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D.C. Circuit allows hospitals to appeal Medicare reimbursement decisions based on the government's use of flawed data

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The decision clears the way for hospitals around the country to seek additional funds from Medicare where the government has used faulty data to calculate costs.

In *Saint Francis Medical Center, v. Azar*, No. 17-5098 (D.C. Cir. June 29, 2018), 277 appellant hospitals alleged that the government had been using flawed data to calculate Medicare reimbursements since 1983. The government argued that the claims were time barred and that hospitals should not be permitted to challenge factual determinations made years or decades ago. The government based its argument on a regulation promulgated in 2013 by the Secretary of Health and Human Services (the "Secretary"), which bars hospitals from seeking additional Medicare payments by challenging factual determinations that are relevant to the payment year at issue, but that were made many years earlier. See Provider Reimbursement Determinations and Appeals, 78 Fed. Reg. 74,826, 75,162-69 (Dec. 10, 2013) (the "2013 Regulation").

The Medicare program pays for "reasonable costs" of providing covered services to eligible elderly and disabled individuals. In 1983, Congress created a new Prospective Payment System, under which hospitals are paid a fixed amount for each beneficiary treatment, regardless of their actual costs. The payment amount is determined based on a statutory formula that depends in part on base rates known as "standardized amounts." 42 U.S.C. § 1395ww(d)(2)(C). While prospective payments were adjusted over time, the standardized amounts remained the same. They were calculated in 1983 based on hospitals' cost-reporting data from 1981. See Prospective Payments for Medicare Inpatient Hospital Services, 48 Fed. Reg. 39,752, 39,763-67 (Sept. 1, 1983). Therefore, to this day, the Medicare payments made to hospitals for inpatient services depend in part on factual determinations derived from 1981 data and embedded in 1983 calculations. The *appellant* hospitals alleged that this data erroneously characterized *patient transfers* from one hospital to another as patient *discharges*, thus overstating the *total* number of discharges and understating the allowable operating costs per discharge. Because that determination was embedded in the standardized amount in 1983, it has affected payment decisions ever since.

There are two ways to challenge an annual reimbursement decision. First, under the Medicare Act, a hospital may appeal as of right to the Provider Reimbursement Review Board ("PRRB") and may

seek further review of that decision by the Secretary and then by a federal district court. Second, a hospital may request a "reopening" of the Secretary's or other reviewing entity's determination, which is discretionary by the entity whose decision is at issue and is not subject to administrative or judicial review.

A recurring issue has been whether a hospital, in the course of challenges to annual reimbursement through either appeal or a reopening, may contest so-called "predicate facts"— factual determinations that were made in earlier years, but are used in reimbursement decisions for the current payment year. The 2013 Regulation provides that, when a decision is reopened, a predicate fact must be challenged within three years from when it was first determined. *See* 42 C.F.R. § 405.1885(a)(1), (a)(1)(iii), (b)(2)(iv). The Secretary argued that the 2013 Regulation's three-year limitations period applies to both reopenings and appeals to the PRRB.

The court rejected this argument, finding that there was no basis under the relevant statutory scheme to extend the statute of limitations governing reopening to PRRB appeals. The court reasoned that "[i]n common legal usage, nobody would confuse an appeal, which involves one entity reviewing the decision of another, with a reconsideration or reopening by that same entity that made the decision at issue." *St. Francis*, at 7. That basic distinction "resolves this case." *Id*. Moreover, the court refused to defer to the Secretary's interpretation of the 2013 Regulation, finding it to be "plainly erroneous or inconsistent with the regulation." *Id*. at 13.

The take-away from *St. Francis* is that hospitals considering appeals from a fiscal intermediary to the PRRB are now able to, and should, challenge original factual predicate determinations made more than three years ago, including those for allowable operating costs per discharge made in 1983.

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