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INSIGHT: *Saint Francis v. Azar* Medicare Payment Ruling: Too Good to Be True?

By Mark Polston and Daniel Hettich

For years it has been an iron-clad rule that the Medicare program, operated by the Centers for Medicare & Medicaid Services (''CMS''), will not revisit final payment determinations more than three years after they are made. If a Medicare-providing hospital was unhappy with the amount of reimbursement it received from Medicare, the hospital had two options. It could appeal the agency's final decision to the Provider Reimbursement Review Board (''PRRB''), but it had to do so within 180 days of the agency's final payment decision. 42 U.S.C. § 1395oo(a)(3). The second option was to ask the agency to reopen and revise the final payment determination. But the agency's regulations prohibit CMS from reopening final payment determinations that are more than three-years old. 42 C.F.R. § 1885(b).

What is more, CMS applied this policy not only to the amount of reimbursement a hospital received, as reflected in the hospital's Notice of Reimbursement (''NPR''), but also to any underlying or ''predicate fact'' that supported the amount of payment. 42 C.F.R. § 1885(a)(1)(iii). For example, teaching hospitals by statute cannot claim graduate medical education reimbursement for more full-time residents than the hospital trained during its most recent cost reporting year ending on or before December 31, 1996. 42 U.S.C. § 1395ww(d)(5)(B)(v). This is commonly referred to as the full-time equivalent or ''FTE'' cap. But if there was a factual error in reporting or calculating the hospital's FTE cap in that 1996 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 1996 cost report.

Over the years, this policy 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 or should have been challenged. But because the provider failed to appeal the cost report, or seek reopening within 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. If a provider asked for a reopening of a cost report in, say 2016, to revise an FTE cap set erroneously in 1997, CMS would deny the request under its predicate facts rule. Similarly, if the provider appealed its 2016 cost report to the PRRB, the agency would argue that the FTE cap for 2016 was a ''predicate fact'' determined in 1997 that could not be revisited under its reopening rules.

But this iron-clad rule is now in much doubt following the D.C. Circuit's decision in *Saint Francis Med. Ctr. v. Azar*, No. 17-5098, 2018 BL 232132 (D.C. Cir. June 29, 2018). In that case, the D.C. Circuit held that the prohibition on revisiting predicate facts found in Medicare's reopening regulation does not apply to a hospital's cost report appeal to the PRRB. The teaching hospital described above can now, in theory, appeal its 2016 cost report and hope to challenge the FTE cap set erroneously so many years ago. This is just one of the significant implications of the *Saint Francis* decision.

The *Saint Francis* Decision

In *Saint Francis*, the D.C. Circuit eliminated CMS's so-called predicate facts policy in one fell swoop. The plaintiffs, a group of 277 hospitals, assert that the present-day standardized rate that is used to determine all inpatient hospital payment rates is deflated. CMS calculates a ''standardized rate'' each fiscal year which is actually an update of the original standardized rate

determined in 1983 when Congress enacted the Inpatient Prospective Payment System (''IPPS''). The original standardized rate reflects the average operating costs for all inpatient cases as determined by costs reported by hospitals in 1981. 42 U.S.C. § 1395ww(d)(2)(A). The plaintiffs in *Saint Francis* allege that the original standardized rate is understated because it improperly factored transfer cases into the average. As a result, each year's standardized rate—including the rate that will be determined in future years—has been and will be understated unless the error is corrected. CMS argued that the hospitals' challenge was barred by its predicate facts regulation; the original standardized rate was a factual determination made far more than three years ago and, therefore, could not be revisited even if it were in error.

Assuming the plaintiffs are correct on the merits, the *Saint Francis* case raises an interesting question: what interest does the Medicare program have in perpetuating a decades-old error that pays hospitals less than what they are entitled to by statute?

In a unanimous decision, the D.C. Circuit found that the predicate facts regulation does not prevent hospitals from *appealing* factual determinations to the PRRB that are beyond the three-year limitations window; on its face, the regulation relied upon by CMS only applies to the agency's decision to *reopen* cost reports, and it does not address challenges by providers to predicate facts in the context of cost report *appeals*. 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 PRRB.

Implications

As things stand today, the decision could have far-reaching implications. There are a number of examples of provider reimbursement in the Medicare program that are determined by reference to a base-year figure or calculation similar to the original standardized rate for inpatient cases. For the most part, hospitals have simply lived with the fact that, if there was an error in that base-year calculation, there was nothing to be done if the base year NPR was older than three years. For example, teaching hospitals are reimbursed for the direct costs of their graduate medical education programs based upon the average cost per resident (''PRA'') determined in a base year. 42 U.S.C. § 1395ww(h)(3). Other examples of potentially erroneous base-year calculations that could permanently dilute future reimbursement include 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 that set the FTE cap discussed above. Not every provider is going to have an error in its base-year calculation for its PRA or hospital-specific rate, of course. But it would not be unreasonable for hospitals to spend some resources to comb through base-year cost report and audit work papers to prospect for any possible challenges that might bring higher reimbursement in future years.

Perhaps the most significant implication of *Saint Francis* involves the merits of the plaintiffs' challenge—that the original standardized rate that has been used to set all inpatient rates since 1983 is flawed. 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. But what was once unthinkable is now the reality. While the D.C. Circuit did not rule on the merits of the plaintiffs' claim—that still needs to be proven in court—it is now possible for other providers to challenge the same claim before the PRRB and in court. Therefore, hospitals need to determine whether they should raise the same challenge as a protest item when they file future cost reports. If the *Saint Francis* plaintiffs prevail, then hospitals might be in a position to claim the same relief that the *Saint Francis* plaintiffs receive.

Perhaps more significantly, there is no reason to believe that the *Saint Francis* plaintiffs have identified the *only* error in setting Medicare payment rates. The Medicare payment system is extremely complex, and the Medicare statute sets forth a number of payment formulae that require the agency to use existing data to calculate reimbursement rates and which, most important, require the agency to make calls about which data to use and how to interpret that data. There could be any number of similar ''errors'' baked into Medicare payment rates. The *Saint Francis* decision gives hospitals and consultants an additional incentive to search for those errors and bring them to light in appeals before the PRRB.

Are there risks to protesting the standardize rate issue raise by the *Saint Francis* plaintiffs or to pursuing other such appeals that allege long-ago errors in Medicare rate setting? Perhaps. The *Saint Francis* decision is new, and it is not clear how CMS will react to the decision should it lose on the merits. If it is forced to recalculate the original standardized rate, is it possible that the agency will take the opportunity to look for errors that were made in favor of hospitals to either offset the agency's error or lower rates even further? It is not clear whether the agency has that authority or whether the *Saint Francis* decision would allow the agency to do so.

Will the Decision Stand?

There are some caveats that need to be made about the *Saint 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 rate. 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, and one would expect the agency to do so as its first line of defense to future 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 Medicare statute imposes only three requirements

for hospitals that want to appeal their Medicare payment determinations. They must file from a final payment determination with at least $10,000 in controversy and within 180 days of the payment determination. Conspicuously missing from that list is any limitation on appealing predicate facts that had been determined in a prior cost reporting period. 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. 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 he described as the epitome of irrational.

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. Until then, providers should review their 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 such retroactive rulemaking.

What Should Providers Do Next?

Hospitals should further familiarize themselves with the *Saint Francis* decision so that they fully understand the implications and potential opportunities arising from it.

- 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 consider appealing the *Saint Francis* standardized rate 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 consider adding 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. For the time being, the *Saint Francis Medical Center* decision opens the doors to these appeals.

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