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ALERT ▪ Health Care

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D.C. District Court Invalidates Reimbursement Decision Applying Rule Denying Capital DSH Payments to Urban Hospital Reclassified to Rural but Leaves Rule on the Books

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On September 30, 2021, the U.S. District Court for the District of Columbia issued a favorable decision for the plaintiff hospital in *Toledo Hospital v. Becerra*, in its challenge to an adverse reimbursement decision by the Secretary of the Department of Health and Human Services (Secretary) relating to capital costs under the Medicare Act (Act).[1] This Alert summarizes the key portions of the District Court's analysis and discusses what this decision could mean for similarly situated hospitals.

Plaintiff in the case, Toledo Hospital (Toledo), challenged a 2006 final rule (2006 Rule) promulgated by the Secretary that rendered geographically urban hospitals like itself, which had been reclassified under Section 401 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 as rural for operating purposes, ineligible for capital disproportionate share hospital (DSH) adjustments.[2] Toledo argued that the 2006 Rule (1) violates the plain meaning of the Medicare statute; and (2) is arbitrary and capricious under the Administrative Procedure Act (APA).[3] In short, the Court set aside the Secretary's decision because the 2006 Rule, which it relied upon, was arbitrary and capricious, but instead of vacating the Rule, the Court remanded for reconsideration of Toledo's capital DSH adjustment eligibility.[4] The Court's decision could allow hospitals like Toledo to pursue capital DSH payments and also underscores the importance of potentially challenging rules directly rather than waiting many years, beyond the standard six-year statute of limitations, for them to be applied.

Court's Ruling and Reasoning

The central question in this case is whether geographically urban hospitals with more than 100 beds that are reclassified as rural under Section 401 for operating PPS purposes are nonetheless eligible for capital DSH adjustments. Only urban hospitals with more than 100 beds can receive a capital DSH adjustment.[5] Under the 2006 Rule, CMS treats geographically urban hospitals that reclassify from urban to rural under Section 401 as rural for capital DSH adjustment purposes.[6] As a result, such hospitals with more than 100 beds, which would otherwise qualify for capital DSH adjustments as urban hospitals, become ineligible because they are reclassified for operating PPS purposes.[7]

Beyond the Plain Meaning of the Act

Toledo argued that the 2006 Rule violates the plain language of the Act for two reasons, both of which the Court rejected. First, the Court rejected Toledo's argument that the statute limits Section 401 reclassifications to operating PPS and does not permit the agency to treat a hospital as rural for capital PPS purposes.[8] The Court found that the statute permits CMS to apply a Section 401 reclassification for purposes of capital PPS.[9] Second, Toledo argued that the 2006

[1] *See Toledo Hospital v. Becerra*, No. 19-cv-3820 (DLF), 2021 WL 4502052 (D.D.C. Sept. 30, 2021).
[2] *Id.* at *4-5.
[3] *Id.*
[4] *Id.* at 12.
[5] *Id.* at 4.
[6] *Id.*
[7] *Id.*
[8] *Id.* at *7.
[9] *Id.*

Rule violates the statute because it fails to pay hospitals more for the greater capital costs that they incur.[10] The Court also rejected this argument, finding that the capital PPS provision of the statute "merely requires the Secretary to 'take into account' variations in relative capital costs," not that the Secretary necessarily pay more to hospitals that incur greater costs.[11] In other words, the Secretary need only "consider" variations in relative capitals costs when making capital DSH adjustment determinations.[12]

Arbitrary and Capricious

Toledo also argued that the 2006 rulemaking was arbitrary and capricious under the APA because the Secretary (1) misrepresented the regulatory history to claim incorrectly that it had a prior policy, and (2) failed to "take into account" the cost of capital in different geographic areas and facilities.[13] The Court agreed.[14]

The Court found that there was no pre-existing policy related to Section 401 reclassifications before 2006, and that even if there were, the Secretary "never announced such a policy, much less explained the basis for it."[15] The Court, therefore, rejected the Secretary's argument that the 2006 Rule was merely a technical correction to an "'inadvertent' error" in a prior rulemaking.[16] The Court also found that the Secretary failed to consider the relative costs "for hospitals, like Toledo Hospital, that had reclassified as rural under Section 401 but are physically located in an urban area" when determining their capital DSH adjustments.[17]

Ultimately, the Court concluded that because the 2006 Rule was unreasonable, the Secretary could not rely on it to deny capital DSH adjustments to Toledo.[18] However, instead of vacating the 2006 Rule, the Court remanded the case to the fiscal intermediary to redetermine Toledo's eligibility for the capital DSH adjustment.[19] The Court concluded that vacatur is inappropriate when reviewing an adjudication, especially when, as here, the plaintiff is unable to challenge the 2006 Rule directly because the six-year statute of limitations has lapsed.[20]

Looking Ahead

The District Court's decision could pave the way for hospitals like Toledo, which appealed the denial of capital DSH adjustments based solely on reclassification under Section 401, to successfully appeal those adverse decisions. However, under regulations adopted effective for cost reporting periods beginning on or after January 1, 2016, it could be critical for affected hospitals to have claimed a capital DSH payment on their cost report or to have protested this issue in order to obtain reimbursement in the event of a successful appeal. *See* 42 C.F.R. § 413.24(j). Accordingly, we would recommend that affected hospitals that may want to challenge the policy include a protested item on their cost reports and ultimately file administrative appeals with the Provider Reimbursement Review Board. Granted, the government could take the position that it can rely on the 2006 Rule in adjudications because the Court explicitly chose not to vacate

[10] *Id.*
[11] *Id.*
[12] *Id.* at *8.
[13] *Id.* at *8; *see also* 42 U.S.C. § 1395ww(g)(1)(B)(ii) (The Secretary "may provide for an adjustment to *take into account* variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located." (emphasis added)).
[14] *Id.* at *11-12.
[15] *Id.* at *11.
[16] *Id.* at *8.
[17] *Id.* at 12.
[18] *Id.*
[19] *Id.*
[20] *Id.*

the 2006 Rule, and noted that challenges to the Rule were now time-barred. But hospitals could argue that they would be entitled to the same relief as Toledo to the extent that they have proper appeals on the issue.

The Court's finding that vacatur is an inappropriate remedy when reviewing an adjudication also serves as an important reminder to consider challenging rules under the Medicare PPS directly pursuant to 42 U.S.C. § 1395oo(a)(1)(A)(ii) instead of waiting for them to be applied.[21] Toledo filed this complaint challenging the 2006 Rule on December 24, 2019, only after it had been denied the capital DSH adjustment. The Court's hesitancy to disturb a rule while reviewing an adjudication and its consideration of the statute of limitations also highlight the increasing importance of briefing on remedy.

If you have any questions related to this decision, please feel free to contact your usual Ropes & Gray advisor or one of the authors listed below.

[21] *Id.*