HCFA Rulings

Department of Health and Human Services

Health Care Financing Administration

Ruling No. 91-1 Date: September 1991

HCFAR 91-1-1

MEDICARE PROGRAM

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

Notice of Decision to Follow a Consent Order Providing for the Discontinued Application of the 1986 Medicare Malpractice Rule and a Reversion to the Pre-1979 Utilization Method of Paying Certain Hospital Malpractice Insurance Costs

PURPOSE: This Ruling provides notice of the determination of the Health Care Financing Administration (HCFA) that it will follow the Consent Order in Children's National Medical Center, et al. v. Sullivan, Civil Action No. 90-1362-WBB (D.D.C. July 16, 1991) (Children's National), which provides that the 1986 Medicare malpractice rule, 42 CFR 413.56, is invalid and shall not be enforced. As explained below, the Children's National Consent Order reflects HCFA's determination that it cannot continue to apply or defend the 1986 rule due to the fact that the agency has not completed the implementation of that regulation. The Ruling also explains how HCFA and its fiscal intermediaries will pay certain hospital malpractice insurance cost claims and appeals that are now pending before the intermediaries, the Provider Reimbursement Review Board (PRRB), the Deputy Administrator of HCFA, and in the Federal courts in accordance with the pre-1979 utilization method.

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CITATIONS: Sections 1861(v)(1)(A), 1871, and 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395x(v)(1)(A), 1395hh, and 1395ww(d)(1)(B)); 42 CFR 412.20-412.32, 413.53(a)(1)(i), and 413.56; 51 FR 11142 (April 1, 1986) and 52 FR 9833 (March 27, 1987).

PERTINENT HISTORY: For covered services furnished to Medicare beneficiaries in cost reporting periods beginning before October 1, 1983, hospitals and other providers are entitled to payment of the lesser of the reasonable cost or the customary charges for these services. 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 numerous cost determination regulations, see 42 CFR Part 413, including cost apportionment regulations, see 42 CFR 413.50 through 413.56, such as the 1986 malpractice rule.

For inpatient hospital services furnished in cost reporting periods beginning on or after October 1, 1983, general acute-care, short-stay hospitals are paid under the Medicare prospective payment system on the basis of predetermined fixed payment rates for each discharge, according to a patient's

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"diagnosis-related group" (DRG). See 42 U.S.C. 1395ww(d); 42 CFR Part 412. However, hospital outpatient services are still paid under the cost-based reimbursement system, as are inpatient services furnished by certain specialty hospitals and distinct-part hospital units that are excluded from the prospective payment system. (42 U.S.C. 1395ww(d)(1)(B); 42 CFR 412.20 through 412.32.)

Malpractice Insurance Costs -- For cost reporting periods beginning prior to July 1, 1979, provider malpractice insurance costs (that is, 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 CFR 405.452(b)(1), redesignated 42 CFR 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 pay 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

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paid to all patients. See 51 FR 11143. See also 44 FR 31641 (June 1, 1979), adding 42 CFR 405.452(b)(1)(ii), redesignated as 42 CFR 405.452(a)(1)(ii).

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. denied, 485 U.S. 1020 (1988) (collecting cases), and the availability of new data, the Secretary promulgated an interim final rule with comment period, which, effective May 1, 1986, replaced the 1979 malpractice rule with a new methodology for apportioning hospital malpractice insurance costs in "the 1986 malpractice rule." See 51 FR 11142, 11195-96, adding 42 CFR 405.457 (April 1, 1986), redesignated as 42 CFR 413.56. The 1986 regulation is based on a hospital's Medicare utilization rate, in addition to including aspects of the claims-paid approach of the 1979 rule. See 42 CFR 413.56(b).

Subsequently, the Secretary confirmed the finality of the 1986 malpractice rule and responded to public comments on the interim final rule. 52 FR 9833 (March 27, 1987). However, as a result of consideration of two comments and reevaluation of pertinent data, the Secretary revised one implementing policy for the 1986 rule by establishing separate sets of "scaling factor formula" values for general acute-care,

short-stay hospitals subject to the prospective payment system and for specialty hospitals

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excluded from the prospective payment system. See 52 FR 9836. The scaling factor formula values originally established in the preamble to the 1986 interim final rule, see 51 FR at 11145-48, 11195-96, applied to all hospitals and were based on data for both general acute-care, short-stay hospitals (subject to the prospective payment system) and specialty hospitals excluded from the prospective payment system. The 1987 confirmation document established new formula values for general acute-care, short-stay hospitals that are based solely on data for such hospitals and which happen to be identical to the values established in the 1986 interim final rule. See 52 FR at 9836. The 1987 confirmation document further provided that separate formula values were to be established for specialty hospitals excluded from the prospective payment system, but in the interim the values established originally in the 1986 interim final rule would continue to govern specialty hospitals. See 52 FR 9836. As explained below, however, HCFA has not developed all the scaling factor formula values that are required for full implementation of the 1986 rule.

Due to the issuance of Health Care Financing Administration Ruling 89-1 (January 26, 1989) (HCFA Ruling 89-1) and the advent of the prospective payment system, the 1986 malpractice rule now has a limited scope of applicability. As promulgated initially, the 1986 malpractice rule applied retroactively, subject to the Medicare program's general rules of administrative finality, to

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cost reporting periods beginning on or after July 1, 1979. See 42 CFR 413.56(a). However, HCFA discontinued retroactive application of the 1986 malpractice rule in HCFA Ruling 89-1, which was issued in response to Bowen v. Georgetown University Hospital, 488 U.S. 204 (1988) (Georgetown I), wherein the Supreme Court invalidated retroactive application of the 1984 Medicare wage index rule. HCFA Ruling 89-1 interprets the Georgetown I decision to control properly pending, and not otherwise settled, malpractice insurance cost reimbursement claims for cost reporting periods beginning before May 1, 1986, the effective date of the 1986 malpractice rule, and that Ruling further requires that these claims be paid under the pre-1979 utilization method.

While HCFA Ruling 89-1 largely limited the application of the 1986 malpractice rule to cost reporting periods beginning on or after May 1, 1986, the advent of the prospective payment system further circumscribed the role of the 1986 rule in hospital reimbursement. For hospitals subject to the prospective payment system, malpractice insurance costs attributable to inpatient services are subsumed under the prospectively determined payment rates that are applied to the various DRGs. Thus, the 1986 malpractice rule only governs malpractice insurance costs attributable to outpatient services for hospitals subject to the prospective payment

system, and all services furnished by specialty hospitals and distinct-part hospital units excluded

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from the prospective payment system for cost reporting periods beginning on or after May 1, 1986.

The Children's National Consent Order -- The Consent Order in the Children's National case resulted from HCFA's efforts to develop, consistent with the 1987 confirmation document, see 52 FR 9836, separate scaling factor formula values for hospitals excluded from the prospective payment system. In the course of investigating this matter, HCFA determined that it is also necessary to develop separate formula values for malpractice insurance costs attributable to hospital outpatient services and for costs attributable to inpatient services furnished by facilities excluded from the prospective payment system. However, HCFA has not derived separate formula values for inpatient and outpatient services for "the R factor" in the formula (that is, the national Medicare malpractice loss ratio, as adjusted for associated claims adjustment expense), due to the difficulty of securing hospital data attributing malpractice claims (and associated claims adjustment expense) separately to outpatient services and inpatient services. Moreover, separate scaling factor formula values hospitals excluded from the prospective payment system have not been developed.

The plaintiff-hospitals in the Children's National case challenged the agency's use of the 1986 malpractice rule to determine, for their FY 1987 or FY 1988 cost reporting periods,

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their payment for malpractice insurance costs attributable to outpatient services and, in the case of hospital facilities excluded from the prospective payment system, inpatient services. These plaintiffs alleged that the 1986 malpractice rule is invalid because the scaling factor formula values were derived exclusively from inpatient data for general acute-care, short-stay hospitals (subject to the prospective payment system) whereas the 1986 rule applies, due to HCFA Ruling 89-1 and the advent of the prospective payment system, only to outpatient services and inpatient services furnished by hospitals (or units thereof) excluded from the prospective payment system. In light of the fact that HCFA has not developed the additional scaling factor formula values necessary to complete implementation of the 1986 rule, the agency entered into the Consent Order which provides that the 1986 malpractice rule is invalid and shall not be enforced. The Consent Order was approved by the United States District Court for the District of Columbia on July 16, 1991.

Since separate scaling factor formula values for outpatient services and for inpatient services furnished by hospital facilities excluded from the prospective payment system have not been developed, the agency has determined to follow the Consent Order by ceasing application of the 1986 malpractice rule and instead reverting to

the pre-1979 utilization method. Specifically, HCFA is instructing the intermediaries to pay properly pending claims or appeals for hospital malpractice

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insurance costs attributable to outpatient services, or, in the case of hospitals (or units thereof) excluded from the prospective payment system for inpatient services, for cost reporting periods beginning on or after May 1, 1986, in accordance with the pre-1979 utilization method.

For a claim with respect to a cost reporting period to be "properly pending" all of the following requirements must be met:
(1) The hospital must have timely filed its cost report with its intermediary. (2) The cost report must state the amount of malpractice insurance costs incurred for that year. (Hospitals that filed their cost reports in conformance with the 1986 rule, thereby "self-disallowing" the incremental cost that otherwise would have been payable under the utilization methodology, will be treated as having claimed payment under the pre-1979 utilization methodology.) (3) A notice of program reimbursement has not been issued pertaining to the claim.

For an appeal with respect to a cost reporting period to be “properly pending", all of the following requirements must be met:
(1) An initial notice of program reimbursement (NPR) must have been issued reflecting application of the 1986 malpractice rule.
(2) The hospital must have timely filed an appeal of the intermediary's disallowance which must currently be pending before the intermediary, the PRRB, the HCFA Administrator, or the

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courts. Hospitals which are within the time period for filing such an appeal also meet this requirement. (Hospitals that self-disallowed payment under the pre-1979 utilization methodology must have appealed the initial notice of program reimbursement.) See 42 U.S.C. 1395oo; 42 C.F.R. Part 405, Subpart R.

HCFA's nationwide acquiescence in the Children's National Consent Order renders moot for lack of an actual case or controversy all properly pending appeals challenging the 1986 malpractice rule for cost reporting periods beginning on or after May 1, 1986, provided that such appeals satisfy the jurisdictional requirements of 42 U.S.C. 1395oo or 42 CFR 405.1811 and are otherwise subject to the terms of this Ruling. HCFA is taking the steps necessary to ensure prompt payment of claims under this Ruling in each properly pending Federal court case seeking hospital malpractice insurance cost reimbursement under the pre-1979 utilization method.

In order to resolve in an orderly manner properly pending administrative appeals that have been rendered moot by the agency's nationwide acquiescence in the Children's National Consent Order and to facilitate payment of affected reimbursement claims (described above), the administrative tribunal (that is, the

intermediary, the PRRB, or the Deputy Administrator of HCFA) before which such appeal is pending will, first, determine whether the appeal satisfies the jurisdictional prerequisites

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imposed by 42 U.S.C. 1395oo or 42 CFR 405.1811; and, second, if the applicable jurisdictional requirements are satisfied, then will make a determination as to whether the hospital 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 will be remanded to the appropriate intermediary for payment under the terms of this Ruling.

RULING: It is HCFA's Ruling that the Consent Order in Children's National, supra, controls and thereby renders moot for lack of an actual case or controversy properly pending appeals challenging the 1986 Medicare malpractice rule, 42 CFR 413.56, for cost reporting periods beginning on or after May 1, 1986, provided that such appeals satisfy the jurisdictional requirements of 42 U.S.C. 1395oo or 42 CFR 405.1811. Accordingly, HCFA is instructing the intermediaries to pay under the pre-1979 utilization method any properly pending claim or appeal for hospital malpractice insurance costs attributable to outpatient services or, in the case of hospitals (or units thereof) excluded from the prospective payment system, for inpatient services, for cost reporting periods beginning on or after May 1 1986.

It is also HCFA's Ruling that in order to ensure that the foregoing Ruling will be implemented in an expeditious and orderly manner with respect to properly pending appeals of the

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above-described malpractice insurance cost reimbursement issues, HCFA will take appropriate measures in the Federal courts to ensure prompt payment of claims in properly pending appeals under the pre-1979 utilization method. Similarly, it is HCFA's Ruling that, for any claim or appeal of the above-described malpractice insurance cost reimbursement issues that are pending administratively (that is, before the Deputy Administrator of HCFA, the PRRB, or the intermediary), that the administrative tribunal will, first, determine whether the appeal satisfies the pertinent jurisdictional prerequisites, 42 U.S.C. 1395oo or 42 CFR 405.1811; and, second, if the applicable jurisdictional requirements are satisfied, then a determination will be made as to whether the hospital 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 case will be remanded to the appropriate intermediary for payment under the terms of this Ruling.

EFFECTIVE DATE

This Ruling is effective September 30, 1991.

DATED: 9/29/91

Gail R. Wilensky, Ph.D.
Administrator, Health Care
Financing Administration