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HRO Alert

HRO HEALTHCARE LAW ALERT

THE BAYSTATE DECISION – DON'T LEAVE YOUR MONEY ON THE TABLE

Executive Summary

Earlier this month, in Baystate Health Systems v. Leavitt¹, the DC Circuit Court of Appeals held that the Department of Health and Human Services (DHHS) Secretary must reopen and recalculate disproportionate share hospital (DSH) payments, even though the plaintiff hospitals did not request a reopening through administrative channels.

Specifically, the Secretary has been ordered to "...cause his fiscal intermediaries to reopen and revise the Notices of Program Reimbursements issued to plaintiffs within the three-year period prior to February 27, 1997."

The Court noted that where, as in Baystate, the Secretary has admitted error in its prior administrative interpretations, as it did with HCFA Ruling 97-2, the Secretary's own regulations suggest that "...all hospitals undercompensated due to [such] an erroneous interpretation of the law have a personal right to...a reopening."

Technical Discussion

Background

The holding in Baystate benefits acute-care hospitals that receive payments under Medicare Part A for services to Medicare beneficiaries. Since 1983, the Secretary of Health and Human Services has made payments to cover hospital operating costs for inpatient care under the Prospective Payment System (PPS), which reimburses according to a uniform national rate schedule.² Some such hospitals, because they serve a disproportionate share of low-income Medicare recipients, are eligible for disproportionate share hospital (DSH) adjustments to their PPS payments.³

The Secretary of HHS has delegated authority to administer the Medicare Act to the Centers for Medicare and Medicaid Services (CMS)(formerly the Health Care Financing Administration (HCFA)). Determinations of payment amounts are in turn often delegated to fiscal intermediaries, generally private insurers that manage the payments for the Secretary.⁴ During the years affected by Baystate, estimated payments were made

¹ See Baystate Health Systems v. Leavitt, 2005 U.S.App. LEXIS 13118.

² See 42 U.S.C. §1395ww(d).

³ See 42 U.S.C. §1395ww(d)(5)(F).

⁴ See 42 U.S.C. §1395h.

periodically, and an annual accounting was done by the intermediary in the form of a Notice of Provider Reimbursement (NPR), based on a cost report submitted by the provider after the close of each fiscal year.

The Medicare Act has detailed instructions on the procedures for seeking review of payment determinations.⁵ The Secretary's regulations provide additional channels for administrative review, including two possibilities for the reopening of a determination, with a three-year limit.⁶ The first provides for reopening, at the discretion of the decision maker, usually the Intermediary, on the motion of the provider. The second possibility, which was at issue in *Baystate*, *mandates* reopening in one special circumstance. It directs that the decision

"shall be reopened and revised by the intermediary if ... the [HCFA] notifies the intermediary that such determination or decision is inconsistent with the applicable law, regulations, or general instructions issued by the [HCFA]."⁷

The Substantive Issue

Under the statute authorizing DSH adjustments, eligibility for and calculation of the amount of the DSH payment requires the summing of two fractions. The numerator of one of these two fractions calls for the number of inpatient days of patients who "were *eligible* for medical assistance under a State plan [i.e., Medicaid]."⁸ The Secretary promulgated a regulation on how to make the calculation and subsequently amended it a number of times.⁹ At the same time, the Secretary published an interpretation of that rule in the Federal Register, as part of the notice and comment rulemaking implementing the PPS.¹⁰ In her interpretation, the Secretary declared that "Medicaid covered days will include only those days for which benefits are *payable*."¹¹ This interpretation had the effect of reducing payments by limiting adjustments for patients who were "eligible" for Medicaid benefits, under the natural reading of the word, but who, because of a particular state's program, were not receiving such benefits on a given day.

5 See 42 U.S.C. §1395oo(a)(1)(A).

6 See 42 CFR §405.1885(a) and (b).

7 See 42 CFR §405.1885(b) (emphasis added).

8 See 42 U.S.C. §1395ww(d)(5)(F)(vi)(II) (emphasis added).

9 See 42 CFR §412.106 (1993) (version in force when original DSH calculations were made).

10 See 51 Fed. Reg. 16,772, 16,777 (May 6, 1986); 51 Fed. Reg. 31,454, 31,460 (September 3, 1986).

11 See 51 Fed. Reg. at 16,777/2-3 (emphasis added).

The Secretary's interpretation was successfully challenged in a number of jurisdictions;¹² including by this author on behalf of West Virginia hospitals.¹³ In light of these challenges, the Administrator of HCFA (now CMS) issued a ruling that rescinded, nationwide, the Secretary's challenged interpretation (HCFAR 97-2).¹⁴ The ruling established a new interpretation more favorable to hospitals, providing that Medicaid-eligible days would be counted "...whether or not the hospital received payment for those inpatient hospital services." The new interpretation was to be effective in the month of its publication and applied to all as yet unsettled cost reports and all cases in which "jurisdictionally proper" appeals were still pending. Key here, the ruling explicitly foreclosed retrospective application. Like all such rulings, HCFAR 97-2 was issued without notice or opportunity for comment.

The Procedural Issue

Not surprisingly, two hospitals challenged the Secretary's refusal to afford retroactive relief, in Monmouth Medical Center v. Thompson, and they won.¹⁵ While the challengers advanced many arguments, the winner was styled as a request for the court to exert *mandamus* jurisdiction and relief, by ordering the intermediaries to reopen their determinations.¹⁶ The Government advanced (but lost) the argument that the challengers had failed to exhaust their theoretical administrative remedies, noting that both hospitals were within the "three year reopening period" when they made their requests for reopening. In this case, the Court measured the three years from the issuance of HCFAR 97-2.

Within months, more than 250 hospitals filed for their own retrospective relief. Their cases were consolidated, for efficient management, and were styled under the caption In re: Medicare Reimbursement Litigation Baystate Health Systems, et al v. Leavitt.¹⁷ This was the beginning of Baystate, the subject of this HRO Alert.

In Baystate, as in Monmouth, the hospitals filed suit for declaratory and injunctive relief in the nature of *mandamus*. Again, many arguments were advanced. The ultimate winner was the argument that the Monmouth decision required the Baystate Court to direct the intermediaries to reopen and recalculate their NPR's for the three years prior to the HCFAR 97-2. This notwithstanding the fact that the Baystate hospitals had all failed (1) to request reopenings, and (2) to proceed through the administrative review channels provided for in the statute and regulations.

¹² See Cabell Huntington Hosp. v. Shalala, 101 F.3d 984 (4th Cir. 1996); Legacy Emanuel Hosp. & Health Ctr. v. Shalala, 97 F.3d 1261 (9th Cir. 1996); Deaconess Health Serv. Corp. v. Shalala, 83 F.3d 1041 (8th Cir. 1996); Jewish Hosp., Inc. v. Secretary of Health and Human Services, 19 F.3d 270 (6th Cir. 1994).

¹³ See Cabell Huntington Hosp. v. Shalala, 101 F.3d 984 (4th Cir. 1996).

¹⁴ See Health Care Financing Administration Ruling 97-2 (February 27, 1997).

¹⁵ See Monmouth Medical Center v. Thompson, 257 F.3d 807 (DC Cir. 2001).

¹⁶ See 28 U.S.C. §1361. Although *mandamus* is classified as a legal remedy, its issuance is largely controlled by equitable principles.

¹⁷ See In re Medicare Reimbursement Litigation, 309 F. Supp. 2d 89 (D.D.C. 2004)

Noting that the remedy of *mandamus* is “a drastic one,” the District Court cautioned that *mandamus* is available only if: “(1) the plaintiff has a clear right to relief; (2) the defendant has a clear duty to act; and (3) there is no other adequate remedy available to plaintiff.”

Clear Right to Relief. The Court found that HCFAR 97-2 established, by the Secretary's own admission, a clear right to relief.

Clear Duty to Act. Here, the Court wrestled with the question of whether HCFAR 97-2 imposed a “clear mandatory duty” on Medicare intermediaries to reopen all intermediary determinations (related to DSH) rendered in the three-year period prior to the ruling – even in the absence of a provider's request to do so. The Court concluded that such a duty did exist.

No Other Adequate Remedy. The government of course argued failure even to initiate, much less exhaust, administrative remedies. However, the Court had little trouble concluding that any such administrative remedies would have been unavailing in light of HCFA's published position that the Secretary would not reopen past NPRs on the basis of her changed interpretation (her tacit admission of past error) in HCFAR 97-2.

Ultimately, the District Court concluded that HCFA's original rule (“eligible” means “paid days”) was an error of law that intermediaries are required to remedy.

The Secretary immediately appealed – and lost again.¹⁸ The DC Circuit Court dispensed with the Secretary's appeal by starting with its own decision in Monmouth. As noted above, the Monmouth court found that the Secretary had a clear duty to require intermediaries to reopen the hospitals' NPRs, because HCFAR 97-2 amounted to a notice of inconsistency (prior error) and because the Secretary's own regulations mandate reopening when HCFA issues such a notice.¹⁹

Somewhat surprisingly, the Secretary challenged the validity of Monmouth and also argued failure to exhaust administrative remedies. The Court quickly dismissed both of these arguments.

Next, conceding that his regulations create a duty to reopen NPRs of all affected hospitals when HCFA issues a notice of inconsistency, the Secretary argued that only those hospitals which had either appealed to the Provider Reimbursement Review Board (PRRB) or sought reopening, as did the Monmouth hospitals, could seek *mandamus* to have their NPRs reopened. The Court, however found that **the regulations do not require hospitals to file anything at all to obtain relief**, stating as follows:

“...we see no basis for holding that only those hospitals that appealed or sought reopening have a personal right to the reopening required by [the regulation]

¹⁸ See *Baystate Health Systems v. Leavitt*, 2005 U.S.App. LEXIS 13118.

¹⁹ See *Monmouth*, 257 F.3d at 813-15, and 42 C.F.R.section 405.1885(b).

Indeed, the fact that the [regulation] contains no prerequisite for relief beyond a notice of inconsistency *suggests that all hospitals undercompensated due to an erroneous interpretation of the law have a personal right to ... reopening.*²⁰ (Emphasis supplied.)

Finally, the Secretary argued the equities, essentially saying that to permit the Baystate hospitals to recover retroactive DSH payments would be "unfair." Predictably, this argument was rejected. The Court noted that it was the hospitals, and not the Secretary, that would be faced with the burden of locating and presenting data from prior years for the intermediaries to use in recalculating DSH entitlement upon reopening. Finally, the Court closed with the following observation:

"In his opening brief, the Secretary takes pains to point out the extraordinary sums at stake in the hundreds of cases now pending in the district court -- more than \$1 billion, according to the Secretary. Yet as his counsel rightly conceded at oral argument, Congress imposed on the Secretary a clear statutory duty to pay the hospitals these funds. **Having to pay a sum one owes can hardly amount to an equitable reason for not requiring payment.**"²¹ (Emphasis supplied.)

Conclusions

The DC Circuit Court got it right. Having admitted in HCFAR 97-2 that she had misinterpreted and misapplied the law for many years, the Secretary should not be permitted to hide behind procedural "Gordian knots" in order to avoid paying hospitals sums they are due.

More claims will now quickly surface. If you wish to inquire further about options for your hospital, please call Steve Nash (303) 866-0659, or call any of the other HRO attorneys listed on this HRO Alert.

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²⁰ See *Baystate*, 2005 U.S.App. LEXIS 13118 at page 3.

²¹ See *Baystate*, 2005 U.S.App. LEXIS 13118 at page 4.