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When Must A Hospital Challenge The Medicare Reimbursement Policy?

By Robert L. Schwartz

Bethesda Hospital Association

v.

Otis R. Bowen

(Docket No. 86-1764)

Argued February 29, 1988

This is the rare situation in which both sides have asked the Court to hear a case—in this instance to clarify the requirements of the process through which hospitals can challenge how they have been reimbursed under the Medicare program.

ISSUE

The issue for the Court is whether the Medicare statute permits hospitals that do not formally request Medicare reimbursement for particular items in the cost reports filed with their fiscal intermediaries (who audit the reports) to seek reimbursement for those items when they appeal the fiscal intermediary's decision to the appropriate administrative board or court.

FACTS

There are few statutes and regulations as arcane as those surrounding Medicare and Medicare reimbursement. Until 1983, hospitals (and many other Medicare providers) were reimbursed for their actual cost of providing care to Medicare patients. Under this retrospective payment system, each year each hospital would prepare a cost report in a form required by the Secretary of the Department of Health and Human Services. This cost report would include all of the costs of operating the hospital, and it would allocate a portion of those costs to the care provided to Medicare patients. The fiscal intermediary, a government contractor and most often a private insurance company, would review the cost reports in accordance with current Medicare regulations and issue a Notice of Program Reimbursement. This notice determined the total Medicare payment due to the hospital for the year that was the subject of the cost report.

Because the hospital would have received estimated Medicare payments periodically during the year, the notice would result in the hospital paying the government, or the government paying the hospital, the difference between the

estimate and the actual amount due. A hospital dissatisfied with the result reached by the fiscal intermediary could appeal to the Provider Reimbursement Review Board (PRRB), and then to the federal courts.

In this case, the Bethesda Hospital Association and the Deaconess Hospital Association of Cincinnati filed a cost report for 1980 with their fiscal intermediary. The report claimed reimbursement for their malpractice premium costs in accord with a formula required by a 1979 Medicare regulation that was very unfavorable to hospitals. That regulation effectively allocated more of those premiums to non-Medicare patients than had the previous malpractice premium allocation rule. In fact, Bethesda and Deaconess (and virtually all others in the country), thought that the 1979 regulation was invalid and they intended to challenge it. Despite this, the hospitals "self-disallowed" the additional reimbursement that they would have been entitled to receive before the 1979 regulation was adopted because they knew that the fiscal intermediaries were bound by the 1979 regulation, and thus they knew that they had no chance of winning their challenge until the issue was reviewed by the PRRB or the courts.

When the hospitals appealed the result of the fiscal intermediary's audit to the PRRB, they were told that they could not raise the propriety of the 1979 malpractice regulation because they had not raised it before the fiscal intermediary. Bethesda and Deaconess, along with several other Ohio hospitals, appealed to the federal district court, which determined that the two hospitals were still entitled to raise their legal objection to the 1979 regulation, even though they did not raise it with their fiscal intermediary. The court of appeals reversed the district court on that issue (810 F.2d 558 (1987)), and Bethesda and Deaconess asked the Supreme Court to review the issue.

There is no question that the other Ohio hospitals, which did not follow the 1979 regulation when they prepared their 1980 cost reports (or otherwise drew attention to their objection to the 1979 malpractice regulation in their cost reports), can challenge the validity of the restrictive 1979 malpractice premium allocation system. In fact, that regulation was found invalid by every one of the several courts which considered it, and it has now been withdrawn in favor of a new allocation rule, which is under challenge in other proceedings.

BACKGROUND AND SIGNIFICANCE

This case is very important to some hospital fiscal management offices and to the Medicare administration, but is of

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limited significance outside of those narrow groups. The government, which won this case in the court of appeals, joined with the hospitals to ask the Supreme Court to hear this case because the courts of appeals are split on the issue, the efficient administration of the Medicare system requires that the question of whether a hospital can appeal a "self-disallowance" be finally determined and there is no other institution that seems to be able to resolve the dispute. Three appellate courts have determined that the PRRB can hear self-disallowed claims, two have determined that it cannot, one circuit is split on the issue, and one has determined that the PRRB has discretion to decide whether it will hear these claims.

The already relatively minor significance of this case is further diminished by the fact that most hospital reimbursements are now made on a prospective (rather than retrospective) payment system, with hospitals reimbursed a determined amount for every admission, and the cost report system of reimbursement is consequently much less important to most Medicare providers. Despite this, some kinds of Medicare providers—including children's hospitals, psychiatric hospitals, skilled nursing facilities and some outpatient providers—are still reimbursed on the basis of their costs. Also, some hospital costs, like the direct costs of medical education, are still figured this way. In addition, the earlier cost reports provided the basis of some subsequent prospective payment amounts, so this case is not entirely of historical significance.

This case will take on a real and general significance only if the Court decides to use it as a vehicle to explore some of the secondary issues raised by the parties. These issues include the strength of the presumption favoring judicial review, which the hospitals believe to be very strong, and the amount of deference to be accorded the Department of Health and Human Services in interpreting the statute, which the government believes to be very great. Finally, the

Court may be required to determine if an agency can interpret a statute to effectively cut off judicial review of its actions without giving formal notice that it interprets its statute to do this.

ARGUMENTS

For Bethesda Hospital Association and Deaconess Hospital (Counsel of Record, Caryl T. Hedlund, 1600 Maryland National Bank Building, Baltimore, MD 21202; telephone (301) 685-1120)

1. The Secretary's policy of denying administrative and thereby judicial review is inconsistent with the plain language of the statute.
2. Deference to the Secretary's interpretation of the statute is not warranted.
3. The statute should not be interpreted to contain an implied delegation of discretionary power to the Secretary or the PRRB to limit or foreclose administrative and judicial review.
4. The Secretary cannot preclude judicial review without notice.

For Otis Bowen, Secretary of Health and Human Services (Counsel, Andrew J. Pincus, Department of Justice, Washington, DC 20530; telephone (202) 633-2217)

1. A provider may invoke the PRRB's jurisdiction only when it seeks review of a claim raised before the intermediary.
2. Even if the PRRB has power to hear a case in which a provider did not raise its claim before the intermediary, the PRRB may exercise its discretion to decline to hear such a case.

AMICUS BRIEF

In Support of Bethesda Hospital Association
The American Hospital Association