Summary of the Lawsuit

Deep federal cuts in safety net hospital funding will result in reduced services, closed clinics, shortened hours, and layoffs. Patients will be forced to postpone or forego treatment, travel long distances in search of another provider, or seek care in overburdened emergency rooms, further straining emergency preparedness in many communities. Those likely to be hardest hit include low-income Medicaid recipients and the uninsured in both rural and urban areas. The lawsuit filed March 7, 2002 details these devastating impacts – all due to a regulation that the U.S. Department of Health and Human Services (HHS) states will take effect on March 19. Because HHS disregarded this harm in the rulemaking process, the lawsuit seeks to enjoin HHS from implementing the regulation until appropriate analysis of the real-world impact is taken into consideration.

The lawsuit spells out in great detail the very specific harm that the HHS regulation will have on safety net hospitals across the country. These hospitals are all beneficiaries of a special public hospital payment provision, adopted just one year ago, under which states make supplemental payments to them in support of their unique mission of serving the poor. The new HHS rule seeks to rescind that special provision. Hospitals and hospital associations in Arkansas, California, Florida, Georgia, Minnesota and New York submitted declarations in support of the lawsuit describing the devastating result of this action in reduced access to care for their low income and vulnerable patient populations. Over 200 comments were submitted to HHS in response to the proposal to rescind the special provision, many of which similarly detailed the expected fallout. (Only 2 commenters supported HHS's action.)

As the lawsuit demonstrates, HHS ignored these comments and instead focused single-mindedly on saving federal Medicaid dollars and preventing perceived misuse of the program. The plaintiffs, however, charge that the basis for HHS'S claims of potential misuse – a report of the Office of the Inspector General (OIG) – was completely irrelevant. The OIG report looked at supplemental hospital payment programs in just three states, and those programs were established before the special public hospital payment provision was adopted. Analyses of state programs

under a completely different regulatory regime cannot be legitimate grounds for making these devastating cuts to safety net support programs. The lawsuit therefore claims that HHS's actions are arbitrary and capricious and a violation of the Administrative Procedure Act.

Additional claims spell out various other missteps by HHS in its haste to rush the regulation into final form, including violations of the Regulatory Flexibility Act and the Social Security Act. Finally, the plaintiffs demonstrate that HHS failed to comply with basic procedures spelled out in the Congressional Review Act, which requires agencies to provide Congress with 60 days notice before implementing major regulations such as this. Because HHS failed to do so in a timely manner, the regulation cannot be implemented on March 19 as HHS plans.

The lawsuit was filed in United States District Court for the Eastern District of Arkansas in Little Rock, Arkansas.

Key Arguments in the Lawsuit

The new regulation is arbitrary and capricious and violates the APA.

- HHS violated the Administrative Procedure Act (APA) in adopting the regulation in an arbitrary and capricious manner by relying on inaccurate and irrelevant data.
- HHS primarily relies on a report issued by the Office of the Inspector General (OIG) on September 11, 2001, which reviews state UPL programs operating under old regulations that predate, and would be impermissible under, the rule implementing the higher public hospital limit.
- HHS ignored the experience of the only two hospital UPL plans approved under the higher limit, in Arkansas and Mississippi, at the time they issued the proposed rule. HHS officials had previously characterized these plans as appropriate and legitimate.
- HHS had not collected any data on the higher public hospital UPL at the time HHS proposed its elimination, even though data reporting requirements were an integral part of the rule that created the higher public hospital UPL to protect against abuse.
- During the rulemaking process in December 2001, Congress explicitly directed HHS not to modify the public hospital UPL until it could properly assess the implementation of it, and expressed concern about the regulation's impact on safety net hospitals. HHS ignored this congressional directive.

HHS review of comments submitted on the new regulation was insufficient, and ignored data that demonstrated the harm it would cause.

- HHS ignored or glossed over significant comments made by hospitals during the public comment period. Many of those comments pointed out deficiencies in the OIG report, to which HHS failed to respond in the final rule.
- HHS responded to the overwhelming number of significant comments detailing the explicit and devastating harm that would be imposed on safety net hospitals and their patients with the extraordinarily dismissive statement that the new regulation "will assure access to those hospitals for Medicaid beneficiaries."

HHS failed to assess the negative impact that the rule will have on hospitals.

- The new rule fails to comply with the Regulatory Flexibility Act (RFA). The RFA requires an agency to assess the negative impact that a rule will have on small entities. For purposes of the RFA, all hospitals are considered to be small entities.
- HHS failed to assess the harm and cited mitigating factors for its implementation, without analyzing any reliable data regarding those factors.

The new regulation will cause irreparable harm.

- The lawsuit states that the plaintiffs will suffer irreparable harm if the rule is implemented and that hospitals around the country will be required to make severe cutbacks in services to the poor and to their communities at large.

The new regulation must be postponed to give Congress the requisite 60-day review period.

- The regulation cannot be implemented on March 19 as planned because HHS has not provided Congress with 60 days to review it as required by the Congressional Review Act (CRA). The

CRA specifies that major rules such as this one can only be effective the later of either its publication in the Federal Register (in this case, January 18), or the date that Congress receives a report on the new rule. Congress did not receive the new rule until February 20, 2002, making it effective no sooner then 60 days thereafter.

Timeline

Prior to January 2001

- UPL regulations required that aggregate Medicaid payments to a category of inpatient facilities (including hospitals, skilled nursing facilities, and intermediate care facilities for the mentally retarded) be no greater than the amount paid for those services under Medicare payment principles. The aggregate nature of the UPL permitted significantly higher payments to some hospitals or nursing homes.

Early 2000

- Reports surface that some states are using UPL flexibility to pay public nursing homes hundreds of millions of dollars in federally-financed supplemental payments, much of which is returned to those states for other uses.

October 2000

- HHS issues a proposed rule to prevent the inappropriate use of federal Medicaid funds such as was uncovered in the nursing home programs.
- This new rule revises payment categories for UPL calculations and creates a special higher limit (150 percent) for public hospitals that are not owned or operated by state government.
- HHS cites ongoing reviews of UPL programs by the Office of Inspector General detailing problems with nursing home payments but finding that hospitals in UPL programs kept a majority of the supplemental funding.
- The rule aims to curb abuses, and at the same time recognizes the critical role of public hospitals in serving the poor and providing specialized services to their communities. The rule requires greater scrutiny of state plans that utilize the 150 percent limit, e.g., by requiring states to identify how the funds are used.

December 2000

- Congress passes the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), which endorses the **October 2000** HHS proposed rule creating the higher public hospital UPL.
- BIPA requires that the rule be implemented, and requires a longer transition period for states with longstanding reliance on supplemental payments.

January 12, 2001

- HHS issues final rule, effective March 13, 2001, creating the 150 percent UPL for public hospitals.

February 2001

- Bush Administration releases its first budget, and announces its intent to cut an additional $17 billion in Medicaid supplemental payments by eliminating the higher UPL for public hospitals, alleging incorrectly that funds do not go to the hospitals intended and that there are continued abuses of the UPL program.

April 2001

- HHS changes policy permitting additional states (including Florida, Virginia, Wisconsin, and Michigan) to take advantage of UPL programs that were outlawed by the **January 12, 2001** regulation.
- HHS issues a rule limiting their use of these programs to only one year. This rule becomes effective in September, 2001.

September 11, 2001

- The HHS Office of Inspector General (OIG) releases report consolidating previously published reviews of UPL plans in six states, only three of which are public hospital plans (the others were nursing home plans).
- The OIG reviews are the same reviews relied on by HHS in establishing the 150 percent limit in January 2001.
- All state plan practices reviewed by the OIG predate the, **January 12, 2001** regulations, and would have been impermissible under those regulations.

November 2, 2001

- The General Accounting Office issues a report detailing abuses of Medicaid UPL plans for nursing homes in Virginia and Wisconsin that were approved pursuant to the special exemption created by the Administration in April 2001. These programs were allowed to take advantage of the regulatory flexibility that existed prior to the creation of the **January 12, 2001** higher public hospital UPL.

November 20, 2001

- OMB approves a request from HHS to collect data from states on the implementation of the higher public hospital limit, based on reporting requirements in the **January 12, 2001** regulation. It is unclear whether any requests have been sent to states to submit the data.

November 23, 2001

- HHS issues proposed rule to eliminate the higher (150 percent) UPL for public hospitals.
- HHS cites the **September 11, 2001** OIG report as the basis for its policy change, the very same reviews of state UPL programs that had led HHS to conclude one year earlier that hospitals (unlike nursing homes) were retaining supplemental payments.

December 19 and 20, 2001

- In conference report language to the Labor-HHS-Education appropriations bill, Congress reiterates support for the **January 12, 2001** rule and the BIPA
- Congress directs the Administration to maintain its course complying with its intent on the 150 percent special public hospital limit, and to make modifications only after assessing the implementation in consultation with states and other stakeholders.

December 24, 2001

- Comments on the **November 23** proposed rule to eliminate the 150 percent limit for public hospitals are due on Christmas Eve.
- By the filing deadline, at least 220 comments are received by HHS.

January 18, 2002

- HHS issues final rule, which is essentially the same as the **November 23, 2001** proposed rule, and definitively eliminates the 150 percent special funding limit for public hospitals.

February 20, 2002

- Congress receives from HHS the **January 18, 2002** final UPL rule eliminating the 150 percent special funding limit for public hospitals to Congress.

Late February, 2002

- HHS grants Wisconsin approval to retain its UPL program, approved only ten months earlier, through the longest eight-year transition period, otherwise available only to plans in existence since 1992. Prior to this decision, Wisconsin had only a one-year transition period.

March 7, 2002

- Hospitals and others file suit against HHS contesting implementation of the **January 18, 2002** rule.

Background on the Special Public Hospital Medicaid Payment Rule

The special public hospital payment rule at issue in this litigation was adopted as part of a broader regulation issued at the explicit direction of the 106th Congress to prevent certain abuses reported to have occurred in some states. While that broader regulation finalized in January, 2001 was expected to save over $76.7 billion in federal Medicaid expenditures over ten years, HHS was particularly concerned about its unintended impact on legitimate payments important to public hospitals and vulnerable patient populations. HHS therefore included a higher limit of 150 percent for public hospitals to guard against such an impact, stating that

> [W]e believe that allowing higher Medicaid payments will fully reflect the value of public hospitals' services to Medicaid and the populations it serves. Public hospitals are established to ensure access to needed care in underserved areas, and often provide a range of care not readily available in the community, including expensive specialized services, such as trauma and burn care and outpatient tuberculosis services. They also provide a significant proportion of the uncompensated care in the nation.
>
> The size and scale of public hospitals create extreme stresses and uncertainties, especially given their dependence on public funding sources. We are concerned that these stresses may threaten the ability of these public hospitals to fulfill their mission and fully serve the Medicaid population. As such, we are proposing a higher UPL for these facilities.
>
> 65 Fed. Reg. 60153.

Less than a year later, in November, 2001, HHS arbitrarily and capriciously reversed this policy. HHS did not demonstrate that safety net hospitals do not need this funding, and offered no proposal for alternative programs or spending to replace it.