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Legal Sidebar

Implications of the HHS Notice of Proposed Rulemaking on Section 1557 and Medicare Part B

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On July 25, 2022, the Department of Health and Human Services (HHS) announced a Notice of Proposed Rulemaking (NRPM) under Section 1557 of the Patient Protection and Affordable Care Act (ACA). Section 1557 contains various antidiscrimination requirements that apply to certain health care programs, including those that receive "federal financial assistance." On several occasions since the ACA became law in 2010, HHS has proposed regulations, which have since become the subject of litigation and public controversy, under Section 1557. While HHS proposes a number of regulatory changes regarding Section 1557's antidiscrimination requirements in the latest NPRM, this Sidebar discusses a significant change in its proposed treatment of Medicare Part B as "federal financial assistance." The NPRM proposes to reverse HHS's "longstanding position" that Medicare Part B does not constitute federal financial assistance. If this proposed change were adopted, it would subject all Medicare Part B providers, including outpatient providers, suppliers, and ambulance services, to Section 1557's antidiscrimination requirement.

Background

Section 1557 provides that a person "shall not . . . be subjected to discrimination under[] any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by . . . any entity established in this title . . . ." The NPRM proposes to define "health program or activity" broadly to include an entity that assists individuals in obtaining health services, provides health insurance coverage, and educates health care providers, provides clinical care, or undertakes health research. For the enforcement of its provisions, Section 1557 references four other federal civil rights statutes: Title IX of the Education Amendments of 1972, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act, and the Age Discrimination Act of 1975. Section 1557, like all of these predecessor antidiscrimination statutes, conditions the receipt of "federal financial assistance," on the recipient's agreement not to discriminate.

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The NPRM proposes to define "federal financial assistance" under Section 1557, in relevant part, as any "subsidy, contract (other than a procurement contract but including a contract of insurance), or any other arrangement" through which the government provides funding assistance. Additionally, HHS suggests that a "recipient" of federal financial assistance should be "any . . . entity, or any person, to whom Federal financial assistance is extended directly or indirectly," but excludes any ultimate beneficiaries of federal funding.

HHS offers two reasons in the NPRM for its change in interpretation reflecting that Medicare Part B now constitutes federal financial assistance. First, HHS contends that Medicare Part B, which is considered a "contract of insurance or guaranty," should not be excepted from the definition of federal financial assistance. Second, HHS reasoned that federal funds confer a benefit on Part B providers and ultimately subsidize the care that Part B beneficiaries receive from those providers.

Part B as an Exception to Federal Financial Assistance

Congress created Medicare Parts A and B (also known as "original Medicare") via the Social Security Amendments of 1965 (P.L. No. 89-97) to provide basic health insurance coverage for Americans over age 65. Medicare Part A currently covers inpatient hospital services, skilled nursing care, and some home health care, while Medicare Part B covers outpatient services, including physician and outpatient services furnished in offices, hospital outpatient departments, and ambulatory surgery centers, as well as some home health and preventive services. As of 2021, more than 36 million Americans receive health care through Medicare Parts A and B.

HHS classifies Medicare Part A as "federal financial assistance" for purposes of federal civil rights statutes. However, for many years, HHS considered Medicare Part B as a contract of insurance and therefore exempt from other federal civil rights statutes. The text of Title VI of the Civil Rights Act of 1964 specifically exempts contracts of insurance from its definition of federal financial assistance. In 1976, the Department outlined that Medicare Part B was exempted as a contract of insurance when proposing regulations under Section 504 of the Rehabilitation Act. In the final rule on Section 504, published in 1977, the Department clarified that "whether or not Medicare Part B arrangements involve a contract of insurance . . . no federal financial assistance flows from the Department to the doctor or other practitioner under the program." Instead, the program essentially made "payments to direct beneficiaries." The NPRM explains that Section 1557 is distinguishable from Title VI and Section 504 because Section 1557 sets forth that contracts of insurance *can* constitute federal financial assistance.

The Evolution of Provider Participation in Medicare Part B

In addition to specifying that Section 1557's definition of federal financial assistance includes contracts of insurance, HHS also argues that changes in the Medicare Part B payment structure, as well as case law developments in federal civil rights law, support its assertion that Part B payments constitute federal financial assistance under Section 1557. Before explaining its changed view that Medicare Part B constitutes federal financial assistance, HHS first distinguishes the various ways in which providers receive federal funds from the program. Medical providers who enroll with Medicare Part B are classified as either "participating" or "non-participating," depending on how they receive payment for services. By contrast, providers who do not accept any payment from Part B are considered to have "opted out" of the program. The NPRM states that HHS will consider payments to both participating and non-participating providers to be federal financial assistance, but not payments to "opt out" providers.

Participating Providers

A Medicare participating provider agrees to accept the pre-determined amount that Medicare will pay for services and directly bills Medicare for services provided to beneficiaries. In this arrangement, a beneficiary "assigns" his claims rights to the provider. In turn, the participating provider only collects a set deductible and/or coinsurance amount from the beneficiary. Although the practice of assigning claims has existed for many years, it became the predominant practice after Congress passed the Omnibus Budget Reconciliation Act, 1989, which changed the way physicians were compensated under the program.

HHS reasons in the NPRM that the payment that the participating provider receives from Medicare on behalf of the beneficiary for services rendered to that beneficiary constitutes federal financial assistance because the payment confers a benefit on the provider and effectively subsidizes the care provided. The NPRM explains that providers "receive the benefit of a reliable source of payment for the services provided to eligible patients, at least some of whom may have been unable to afford services otherwise," thus making the payments federal financial assistance.

HHS explains in the NPRM that, unlike when the Medicare Part B program began, providers now most often bill Part B directly for services they provide to beneficiaries. It is no longer as common for beneficiaries to pay for services out of pocket and then be reimbursed by Medicare Part B for their expenses. According to HHS, this change in Part B's structure makes funds received by providers for Part B services more like federal financial assistance, because a federal benefit is "flowing" from the department to the provider.

Non-Participating Providers

In addition to participating providers, who have more of a direct contractual relationship with Medicare Part B, the NPRM outlines that non-participating providers also receive federal financial assistance from Medicare Part B. Non-participating providers do not agree to a pre-determined Medicare payment amount, as participating providers do, and thus they can charge beneficiaries up to 15% more for the services they provide. Typically, beneficiaries pay non-participating providers directly for services rendered, and the provider then bills Medicare for reimbursement on their behalf. Non-participating providers thus do not generally receive direct compensation from Medicare, but HHS reasons in the NPRM that these providers still receive federal financial assistance because they participate in the Part B program overall, which then effectively subsidizes the cost of the care they provide to beneficiaries. HHS explains that through Medicare Part B, the government is assisting non-participating providers by allowing them to access a patient population that "either (a) would not have been able to afford any medical services, or (b) would not have been able to afford these specific providers." In this way, Medicare Part B is still providing federal financial assistance to non-participating providers, albeit in a more indirect way.

In support of its rationale that non-participating providers receive federal financial assistance from Medicare Part B, HHS points to the Supreme Court's analysis of "receiving federal financial assistance" in *Grove City College v. Bell*. In *Grove City College*, the Court held that, for purposes of being subject to Title IX of the Education Amendments of 1972, an educational institution received federal financial assistance by accepting students who received grant funding from the U.S. Department of Education. In finding that the college received federal financial assistance and was subject to Title IX's requirements, the Court's majority reasoned that "[w]ith the benefit of clear statutory language, powerful evidence of Congress' intent, and a longstanding and coherent administrative construction of the phrase 'receiving federal financial assistance,'" it had "little trouble concluding that Title IX coverage is not foreclosed because federal funds are granted to Grove City's students rather than directly to one of the college's educational programs." The Court explained that even though the institution did not receive the federal

funding directly from the Department of Education, the institution was still the intended recipient of the funds.

Applying the Court's analysis of what constitutes federal financial assistance in *Grove City College* to Medicare Part B, the NPRM asserts that Medicare Part B payments for non-participating providers should be considered federal financial assistance. HHS states that in the same way the institution was the intended recipient of the student aid in *Grove City College*, Medicare Part B payments are "structured to ensure that [they] effectively supplement[]" providers' own medical practices. In other words, even though non-participating providers receive payment for services from Medicare Part B beneficiaries, rather than directly from Medicare itself, those providers should still be considered recipients of federal financial assistance because Part B then reimburses the beneficiaries, many of whom would be otherwise unable to access the provider due to financial constraints.

The NPRM also notes that the payments received by Part B providers constitute more than mere general government assistance. In *Grove City College*, the Court rejected the institution's argument that the federal grant funding it received through its students was comparable to "general purpose government assistance to low-income families," such as welfare payments. The Court reasoned that the institution was aware of which students were receiving the federal education grants, which were specifically to pay for their education, but that it would be unaware of whether a student was receiving general federal assistance, like welfare or Social Security payments. Significantly, the Court said that the institution "remain[ed] free to opt out" of the program. Similarly, HHS states that the federal funds received by providers through Medicare Part B is likewise not general government assistance given to beneficiaries. Instead, HHS reasons that, like in *Grove City College*, "[e]ntities such as non-participating providers are aware of the flow of federal financial assistance to them and are permitted to opt out" of Medicare Part B entirely. The NPRM further clarifies that providers who opt out of Medicare Part B altogether are not subject to the rule because if a provider chooses not to participate in Medicare Part B at all, that provider would not receive federal financial assistance from the program.

Considerations for Congress

Should Congress seek to clarify to which programs or entities Section 1557 should apply, it could amend the statute to describe the purview of Section 1557 and what should fall under its umbrella. For example, Congress could spell out which health programs are covered by Section 1557 and which institutions should be recipients of federal financial assistance. Alternatively, Congress could expressly include Medicare Part B providers under Section 1557, irrespective of whether Part B constitutes federal financial assistance.

It is difficult to estimate exactly how many new providers would be covered under the NPRM's proposed expansion to Medicare Part B, and the NPRM does not offer an estimate of how many providers would likely be impacted. Many Part B providers are already subject to Section 1557 requirements because they participate in Medicare Part A and/or Medicaid, which are both considered federal financial assistance and have traditionally been subject to federal civil rights laws.

Given the scope of Part B's coverage of outpatient services, however, it may be that at least some providers and suppliers who are not already subject to the rule will now constitute covered entities under Section 1557. Data from the Center for Medicare and Medicaid Services (CMS) demonstrate that Medicare Part B providers and suppliers are significant in number. In 2021, for example, CMS reports that there are more than 1.4 million providers and suppliers who provide Part B non-institutional services (i.e., services not provided in hospitals), including primary care, medical and surgical specialties, emergency medicine, radiology, anesthesiology, obstetrics, pathology, psychiatry, outpatient physical therapy, prosthetics, x-ray therapy and testing, ambulance service suppliers, and opioid treatment programs.

The NPRM was open to the public for comment for 60 days, and the comment period closed on October 3, 2022. HHS will review the comments received and could issue a final rule under Section 1557 at any time. Assuming that the NPRM goes into effect as drafted, a party with standing (i.e., a Medicare Part B provider or supplier that is not otherwise subject to Section 1557 through its participation in Medicare Part A or Medicaid) could challenge the rule under the Administrative Procedure Act (APA) (5 U.S.C. § 706). Under the APA, courts invalidate and set aside agency actions that are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," and those made "in excess of statutory jurisdiction."

A party with standing could also challenge the proposed rule on the grounds that it exceeds HHS' statutory authority in Section 1557 or is otherwise not in accordance with law. To assess this question, a court would likely look to Section 1557's text and legislative history.

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