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Client Alert

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D.C. Circuit Clears the Way for Hospitals to Challenge Base-Year Factual Determinations

The United States Court of Appeals for the District of Columbia Circuit recently held in *Saint Francis Medical Center v. Azar* that Medicare's reopening regulation, which prohibits providers from seeking to revise payment determinations after three years, including the "predicate facts" that support those determinations, does not apply to cost report appeals.[1] The *Saint Francis* decision has broad implications. Many categories of Medicare reimbursement rely upon factual determinations that are made in so-called base-years. For example, the number of reimbursable full-time equivalent ("FTE") residents claimed by teaching hospitals cannot exceed the number claimed on their 1996 cost reports—the base year. If these years-old fact determinations were made in error, they can now be revisited on appeal and, potentially, increase future year reimbursements. In addition, the providers in the *Saint Francis* case allege that the original IPPS standardized rate, which was determined in 1983, was improperly calculated. The D.C. Circuit's decision now paves the way for all providers to file such appeals for current and future cost report years. King & Spalding recommends that its clients consider filing such "standardized amount" appeals, but just as important, we recommend that clients begin to inventory whether there may be cost reporting errors in past years that affect base-year determinations that now can be challenged on appeal.

THE *SAINT FRANCIS* DECISION

It has long been the policy of the Centers for Medicare & Medicaid Services ("CMS") that it will not revisit final payment determinations after three years.[2] The agency has argued that this policy not only applies to the aggregate payment in Notices of Reimbursement ("NPRs"), but also to any underlying or "predicate fact" that supported the payment determination. So, for example, teaching hospitals by statute cannot claim graduate medical education reimbursement for more resident FTEs than the hospital claimed on its 1996 cost report or the cost report for the first year it became a teaching hospital if later than 1996.[3] This is commonly referred to as the FTE cap. But if there was a factual error in reporting or calculating

the hospital's FTE cap in that base-year, that error was carved in stone if the hospital did not appeal the error after it was initially determined in the base year cost report or reopened within three years of the NPR for that cost report. Over the years, this has left many providers frustrated. It is not infrequent that a provider will learn after the fact that an original base-year calculation was incorrect. We are representing at least two such clients now. But because the provider failed to appeal the cost report, or seek reopening in three years, that base year miscalculation had the effect of setting reimbursement for all future cost reporting periods *even though the reimbursement amounts in later years were inconsistent with regulatory or statutory rules*. Other examples of potentially erroneous base-year calculations that could permanently dilute future reimbursement include errors in a teaching hospital's per resident amount, or PRA, used to determine pass-through graduate medical education costs, errors in the base-year calculation of a hospital's average inpatient operating costs used to determine the hospital specific rate for sole community hospitals ("SCHs") and Medicare dependent hospitals ("MDHs"), as well as errors in the number of resident FTEs claimed in base-year teaching programs discussed above.

In *Saint Francis*, the D.C. Circuit eliminated CMS's so-called predicate facts policy with one quick strike of the pen. The plaintiffs, a group of 277 hospitals, asserted that the present-day standardized amount used to determine inpatient payment rates is understated.[4] The standardized amount used in each fiscal year is actually an update of the original standardized amount determined in 1983 when Congress initially implemented the Inpatient Prospective Payment System ("IPPS"), and that amount reflects the average operating costs for all inpatient cases as determined by costs reported in 1981. The plaintiffs in *Saint Francis* allege that the 1983 standardized amount is understated because it improperly factored transfer cases into the average.[5] As a result, each year's standardized amount—including future years—has been and will be understated. The question before the D.C. Circuit was whether the hospitals' challenge was barred by CMS's predicate facts regulation, which states that factual findings from prior years cannot be revisited more than three years after they are first determined.[6]

In a unanimous decision, the D.C. Circuit found that the predicate facts regulation does not preclude hospitals from appealing factual determinations beyond the three-year limitations window because, by its terms, the regulation only applies to the agency's reopening of cost reports, and it does not on its face address challenges by providers to predicate facts in the context of cost report appeals.[7] Therefore, even though the providers in *Saint Francis* were challenging a decades-old fact determination by CMS, their appeal was not barred because they were challenging the impact of that factual error on current and future year cost reports. Those providers are now free to pursue that claim in an appeal before the Provider Reimbursement Review Board.

WHAT ARE THE IMPLICATIONS OF *SAINT FRANCIS*?

As things stand today, the decision has far-reaching implications. Providers have long lived with the assumption that if there was a factual error in a base-year determination, they simply had to live forever with the resulting reduction in reimbursement for all future years. But that is the case no more. There are, of course, many examples of provider reimbursement in the Medicare program that are determined by reference to a base-year figure or calculation. The most common are the PRA and FTE cap for graduate medical education and base-years for hospital-specific rates. All of these determinations can be appealed in future cost reporting years. For example, if a provider is aware of the fact that its FTE cap had been erroneously set, but never appealed, it may now file an appeal from its most recently settled cost report and challenge the final indirect and direct graduate medical education reimbursement for that year, claiming that it is in error because the base-year FTE cap is erroneous. Such an appeal would have been dismissed in the past because of the predicate facts rule. But at this point, those appeals may now move forward for the Board to determine whether, in fact, the FTE cap was erroneously set.

Another clear implication of *Saint Francis* involves the merits of the providers' challenge. Before the decision, the idea that providers might be able to correct a perceived error to the standardized rate that was established decades ago in 1983 was unthinkable. That also is no longer true. While the D.C. Circuit did not rule on the merits of the plaintiffs' claim, it is now possible for other providers to challenge the same claim before the Board and in court. Therefore, providers would be wise to protest the standardized amount challenge in all *future* cost reports.

In addition, there may be opportunities to challenge the standardized rate for some limited number of *past* cost reporting periods. Until very recently, CMS took the position that the Board did not have jurisdiction over an appeal if the provider did not protest the item or cost that is the subject of the appeal when filing its cost report. The agency's position on this protest policy was successfully challenged in litigation.[8] CMS recently acquiesced to those decisions and now allows hospitals to pursue appeals on issues that were not protested so long as that protest would have been futile, such as a challenge to a regulation or—in this case—a challenge to the inpatient rate determined by CMS.[9] Therefore, hospitals that have cost reporting periods that have not yet been settled (or which were settled and the 180-day appeal window is still open) may be able to appeal the *Saint Francis* standardized rate issue in those years. However, this opportunity exists only for cost reporting periods that began before December 31, 2015. In 2016, CMS changed its cost report protest policy. Under the new policy, hospitals must still protest unallowable costs even if that protest would be futile. But the protest is now required as a condition of Medicare payment, not Board jurisdiction. This new policy applies for cost reporting periods that began after January 1, 2016. The ability to retroactively pursue the standardized amount issue—or any other erroneous "predicate fact"—is therefore somewhat limited.

ARE THERE ANY CAVEATS TO THE *SAINT FRANCIS* DECISION?

Yes, there are caveats to the *St. Francis* decision. The D.C. Circuit decision was determined by a three-judge panel. All judges concurred in the result and held that the *Saint Francis* providers should be permitted to pursue their appeals of the 1983 standardized amount. But two of those judges limited their decision, holding that CMS's policy that predicate facts cannot be challenged on appeal was not contained in the agency's reopening regulation. In other words, these judges concluded that the reopening regulation barred only CMS and its contractors from reopening old factual determinations. They found that the regulation was silent as to appeals and, therefore, did not cover the situation where providers challenged these predicate facts in cost report appeals before the Board. It is possible that the agency, therefore, could amend its regulations to cover cost report appeals. However, it is not clear that such a rewriting of the regulations would be successful. First, all three judges made it a point to mention that the statute imposes only three requirements for Board jurisdiction. Conspicuously missing from that list was any limitation on appealing predicate facts. Second, one of the judges—Supreme Court nominee, Judge Kavanaugh—wrote a concurring opinion in which he argued that CMS's predicate fact policy is inherently irrational.[10] CMS argued that the predicate fact rule is reasonable because it balances the need for payment accuracy with the need to make payment determinations final at some point, which is in the interest of both providers and the Medicare program. Judge Kavanaugh responded that this might be true for past payment determinations, but the predicate fact rule bakes in past factual errors and allows CMS to make erroneous future payment determination, which is the epitome of irrational.[11]

Therefore, it is not altogether certain that the agency could revise its regulations—a future challenge to new regulations might lead to a decision more consistent with Judge Kavanaugh's concurring opinion. But it may take the agency many months to revise the regulation, and King & Spalding is encouraging its clients to pursue any reviews of base-year factual determinations with due speed so that any possible appeals can be filed before CMS has an opportunity to adopt a new regulation on this issue. While CMS could attempt to apply retroactively any regulatory amendment it may make, as it did when it originally amended its reopening regulation to bar reopening of predicate facts in 2013, providers would have additional grounds to challenge any attempt to apply the regulation retroactively.

WHAT SHOULD HOSPITALS DO NEXT?

Hospitals should further familiarize themselves with the *Saint Francis* decision so that they fully understand implications and potential opportunities arising from it. At a minimum, we recommend the following:

- Hospitals that still have not received final determinations for cost reporting periods beginning prior to December 31, 2015 or are still within the 180-day window to appeal final determinations for periods preceding that date should strongly consider appealing the *Saint Francis* standardized amount issue, even if they did not protest the issue in their cost reports for those years. Those appeals can be brought due to the fact that CMS recently abandoned the protest requirement for cost reporting years beginning prior to December 31, 2015.
- Hospitals should also add the standardized amount claim to their future cost report filings as a protested item until such time as federal courts determine the merits of the *Saint Francis* plaintiffs' claims.
- Finally, hospitals should inventory all other base-year determinations that affect their Medicare reimbursement in future cost reporting periods; review those to determine whether there are any possible base-year factual errors; and evaluate those errors to determine whether there is an opportunity for future appeals. The *Saint Francis Medical Center* decision opens the doors to these appeals.

[1] *Saint Francis Med. Ctr. v. Azar*, 894 F.3d 290 (D.C. Cir. 2018).
[2] *See* 42 C.F.R. § 1885(b)(1).
[3] 42 U.S.C. § 1395ww(h)(4)(F)(i), (d)(5)(B)(v) .
[4] *St. Francis*, 894 F.3d at 293.
[5] *Id*.
[6] § 405.1885(b)(1).
[7] *St. Francis*, 894 F.3d at 294-95.
[8] *Banner Heart Hospital v. Burwell*, 201 F. Supp. 3d 131, 142 (D.D.C. 2016); *Bayshore Cmty. Hosp. v. Hargan*, 285 F. Supp. 3d 9 (D.D.C. 2017).
[9] Ruling No. CMS-1727-R (Apr. 23, 2018).
[10] *St. Francis*, 894 F.3d at 297-98 (Kavanaugh, J. concurring).
[11] *Id*. at 298.