State Hospital Association Fights Changes to Medicaid DSH Payment Rules

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For hospitals that "serve a disproportionate number of indigent patients" Medicaid allows for supplemental payments to help ensure their financial viability. The calculation of those supplemental payments recently became the subject of litigation brought by a state hospital association, culminating with an appeal to the Eighth Circuit Court of Appeals.

The Outcome. Medicaid payments to Disproportionate Share Hospitals (DSH) must be reduced by payments received from Medicare and private insurers. This 2017 CMS rule had been challenged by the state hospital association, but was ultimately upheld as valid.

Why these payments matter. Ultimately, this means lower reimbursements for Disproportionate Share Hospitals. The Eighth Circuit explained that "[w]hen Medicaid-eligible patients have third party coverage such as Medicare or private insurance, the third party insurer pays the hospital first, because Medicaid serves as the 'payer of last resort.'" Further, "Congress has directed the Secretary to ensure that only 'uncompensated care costs' are reimbursed." By holding that third party payments are excluded from "uncompensated care costs" for purposes of calculating supplemental payments, Disproportionate Share Hospitals will not be able to claim higher reimbursements. Because Disproportionate Share Hospital serve higher-risk and higher-need populations, this decision means fewer mission-critical dollars. Commenting on a similar court ruling, one state's children's hospitals association explained that this legal rule "will reduce critical Medicaid funding to safety net providers like children's hospitals."

Reach of this ruling. This opinion has controlling effect over Disproportionate Share Hospitals in Arkansas, Missouri, Iowa, Minnesota, North Dakota, South Dakota, and Nebraska. While not binding in other states, the Eighth Circuit's interpretation of the federal statute at issue here will likely be highly persuasive elsewhere. This particular rule has been something of a lightening rod for litigation, also becoming the subject of a similar challenge in the U.S. Court of Appeals for the DC Circuit.

Statutory Interpretation. The substance of this appeal focused on a thorny legal question of statutory interpretation employing *Chevron* deference analysis. Mainly, when Congress wrote the formula for calculating supplemental payments, what did it mean by "costs incurred" and may the HHS Secretary exclude from "costs incurred" those expenses that have been reimbursed by insurance companies and other third-party payers? The opinion in this case found "costs" was an ambiguous term, drawing on other U.S. Supreme Court precedent to explain that an "unadorned term, the word 'cost' … generally, is a 'chameleon,' a 'virtually meaningless' term." Because the statute was ambiguous the opinion next had to decide whether the HHS Secretary's interpretation of it was reasonable. Finding that the Secretary acted within the scope of his delegation in a way that was not "arbitrary, capricious, or manifestly contrary to

the statute," under *Chevron* the Court ultimately gave controlling weight to the Secretary's interpretation of the statute. There was a concurrence written by Judge Stras in which he explained how he would apply *Chevron* analysis differently, but would reach the same conclusion upholding the Secretary's interpretation.

The benefit of state hospital associations. Legal issues such as this one have a critical effect on the budgets of hospitals. But no one hospital can reasonably be expected to shoulder the expense of federal court litigation let alone an appeal to the Eighth Circuit. This is one important reason why state hospital associations are invaluable. They provide many benefits to their members, including as illustrated here, working to define legal rights and responsibilities applicable to all.

Case reference: *Alex M. Azar v. Missouri Hosp. Ass'n*, case no. 18-1778 (8th Cir. Nov. 4, 2019).

Additional Source: https://www.courthousenews.com/dc-circuit-revives-changes-to-cap-in-medicaid-reimbursement/