Medicare Faces Barrage of Hospital Pay Cases After Chevron's End

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- Supreme Court ruling spurs some to revisit earlier disputes
- *Loper Bright* cited in claims underpayments cost billions

Hospitals are seizing on the US Supreme Court's scrapping of agency deference to sue over Medicare reimbursement policies, seeking to resolve years-long payment disputes they claim have cost them billions of dollars.

Hundreds of hospitals have banded together in dozens of lawsuits since the Supreme Court's June decision in *Loper Bright Enterprises v. Raimondo*, which overturned the principle of deferring to agencies' reasonable interpretations of unclear federal laws outlined in the court's 1984 ruling in Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.

The suits contest a range of issues—from the structure of hospital reimbursement formulas to compensation for resident physicians and overpayment clawbacks by the Centers for Medicare & Medicaid Services.

Loper Bright is spurring hospitals to litigate agency interpretations of these payment policies, with the understanding that courts will review the Medicare statute without a thumb on the scale in favor of the CMS, lawyers say.

"Now the courts will look to determine what is the best interpretation of the statute using tools of statutory interpretation; the plain language, congressional intent, the context, things like that," said Sven Collins, a partner and co-chair of the Medicare appeals practice at Hooper, Lundy & Bookman P.C. "The government does not have an automatic 'win' when the statute itself is ambiguous."

Legal Ambiguities

Many of the lawsuits filed against the CMS focus on the agency's definitions of federal payment law, which hospitals claim could result in financial hardship if the agency interprets them too narrowly. The new cases are still in their early stages.

A high-profile case, Advocate Christ Medical Center v Becerra, which is , could provide a window into how federal judges could rule on Medicare payment disputes after the end of agency deference.

The case centers on the CMS's interpretation of who should be included in a payment formula that calculates additional compensation to hospitals serving a high percentage of low-income patients.

Similar battles over complex payment disputes are playing out in courtrooms across the country, with high stakes for both hospitals and the federal government.

The Department of Health and Human Services's interpretation in *Advocate Christ* lowered reimbursement to affected hospitals by "more than a billion dollars each year," the American Hospital Association claimed in an amicus brief in the pending high court case. Government spending on Medicare continues to rise, exceeding $1 trillion for the first time in 2023, according to the Journal of Health Affairs.

The post-*Chevron* legal landscape will make it difficult for the CMS to defend aggressive interpretations of statutes used to advance policy interests, like keeping costs down, said William Sarraille, a University of Maryland law professor and retired senior member of the health-care practice group at Sidley Austin LLP.

In September, a rural Minnesota hospital at the US Court of Appeals for the District of Columbia Circuit. The three-judge panel, citing *Loper Bright,* found that the CMS's method of determining a decrease in the hospital's patient volume reimbursement adjustment was inconsistent with the statute.

The move reversed a previous decision by the US District Court for the District of Columbia in 2022 that partially cited the since-overturned *Chevron* doctrine when it deferred to the CMS's reading of the Medicare statute.

Many of the recent hospital reimbursement challenges have come after the Supreme Court's decision in July in Corner Post, Inc. v. Board of Governors of the Federal Reserve System. Under the ruling, health-care providers now have six years from when they suffer an injury to challenge a regulation under the Administrative Procedure Act, rather than six years from when the regulation was first issued.

Corner Post opened the door for litigants to challenge determinations made in eras where courts allowed much more interpretive discretion to agencies than today, Julian Polaris, a health partner at Manatt, Phelps & Phillips LLP, said.

"Agencies were much more comfortable with *Chevron*deference," Polaris said. "They weren't issuing the same kinds of lengthy preambles to their rules where they exhaustively went through the public comments and gave lengthy recitations of their own statutory authority."

More Due Diligence

Even before *Loper Bright*, the CMS had begun adapting to courts' growing skepticism of agency actions and their decreased willingness to find statutes ambiguous, making new legal challenges to recent agency determinations less likely, lawyers say.

"Agencies saw the writing on the wall and had already been issuing new rules without thinking they could necessarily count on *Chevron* anymore," Polaris said.

The CMS will increasingly look toward Congress to reduce the likelihood of challenges, Collins and Sarraille said. This includes putting more pressure on lawmakers to define statutory terms more clearly and explicitly give the agency the discretion to decide issues.

"I think there's going to be the need for continued close collaboration between CMS and Congress on some of these more complicated payment and reimbursement issues," said Collins.

Sarraille said the agency will also seek "to defend more of its decisions as 'factual determinations' or 'adjudicative' questions, where it still is entitled to deference, even after *Loper*