HCFA Rulings

Department of Health and Human Services

Health Care Financing Administration

Ruling No. 89-1 Date: January 1989

HCFA Rulings are decisions of the Administrator that serve as precedent final opinions and orders and statements of policy and interpretation. They provide clarification and interpretation of complex or ambiguous statutory or regulatory provisions relating to Medicare, Medicaid, Utilization and Quality Control Peer Review, and related matters.

HCFA Rulings are binding on all HCFA components, the Provider Reimbursement Review Board and Administrative Law Judges who hear Medicare appeals. These decisions promote consistency in interpretation of policy and adjudication of disputes.

This Ruling establishes that two recent U.S. Supreme Court decisions control and therefore render moot for lack of an actual case or controversy various claims and appeals challenging certain Medicare reimbursement regulations that are now pending before fiscal intermediaries, the Provider Reimbursement Review Board, HCFA and in the federal courts. It also explains how HCFA and its fiscal intermediaries will make payment in pending administrative and judicial appeals that are controlled by these two court decisions.

HCFAR 89-1-1

MEDICARE PROGRAM

Hospital Insurance and Supplementary Medical Insurance Benefits (Parts A and B)

Notice of Controlling Adverse Decisions by the Supreme Court and the D.C. Circuit Court of Appeals, and Corresponding Requirement of Remand to the Intermediaries for Payment of Certain Pending Moot Administrative Appeals Challenging the 1981 and 1984 Medicare Wage Index Rules; the 1979 and 1986 Medicare Malpractice Rules; and the Hospital-Specific Rate Under PPS

PURPOSE: This Ruling provides notice of the determination of the Health Care Financing Administration (HCFA) that two recent decisions issued respectively by the United States Supreme Court in Bowen v. Georgetown University Hospital, U.S. 109 S. Ct. 468 (1988) ("Georgetown I"), and the United States Court of Appeals for the District of Columbia Circuit in Georgetown University Hospital v. Bowen, 862 F. 2d 323 (D.C. Cir.1988) ("Georgetown II"), control and thereby render moot for lack of an actual case or controversy various claims and appeals challenging certain Medicare reimbursement regulations that are now pending before the fiscal

intermediaries, the Provider Reimbursement Review Board (PRRB), HCFA and in the federal courts. This Ruling also explains how HCFA and its fiscal intermediaries will make payment in pending administrative and judicial appeals that are controlled by these two court decisions,

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including an explanation of how appeals pending at various administrative levels should be processed.

CITATIONS: Sections 1861(v)(1)(A), 1871, and 1886(b)(3)(A) and (d) of the Social Security Act (42 U.S.C. 1395x(v)(1)(A), 1395hh, and 1395ww(b)(3)(A) and (d)); 42 C.F.R. 412.72(a)(3), 412.72(b), 413.53(a)(1)(i), 413.56; 46 FR 33637 (June 30, 1981); 49 FR 46495 (Nov. 26, 1984).

PERTINENT HISTORY:
Hospital Cost Limits -- For inpatient hospital services furnished in cost reporting periods beginning before October 1, 1983, the provider is entitled to payment of the lesser of the reasonable cost or the customary charges for services it furnishes to Medicare beneficiaries. 42 U.S.C. 1395f(b)(1). The statutory definition of reasonable cost, 42 U.S.C. 1395x(v)(1)(A), authorizes the Secretary to promulgate "regulations establishing the method or methods to be used, and the items to be included, in determining such costs." Pursuant to statutory authority, the Secretary has adopted a cost limits regulation, 42 C.F.R. 413.30, and specific schedules of cost limits, in addition to issuing cost apportionment regulations, 42 C.F.R. 413.50-413.56.

In 1981, the Secretary eliminated federal government hospital wage data from the wage index component of the schedule of cost limits for hospital routine inpatient service costs. 46 FR 33637 and 33638-40 (June 30, 1981) ("the 1981 cost limits"). In 1983, a district court declared invalid for lack of compliance with the notice and comment requirements of the Administrative Procedure Act (APA), 5 U.S.C. 551 et seq., the wage index component of the 1981 wage cost limits. District of Columbia Hospital Ass'n v. Heckler, No. 82-2520 (D.D.C. April 29, 1983). After later providing notice and opportunity for public comment, the same wage index rule was reissued in 1984 and applied retroactively to the 1981 cost limits. 49 FR 46495 (Nov. 26, 1984) ("the retroactive 1984 wage index rule"). On December 12 ,1988, the Supreme Court held that the retroactive 1984 wage index rule is not authorized by the rulemaking authority included in the statutory definition of reasonable cost, 42 U.S.C. 1395x(v)(1)(A), or by the Secretary's general authority to issue regulations necessary to implement the Medicare program, id. at 405(a), 1395hh, and 1395ii. Georgetown I, supra.

Malpractice Insurance Costs -- For cost reporting periods beginning prior to July 1, 1979, provider malpractice

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insurance costs (i.e., the cost of a malpractice insurance policy or of contributions made to a self-insurance fund) were reimbursed in accordance with the pre-1979 utilization method, which required, first, that malpractice insurance costs be included in the general and administrative cost center (G&A pool) along with other provider overhead costs and, second, that insurance costs be apportioned to the Medicare program in accordance with the provider's Medicare patient utilization rate. See 51 FR 11142-43 (April 1, 1986). See also 42 C.F.R. 405.452(b)(1), redesignated as 42 C.F.R. 413.53(a)(1)(i). In 1979, the Secretary determined that it was necessary and appropriate to remove malpractice insurance costs from the G&A pool and reimburse those costs in accordance with the 1979 malpractice rule, which, for cost reporting periods beginning on or after July 1, 1979, directly apportioned a provider's insurance costs based on the ratio of malpractice losses paid to Medicare patients compared to losses paid to all patients. See 51 FR 11143. See also 44 FR 31641 (June 1, 1979), adding 42 C.F.R. 405.452(b)(1)(ii), redesignated as 42 C.F.R. 405.452(a)(1)(ii) (48 FR 39811 (Sept. 1, 1983)). In 1986, in response to litigation challenging the 1979 malpractice rule (see Tallahassee Memorial Regional Medical Center v. Bowen, 815 F.2d 1435, 1441 n.7 (11th Cir. 1987), cert.

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denied, 108 S.Ct. 1573 (1988) (collecting cases)), and the availability of new data, the Secretary promulgated "the 1986 malpractice rule," which, effective May 1, 1986, eliminated the 1979 malpractice rule and established a new methodology for apportioning provider malpractice insurance costs that is based in large part on the provider's Medicare utilization rate. See 51 FR 11142 and 11195-96, adding 42 C.F.R. 405.457 (April 1, 1986), redesignated as 42 C.F.R. 413.56 (51 FR 34790 and 34808-9 (Sept. 30, 1986)). The 1986 malpractice rule applies, subject to the Medicare program’s general rules of administrative finality and reopening, to cost reporting periods beginning on or after July 1, 1979. 42 C.F.R. 413.56(a).

Although the Supreme Court's decision in Georgetown I literally applies only to the retroactive 1984 wage index rule, HCFA has determined that it also controls properly pending administrative and judicial appeals challenging the 1986 malpractice rule, 42 C.F.R. 413.56, for cost reporting periods beginning before the May 1, 1986 effective date of the 1986 regulation. In invalidating the retroactive 1984 wage index rule, the Supreme Court specifically rejected the agency's contention that, in addition to the Secretary's general rulemaking authority

under 42 U.S.C. 1395x(v)(1)(A) and 1395hh, clause (ii) of 42 U.S.C. 1395x(v)(1)(A) authorizes retroactive rulemaking. Georgetown I, supra, 57 U.S.L.W. at 4059-60. Because retroactive application of the 1986 malpractice rule was expressly based on 42 U.S.C. 1395x(v)(1)(A)(ii) and 1395hh (see 51 FR at 11184-87), HCFA has concluded that the Supreme Court's decision also controls properly pending, not otherwise settled, challenges to retroactive application of the 1986 regulation.

In accordance with the foregoing determination, HCFA will extend the basic holding and application of the Georgetown I decision to all properly pending, and not otherwise settled, appeals challenging the wage index component of the 1981 cost limits and the retroactive 1984 Medicare wage index rule and to the application of the 1979 and 1986 Medicare malpractice rules to cost reporting periods beginning before May 1, 1986. Accordingly, HCFA is instructing its fiscal intermediaries to allow properly pending, not otherwise settled, hospital reimbursement claims for malpractice insurance costs for cost reporting periods beginning before May 1, 1986 under the pre-1979 utilization method, 42 C.F.R. 405.452(b)(1).

HCFA's action eliminates any actual case or controversy and thereby renders moot all pending appeals challenging

the 1986 malpractice rule for cost reporting periods beginning before May 1, 1986, provided that such appeals satisfy the jurisdictional requirements of 42 U.S.C. 1395oo, and provided further that the hospital did not accept the May 11, 1988 "HHS Settlement Offer -- Medicare Malpractice Insurance Costs Litigation," or otherwise settle. HCFA is taking the steps necessary to secure a remand from the federal courts to the agency of the above-described wage index and malpractice insurance cost reimbursement challenges for payment. As explained below, similar measures are being undertaken to enable payment of reimbursement claims pending before the Deputy Administrator of HCFA, the PRRB, and the intermediaries that are controlled by the Georgetown I decision.

Prospective Payment System: Hospital-Specific Rate -- For cost reporting periods beginning on or after October 1, 1983, the Medicare program's prospective payment system (PPS) provides that, after a four-year transition period, a hospital's entire payment for the operating cost of inpatient services will, with several exceptions, be based on a predetermined nationally applicable rate for each patient discharge, according to which of numerous specified diagnosis related groups (DRGs) best characterize the patient's diagnosis and treatment. See 42 U.S.C. 1395ww(d); 42 CFR part 412. During the

transition period, an increasing proportion of a hospital's PPS payment is based on the federal rate, and a declining proportion of its payment for each discharge is based on the provider's historical cost (the hospital-specific or HSP rate). Id.

The hospital-specific rate is derived from the historical costs that a hospital incurred in its base year under the cost-based reimbursement system. 42 C.F.R. 412.71. See also 42 U.S.C. 1395ww(b)(3)(A) and 1395ww(d)(1)(A) and (C). The fiscal intermediaries were responsible for calculating the hospital-specific rate prior to the beginning of each hospital's first PPS year, by estimating the reasonable cost otherwise reimbursable for the base year itself, and then making specified modifications to arrive at the hospital-specific rate. See 42 C.F.R. 412.71 and 412.72.

Given that reimbursement amounts in the base year are potentially subject to revision through administrative action and judicial review, the PPS regulations address the consequences of such revisions for the HSP rate. The Secretary's prospective relief rule, 42 C.F.R. 412.72(a)(3), authorizes, as a matter of administrative discretion, automatic prospective adjustments to the HSP

rate to take account of the recognition of additional base year costs in a final judicial decision or as the result of various administrative actions. However, retrospective changes are permitted only if the hospital can establish that the original estimation of base year costs was "unreasonable and clearly erroneous in light of the data available at the time the estimation was made." 42 C.F.R. 412.72(b)(2).

On November 15, 1988, the United States Court of Appeals for the District of Columbia Circuit held in Georgetown II, supra, that when a provider secures a final court judgment on a legal challenge brought under the prior cost-based reimbursement system, the agency must give full effect to such judgments throughout the four-year transition period under PPS. The Court rejected the principles and procedures established by the Medicare regulations, which authorize the automatic prospective adjustments to the hospital-specific rate to reflect newly recognized base year costs but permit retrospective relief only under limited circumstances.

The Government has decided not to file a petition for certiorari in the Georgetown II case. Instead, HCFA

acquiesces on a nationwide basis in the D.C. Circuit's decision, to the extent that the statutory requirements, 42 U.S.C. 1395oo, for administrative and judicial

appeals are satisfied with respect to the provider's challenge to the hospital-specific rate under PPS, and where such HSP rate challenge is predicated on certain factors (described below) that pertain to the hospital's base year costs. Accordingly, HCFA is instructing the intermediaries to adjust the HSP rate throughout the four-year transition period to reflect a hospital's additional base year costs that are newly recognized as the result of these enumerated factors. (Similarly, HCFA is instructing its intermediaries to adjust downward the HSP rate to reflect any subsequently determined decrease in a hospital's base year costs.) Separate settlements such as may be made under the May 11, 1988 "HHS Settlement Offer -- Medicare Malpractice Insurance Costs Litigation," will, of course, be controlled by their own terms and will not be affected by the Georgetown I decision or by HCFA's nationwide acquiescence in the Georgetown II decision.

HCFA's nationwide acquiescence in the Georgetown II decision renders moot for lack of an actual case or controversy all pending (and not otherwise settled HSP rate) appeals that, first, satisfy the jurisdictional requirements imposed by 42 U.S.C. 1395oo

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and that, second, request that the HSP rate be revised retroactively (or for the duration of the four-year transition period) to reflect additional base year costs that are (or will be) newly recognized as the result of: a final, nonappealable court judgment; the administrative actions identified in 42 C.F.R. 412.72(a)(3)(i); pending claims for reimbursement under the pre-1981 wage index component of the 1981 cost limits; or pending malpractice insurance cost reimbursement claims under the pre-1979 utilization method of a hospital that did not accept the May 11, 1988 "HHS Settlement Offer -- Medicare Malpractice Insurance Costs Litigation." HCFA is undertaking appropriate measures in the federal courts to have the above-described challenges to the HSP rate remanded to the agency for payment. Similar steps are being taken to achieve payment of reimbursement claims pending before the Deputy Administrator of HCFA, the PRRB, and the intermediaries that are controlled by HCFA's nationwide acquiescence in the Georgetown II decision.

IMPLEMENTATION: In order to resolve in an orderly manner pending administrative appeals that have been rendered moot by the Georgetown I and Georgetown II decisions and to facilitate payment of affected reimbursement claims (described above), the administrative tribunal (i.e., the

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intermediary, the PRRB, or the Deputy Administrator of HCFA) before which such appeal is pending shall, first, determine whether the appeal satisfies the jurisdictional prerequisites imposed by 42 U.S.C. 1395oo; and, second, if the applicable jurisdictional requirements are satisfied, then a determination shall be made that the provider is entitled to payment of its reimbursement claims under the terms of this Ruling. In the event such a favorable determination is made in an appeal pending before the PRRB or the Deputy Administrator of HCFA, the appeal shall be remanded to the appropriate intermediary for payment.

HCFA recognizes that, given the substantial number of wage index, malpractice insurance cost, and HSP rate reimbursement appeals pending at the PRRB, it could be difficult for the PRRB to identify and decide which of the pending administrative appeals of these issues would be controlled by the Georgetown I and Georgetown II decisions, and also meet the jurisdictional requirements of 42 U.S.C. 1395oo. Thus, HCFA is authorizing an alternative procedure in order to facilitate the orderly disposition of wage index, malpractice insurance cost, and HSP rate reimbursement administrative appeals and to avoid any inordinate delay.

Under this alternative procedure, the provider may request the PRRB to remand a pending appeal of the above-described wage index, malpractice insurance cost, or HSP rate reimbursement issues to the intermediary for payment of the provider's reimbursement claims prior to the time that the PRRB determines whether the provider's reimbursement claims are controlled by the Georgetown I or Georgetown II decisions and whether such claims satisfy the jurisdictional requirements imposed by 42 U.S.C. 1395oo. The intermediary would assume, under this alternative procedure, the initial responsibility of determining whether the provider satisfied the jurisdictional requirements, 42 U.S.C. 1395oo, for appealing its reimbursement claims to the PRRB, and whether the provider is entitled to payment under this Ruling. If the provider is dissatisfied with the intermediary's determination under this alternative procedure that the provider failed to satisfy the applicable jurisdictional requirements or that it otherwise failed to qualify for payment under the terms of this Ruling, then it may resume its original PRRB appeal without prejudice.

RULING: It is HCFA’s Ruling that the Supreme Court's decision in Georgetown I, supra, 109 S. Ct. 468 (1988) controls and thereby renders moot for lack of an actual

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case or controversy appeals challenging the wage index component of the 1981 cost limits or the retroactive 1984 wage index rule, in addition to appeals challenging the 1979 malpractice rule or the 1986 malpractice rule for cost reporting periods beginning before May 1, 1986, provided that such appeals satisfy the jurisdictional requirements of 42 U.S.C. 1395oo, and provided further that the hospital did not accept the May 11, 1988 "HHS Settlement Offer -- Medicare Malpractice Insurance Costs Litigation," or otherwise settle.

Furthermore, it is HCFA's Ruling that the D.C. Circuit's decision in Georgetown II, supra, [“Nos. 88 5026 and 88-5040” are stricken and replaced with handwritten: 862 F.2d 323] (D.C. Cir. Nov. 15, 1988) controls and thereby renders moot for lack of an actual case or controversy all pending (and not otherwise settled HSP rate) appeals that, first, satisfy the jurisdictional requirements imposed by 42 U.S.C. 1395oo and that, second, request that the HSP rate be revised retroactively (or for the duration of the four-year transition period) to reflect additional base year costs that are (or will be) newly recognized as the result of: a final, nonappealable court

judgment; the administrative actions identified in 42 C.F.R. 412.72(a)(3)(i); pending claims for reimbursement under the pre-1981 wage index component of the 1981 cost limits;

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or pending malpractice insurance cost reimbursement claims under the pre-1979 utilization method of a hospital that did not accept the May 11, 1988 "HHS Settlement Offer -- Medicare Malpractice Insurance Costs Litigation."

Finally, it is HCFA's Ruling that in order to ensure that the foregoing Rulings will be implemented in an expeditious and orderly manner with respect to pending appeals in the federal courts of the above-described wage index, malpractice insurance cost, or HSP rate reimbursement issues, HCFA will take appropriate measures in the federal courts to obtain a remand to the agency for payment, or, as may be necessary, for further jurisdictional findings by the administrative tribunal. Similarly, it is HCFA's Ruling that for any claim or appeal of the above-described wage index, malpractice insurance cost, or HSP rate reimbursement issues that is pending administratively (i.e., before the Deputy Administrator of HCFA, the PRRB, or the intermediary) that administrative tribunal shall, first, determine whether the appeal satisfies the jurisdictional prerequisites, 42 U.S.C. §1395oo, and, second, if the applicable jurisdictional requirements are satisfied, then a determination shall be made that the provider is entitled to payment of its reimbursement claims under the terms of

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this Ruling. In the event such a favorable determination is made in an appeal pending before the PRRB or the Deputy Administrator of HCFA, the case shall be remanded to the appropriate intermediary for payment. Moreover, in order to provide an alternative means by which the provider may avoid the possibility of delay before the PRRB and to facilitate prompt payment of reimbursement claims subject to this Ruling, it is also HCFA's Ruling that if the provider requests the PRRB to remand to the intermediary for payment pursuant to this Ruling, an appeal of the above-described wage index, malpractice insurance cost, or HSP rate reimbursement issues -- before the PRRB has determined whether the appeal satisfied the jurisdictional requirements of 42 U.S.C. 1395oo and whether the provider's reimbursement claims are governed by this Ruling -- then the intermediary shall not oppose the provider's motion; the PRRB shall grant the provider's motion; and the intermediary shall make, subject to a determination as to whether the provider satisfies the applicable jurisdictional requirements and otherwise satisfies the terms of this Ruling, appropriate payments. However, if the intermediary ultimately determines that the provider failed to satisfy the jurisdictional prerequisites imposed by 42 U.S.C. 1395oo or otherwise

failed to qualify for payment pursuant to this Ruling, then the PRRB shall permit the provider to resume its original administrative appeal without prejudice.

EFFECTIVE DATE

This Ruling is effective January 26th, 1989.

DATED: 1/26/89

William L. Roper, MD
Administrator,
Health Care Financing Administration