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supreme court: medicare disproportionate share hospital providers denied right to correct reimbursement after government's methodological error revealed

MSK Client Alert

January 28, 2013

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The Medicare Disproportionate Share Hospital Program ("DSH") is a program under which hospitals that serve a disproportionate share of low-income patients receive additional reimbursement from the Centers for Medicare & Medicaid Services (CMS). An estimate of the adjustment is paid as care is provided and "trued up" annually, through submission of a Medicare Cost Report. The Report is typically audited by a fiscal intermediary ("FI") acting on the government's behalf, who notifies the hospital of its approved payment with a Notice of Program Reimbursement. A provider may submit an initial appeal to the Provider Reimbursement Review Board ("Board") within 180 days and has an additional 60 days from that date to identify and add issues to this initial appeal request. By a 1974 regulation, the Secretary of the Department of Health and Human Services ("HHS") authorized the Board to extend the appeal time to up to three years for good cause.

Anyone even peripherally involved in this process knows how complicated it actually is. There is an industry of people who prepare cost reports, review FIs' determinations, file appeals, and negotiate with the FIs and Board about such things. The portion of the DSH adjustment often at issue is based on the percentage of days for which the beneficiary was entitled to Medicare Part A and also received SSI payments from the Social Security Administration (SSA). The SSA provides the SSI information to CMS which then pulls all of the Medicare days for each eligible hospital and determines the percentage of days for which the Medicare beneficiaries were simultaneously eligible for SSI and Medicare, (the "SSI fraction"). Note that the hospital cannot independently make this determination but relies on SSA and CMS to properly communicate and

determine the appropriate SSI fraction. Usually geographical data becomes available to the FIs years after the Report for the cost year under examination was submitted. Negotiations include issues about which year's data is appropriately used, and cost reports are finally "closed" years after they are submitted. I have personally seen the government submit three amended proofs of claim in a provider's Chapter 11 case because of the difficulty in getting a correct determination from its own FI of the DSH adjustment.

In March, 2006 it became public that CMS had omitted data from its calculations and had used a systemically flawed process to determine numerous hospitals' SSI fractions resulting in underpayments to providers.

Of course, within 180 days after this information became public, other providers filed complaints with the Board challenging their DSH adjustments for cost years 1987 through 1994. These appeals were more than a decade late—unless, as the appealing hospitals argued, the time to appeal was equitably tolled due to CMS's failure to inform them that the SSI fractions had been based on faulty data. In its January 22, 2103 decision on the appeals of the other providers, the Supreme Court in *Sebellius v. Auburn Regional Medical Center*, 2013 DJDAR 936, acknowledged that "[the methodological errors revealed by the Board's Bayside decision (the provider in whose appeal this issue arose) would have yielded similarly reduced payments to all providers for which CMS had calculated an SSI fraction."

The Supreme Court granted certiorari to resolve a conflict between circuits as to whether the 180-day limit, as extended to three years for good cause, was jurisdictional. Without much ado, it held that the time limit, like most filing deadlines, was not jurisdictional.

The tougher issue, at least from the perspective of the hospitals, was whether the regulation imposing the time limit should be equitably tolled to adhere to the "fundamentals of fair play," citing regulations permitting the reopening of an FI's reimbursement determination if "it was procured by fraud . . . or similar fault."

But the Supreme Court saw things differently. It held that the "Irwin presumption" of equitable tolling does not apply to an agency's internal appeal deadline; the theory of that presumption that it was a realistic assessment of legislative intent did not apply in an administrative context in which the Secretary was authorized to establish the Board and was given rulemaking authority; and that, unlike the equitable tolling applied to many statutes that were designed to be "unusually protective of claimants," this statute applies to "sophisticated institutional providers assisted by legal counsel and generally capable of identifying an underpayment within the 180-day time period"; and that "[a]s repeat players who elect to participate in the Medicare system, providers can hardly claim lack of notice of the Secretary's regulations." The Secretary lawfully exercised her rulemaking authority in providing for a three year good cause extension. The imbalance in the time of the intermediaries to discover overpayments versus the providers to discover underpayments was justified by the intermediaries dealing with tens of thousands of cost reports.

I question the statement that the providers could have discovered the underpayment within 180 days after the FI determination. How? They didn't learn until 2006 that the SSI fractions underlying DSH calculations had been based on faulty data and methodology which they correctly applied in submitting their Medicare cost reports. Sophistication aside, these rates will vary from year to year. I surmise, then, that the hospital that identified the

issue experienced changes in its individual data that were well beyond the expected range of variation. To support this supposition, please consider that the identifying hospital appealed the SSI factor determination for 1993-1996, while the Board later determined that the systemic error applied to 1987-1994. Clearly, the Supreme Court does not understand how complicated the calculation of the SSI fractions is, and how dependent the provider is on data collected and manipulated by the government. That data is the starting point from which the provider's cost report expert negotiates with the government.

Should providers routinely appeal cost reports just in case, years later, they learn that the government made a mistake and underpaid them? Recall that the providers being stiffed are the ones that handle a disproportionate share of low income Medicare and Medicaid beneficiaries.

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