Becerra v. Empire Health Foundation: Supreme Court Validates HHS Read of Medicare DSH Fraction Statute

Written by Thomas Barker, Erin Estey Hertzog, Andrew M. London

June 27, 2022

Key Takeaways:

- The Supreme Court backed HHS's interpretation of the Medicare statute establishing payments for hospitals that treat a statistically significant share of low-income patients.
- HHS can therefore continue to calculate the disproportionate share hospital (DSH) adjustment in a manner that generally reduces DSH payments to hospitals.
- The Supreme Court reached its decision with no apparent deference to the agency – and without even mentioning *Chevron* – leaving open the question of whether the Court will give agencies *Chevron* deference in future cases.

Late last week, the Supreme Court released its opinion in *Becerra v. Empire Health Foundation*, a case that involves the complex but important question regarding how to calculate the Medicare and Medicaid fractions of a hospital's Disproportionate Share Hospital (DSH) adjustment. Medicare's DSH adjustment is an additional payment made to hospitals that treat a statistically significant share of low-income patients. The specific question presented was how to count patients who qualify for Medicare Part A at times when Medicare is not paying for their hospital treatment. The Department of Health and Human Services (HHS) had issued a regulation interpreting the Medicare statute to count these patients, resulting in lower DSH payments for most hospitals. In considering Empire Health's challenge to this regulation, the Ninth Circuit invalidated HHS's interpretation on the grounds it was inconsistent with statute. However, two other Courts of Appeals had previously deferred to HHS' statutory read. In a 5-4 decision by Justice Kagan, joined by Justices Thomas, Breyer, Sotomayor, and Barrett, the Court settled this circuit split and upheld HHS' regulation.

Background

The Medicare program originally paid for hospital inpatient services on a reasonable cost basis. However, in 1983, Congress adopted the inpatient prospective payment system, or IPPS, which pays hospitals at a fixed rate based on diagnostic-related groupings (DRGs). As initially conceived, the flat payment rate under IPPS did not recognize the higher costs incurred by hospitals treating low-income patients. However, in 1985, Congress added the "disproportionate share hospital" (DSH) adjustment for those hospitals that treat a "disproportionate share of low-income patients." Although the broad parameters of this DSH formula are codified in statute, given the complex statutory text and volume of dollars at stake, the precise details of what is included and excluded under the DSH formula has been subject to extensive litigation.

For purposes of the Medicare DSH adjustment, a given hospital's DSH percentage is determined based on a proxy measure of the hospital's low-income patient load. This measure is called the "disproportionate patient percentage" and is calculated as the sum of two fractions—the Medicare fraction and the Medicaid fraction—expressed as a percentage. At issue in *Empire* was HHS' position, adopted through rulemaking, that an inpatient whose care is not being paid for by Medicare (even though she meets the criteria for Medicare eligibility) 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. This could happen for several reasons: another insurer is liable for the patient's care (employment based insurance, for example), or because the patient has exhausted her Medicare hospital days in a spell of illness, or because Medicare has deemed her care not medically necessary. The question before the Court was: is

this patient nevertheless considered "entitled to benefits" even though Medicare isn't paying for her care.

HHS' policy generally has the result of reducing DSH payments to hospitals for two reasons. First, 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 HHS policy, deemed entitled to Medicare) decreases the value of the Medicaid fraction.

Empire Health Foundation challenged HHS' interpretation as contrary to statute. The trial court invalidated the policy on procedural grounds and vacated the rule. On appeal, the Ninth Circuit concluded that the HHS policy change was properly adopted from a procedural perspective, but concluded that the policy was not supported by the statute. The Supreme Court granted the government's petition for certiorari in *Becerra v. Empire Health Foundation*, 958 F.3d 873 (9th Cir. 2020). Although the case involved an arcane Medicare payment methodology, many viewed the *Empire* case as an opportunity for the Court to revisit the federal courts' longstanding deference to agencies' statutory interpretations under *Chevron U.S.A., Inc. v. National Resources Defense Council, Inc.*, 468 U.S. 1227 (1984). For instance, amicus Americans for Prosperity Foundation did not address the substance of the dispute at all and instead flatly urged the Supreme Court to overrule *Chevron* because it violates the separation of powers doctrine.

The Supreme Court Validates the HHS Read Without Applying *Chevron*

The Court decided the case on textual grounds, holding that "[t]he text and context support the agency's reading: HHS has interpreted the words in those provisions to mean just what they mean throughout the Medicare statute." *Empire* did not explicitly overrule *Chevron*. In fact, Justice Kagan's opinion never even mentioned *Chevron's* two-step framework—unlike all three of the Circuit Courts that considered the question at issue. *See Becerra v. Empire Health Foundation*, 958 F.3d 873 (9th Cir. 2020) (applying a Chevron Step One analysis to hold that the statute was unambiguous and precluded the agency's interpretation); *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"); *Metropolitan Hospital v. United States Department of Health and Human Services*, 712 F.3d at 265 (6th Circ. 2013) (because the statute "is, at best, ambiguous…our analysis proceeds to Chevron's second step").

This is particularly notable because Justice Kagan's opinion, in numerous places, emphasizes the degree to which the Medicare statute is hardly clear on its face, noting that "[t]he ordinary meaning of the fraction descriptions, as is obvious to any ordinary reader, does not exactly leap off the page." This would traditionally result in the application of a *Chevron* Step Two analysis, under which the agency's interpretation would be afforded significant deference. But, instead, the Court conducted its own analysis of the statute and its context, thoroughly examining the term "entitled to" as used throughout the Medicare statute, as well as the structure of the relevant statutory provisions. The Court ultimately concluded that:

> Text, context, and structure all support calculating the Medicare fraction HHS's way. In that fraction, individuals 'entitled to [Medicare Part A] benefits' are all those qualifying for the program, regardless of whether they are receiving Medicare payments for part or all of a hospital stay. That reading gives the 'entitled' phrase the same meaning it has throughout the Medicare statute. And it best implements the statute's bifurcated framework by capturing low income individuals in each of two distinct populations a hospital serves.

But while the Court ultimately reached the same conclusion as HHS, it did so with no apparent deference to the agency.

Conclusion

The Court's decision in *Empire* has two important implications. First, Medicare can continue to include all patients qualifying for Medicare in the DSH fractions, regardless of whether they are receiving Medicare payments for part or all of a hospital stay. Second, and perhaps more importantly, this case may portend a shift away from *Chevron* and the deference it granted to agencies towards a greater reliance on a judge's own read of a given statutory text. In another hospital Medicare reimbursement case decided recently, the Court similarly did not address the *Chevron* doctrine and instead treated the dispute as a straight case of statutory interpretation.

Opinion is available at https://www.supremecourt.gov/opinions/21pdf/20-1312_j42l.pdf.

Please do not hesitate to contact any of the attorneys on this alert if you have any questions.

RELATED INDUSTRIES

- Healthcare

RELATED PRACTICES

- Healthcare
- Medicare & Medicaid Reimbursement for Providers