hospital's Medicare fraction all of the hospital's patient days, for individuals who satisfy the requirements to be entitled to Medicare Part A benefits, regardless of whether Medicare paid the hospital for those particular days?

Facts

Congress created the disproportionate share (DSH) adjustment to the IPPS in 1985, observing that hospitals that serve a disproportionate share of low-income patients have higher Medicare costs per case because "low-income Medicare patients are in poorer health within a given DRG [and] tend to have more complications," and that such hospitals also have "extra overhead costs and higher staffing ratios." Since its creation, the Medicare DSH adjustment has been one of the most heavily litigated components of the IPPS over the past three decades, and most of those cases turn on the precise statutory words used to describe the two fractions in the formula.

The DSH adjustment itself is calculated based upon the hospital's "disproportionate patient percentage," which the statute identifies as the sum of two fractions, expressed as a percentage. The numerator of the first fraction (the "Medicare fraction") is the number of patient days attributable to patients who are dually entitled to Medicare inpatient hospital benefits and Supplemental Security Income (SSI) benefits and the denominator is the number of patient days attributable to all patients who are entitled to Medicare. The numerator of the second fraction (the "Medicaid fraction") is equal to the number

of patient days attributable to patients who are eligible for Medicaid (but not including individuals who are entitled to Medicare—that is, excluding dual-eligible patients), and the denominator is the total patient days at the hospital. If the sum of these two fractions exceeds 15 percent, the hospital is entitled to additional Medicare payments on top of the base prospective payment amount.

At issue in *Empire* is HHS's position that a Medicare inpatient receiving SSI benefits who has exhausted her inpatient hospital benefits during a hospital stay nevertheless remains "entitled to benefits" under the Medicare program and is therefore properly included in the numerator and denominator of the Medicare fraction and the numerator of the Medicaid fraction.¹ That position was adopted via a somewhat convoluted process in HHS rulemaking in 2004 and 2005. In describing a proposed change to the DSH formula in the 2004 rulemaking, HHS misstated its applicable policy regarding counting patients who had exhausted their Medicare benefits. As part of the 2005 rulemaking, HHS corrected its 2004 misstatement and stated its correct policy in a website notice. But when HHS finalized the 2005 rule, it adopted the policy that it had originally (and erroneously) described.

HHS's policy generally has the result of reducing DSH payments to hospitals for two reasons. First, although the inclusion of Medicare/SSI patient days in the numerator of the Medicare fraction increases the value of that fraction, the inclusion of a larger number of patient days in the denominator (all individuals entitled to Medicare as opposed to merely dually eligible patients) decreases the value of the Medicare fraction. Second, because the numerator of the Medicaid fraction excludes patient days of Medicaid patients who are also entitled to Medicare, the exclusion of the patient days for Medicare patients who have exhausted their benefits (because they are still, under the Centers for Medicare and Medicaid Services (CMS) policy, deemed entitled to Medicare) decreases the value of the Medicaid fraction.

Empire Health Foundation, a private health foundation based in Washington, challenged HHS's interpretation articulated in the 2005 final rule and codified in 2007. The trial court invalidated that policy on procedural grounds and vacated the rule. However, the trial court agreed that HHS's policy was a permissible construction of the statute under a *Chevron* Step Two analysis. *Chevron U.S.A., Inc.*

1. A Medicare beneficiary can exhaust her Medicare coverage because of the day limit on an inpatient hospital stay in a spell of illness. Medicare will generally cover only 90 days per spell of illness, plus an additional bank of 60 "lifetime reserve days." 42 U.S.C. 1395d(a)(1).

v. National Resources Defense Council, Inc., 468 U.S. 1227 (1984). Accordingly, both HHS and Empire appealed to the Ninth Circuit.

In its decision, the Ninth Circuit addressed Empire's procedural and substantive claims under the Administrative Procedure Act (APA). With respect to the process by which HHS adopted the policy change, the Ninth Circuit concluded that HHS was not required to provide for an additional period of comment under the APA. The Ninth Circuit found that the 2005 final rule was a logical outgrowth of the proposed rule change, as articulated in the Notice posted on the HHS website. In so concluding, the court noted that several large, sophisticated providers commented in support of the policy that HHS ultimately adopted. The Ninth Circuit analogized the situation to *Long Island Care at Home v. Cooke*, 551 U.S. 158 (2007), a decision in which the Supreme Court held that the action by an agency that adopted the opposite policy than the one that it proposed was "reasonably foreseeable" and that the proposal had provided fair notice to commenters.

But what the Ninth Circuit gave to the government, it then promptly took away. After concluding that the HHS policy change was properly adopted from a *procedural* perspective, it then concluded that the policy was not supported by the statute. In so doing, the Ninth Circuit relied on one of its earlier DSH cases that interpreted the meaning of being "eligible for" Medicaid. See *Legacy Emanuel Hospital & Health Center v. Shalala*, 97 F.3d 1261 (9th Cir. 1996). In *Legacy Emanuel*, the Ninth Circuit concluded that individuals could be counted in the Medicaid fraction so long as they met the conditions for eligibility for Medicaid, even if they were not actually receiving Medicaid benefits. "Eligible for," according to the Ninth Circuit, is a broader term than "entitled to" because the latter connotes an "absolute right to payment." By contrast, according to the Ninth Circuit in *Empire*, people who have exhausted their Medicare benefits are no longer "entitled" to Medicare and therefore should *not* be counted in the Medicare fraction, contrary to HHS's position. Although the government argued that the Ninth Circuit's holding in *Legacy Emanuel* was merely dicta, the Ninth Circuit disagreed.

Case Analysis

The government argues that the secretary of HHS permissibly interpreted the phrase "entitled to benefits under [Medicare] part A" to encompass all persons who meet the statutory requirements to be "entitled to" benefits, even

if that particular inpatient stay exceeds the beneficiary's inpatient care day allotment in a spell of illness. The government points out that a beneficiary who has exhausted one particular Part A benefit (for example, inpatient hospital care) can still access other Part A benefits (for example, home health care), and such a beneficiary is "naturally described as 'entitled to benefits' under [Medicare] part A." The government also notes that other areas of the Medicare statute expressly distinguish between patients who are "entitled to" Part A benefits but have "exhausted" inpatient care from patients that are "not entitled" to Part A benefits at all. According to the government, such statutory references would "make little sense if an individual were entitled to benefits only with respect to specific increments of care for which Medicare pays."

The government also argues that an approach contrary to the secretary's approach would fit poorly with Congress's framework for assessing a hospital's eligibility for the DSH adjustment based on the hospital's proportion of low-income patients who are Medicare Part A beneficiaries versus those who are not. The government asserts that an approach that treats Part A entitlement as a stable and binary determination fits "well with the bifurcated framework" described above and that determining an individual's entitlement to Part A benefits based on the "happenstance that Medicare did or did not pay for a particular unit of care...fits poorly with Congress' framework." At the very least, the government contends, the Supreme Court should defer to the agency's "reasonable" interpretation of the statute, consistent with the Sixth and D.C. Circuits, without having to broach the issue of whether the HHS's reading is the best or only reasonable one.

Empire, for its part, emphasizes that the statutory language governing calculation of the Medicare fraction uses the term "entitled to," while the Medicaid fraction uses the term "eligible for." According to Empire, this key difference in terminology signifies that Congress intended the measure of indigency within the Medicare population to be stricter than the measure of indigency with respect to Medicaid. Empire argues that HHS's conflation of the terms "entitled" and "eligible" belies the common understanding of the terms and effectively eliminates any distinction that they engender.

Moreover, Empire argues that not only does HHS conflate two different terms, it also interprets two instances of "entitled" differently in the same sentence. The Medicare fraction includes patients who are both (1) "entitled to benefits under [Medicare] part A," and (2) "entitled to [SSI]

benefits.” Yet HHS interprets “entitled to” Medicare benefits to mean patients are entitled even when they have no right to payment from Medicare, while interpreting “entitled to” SSI benefits as “requiring not only the right to payment, but also receipt of that payment.” And while the government argues that Congress intended Medicare entitlement to involve a binary determination for the purposes of the DSH adjustment, Empire disagrees and asserts that the statute contemplates “day-to-day variability.”

Significance

The Supreme Court’s decision in *Empire*, as with many other decisions issued by the Court, will resolve a split among the circuits with respect to the lawfulness of HHS’s interpretation of “entitled to” as it relates to the Medicare DSH adjustment calculation. In reaching its decision, the Ninth Circuit applied a *Chevron* Step One analysis, holding that the statute was unambiguous and precluded the agency’s interpretation. By contrast, the D.C. and Sixth Circuits, analyzing the identical regulation, deferred to HHS on *Chevron* Step Two grounds finding that the HHS policy was a permissible construction of an ambiguous statute. See *Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d at 920, (D.C. Cir. 2013) (“the statute [is] ambiguous on this question...we of course defer to the Department’s construction”) and *Metropolitan Hospital v. United States Department of Health and Human Services*, 712 F.3d at 265, (6th Cir. 2013) (because the statute “is, at best, ambiguous...our analysis proceeds to *Chevron*’s second step”). If the Supreme Court reverses the Ninth Circuit and agrees with the government’s interpretation of the statute, thousands of Medicare-participating hospitals across the country, particularly those who treat extremely ill Medicare patients requiring extended stays, could face payment decreases. Moreover, because a hospital’s DSH percentage also determines a hospital’s eligibility for other important designations, including participation in the 340B program as “covered entities,” hospitals hovering just above the required DSH threshold for participation could lose their 340B covered entity status.

The *Empire* decision could also be important for reasons much larger than how it affects Medicare hospital reimbursement. The central focus on HHS’s construction of the statute and how *Chevron* may factor into the Court’s analysis has generated interest among stakeholders who are not necessarily interested in the outcome of Medicare payment policy inasmuch as they are interested in curtailing the administrative state. More specifically, some stakeholders view the *Empire* decision as an opportunity

for the Supreme Court to entirely discard or significantly limit the *Chevron* line of jurisprudence. For instance, amicus Americans for Prosperity Foundation does not address the substance of the dispute at all and instead flatly urges the Supreme Court to overrule *Chevron* because it violates the separation of powers doctrine.

These calls to either overturn or significantly curtail the *Chevron* doctrine parallel calls in other cases before the Supreme Court involving *Chevron* deference. In *American Hospital Association v. Becerra*, 967 F.3d 818 (D.C. Cir. 2020), which was accepted for review on the same day that the Court accepted review in *Empire*, the plaintiff hospitals dispute HHS’s interpretation of the statute that allowed the agency to implement significant Medicare payment cuts for drugs acquired under the 340B program. The question presented for review is whether *Chevron* deference permits the agency’s payment policy. No fewer than seven amicus briefs in that case are urging the Court to dismantle or severely limit the *Chevron* doctrine.

Whether *Empire* or *AHA* present the appropriate vehicles for overturning or curtailing *Chevron* remains to be seen. On the one hand, given that both cases involve the scope of deference to which an agency is entitled, a conservative majority of justices on the Court may see both cases as an opportunity to rein in the administrative state. On the other hand, both involve arcane reimbursement matters (one involving a split in the appellate courts) where the Court may wish to simply clarify the proper application of the law. A broad retrenchment of the *Chevron* doctrine would obviously have government-wide implications that go far beyond the intricacies of the payment policies embedded in the Medicare program.

Thomas Barker is a partner and co-chair of the Healthcare Practice at Foley Hoag LLP. His practice focuses on Medicare and Medicaid regulatory, reimbursement, and coverage matters spanning across health-care providers, payers, innovator pharmaceutical, biotechnology, and medical device clients. He can be reached at tbarker@foleyhoag.com.

Haider Andazola is a senior associate with Foley Hoag LLP who represents companies across the health-care industry before the federal government on issues involving the Medicare, Medicaid, and 340B programs and can be reached at handazola@foleyhoag.com.

PREVIEW of United States Supreme Court Cases 49, no. 3 (November 29, 2021): 3–7. © 2021 American Bar Association

ATTORNEYS FOR THE PARTIES

For Petitioner Xavier Becerra, Secretary of Health and Human Services (Elizabeth B. Prelogar, 202.514.2217)

For Respondent Empire Health Foundation (Daniel J. Hettich, 202.626.9128)

AMICUS BRIEFS

In Support of Respondent Empire Health Foundation

Certain Hospitals and Hospital Systems (David Alexander Hickerson, 202.672.5467)

Federation of American Hospitals (Kelly Anne Carroll, 202.580.7712)

In Support of Neither Party

Americans for Prosperity Foundation (Michael David Pepson, 571.329.4529)