PUBLICATION

HHS Psychiatric Hospital Reimbursement Methodology Upheld [Ober|Kaler]

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On December 29, 2015 the U.S. Court of Appeals for the District of Columbia rejected a challenge to a psychiatric hospital's pre-PPS Medicare reimbursement. *Washington Regional Medicorp v. Burwell* [PDF], No. 1:13-cv-00622 (D.C. Cir. Dec. 29, 2015).

Fayetteville, a psychiatric hospital, challenged the method that the Department of Health and Human Service (HHS) had used to calculate the hospital's reimbursement for services it provided in 2003 and 2004 – the two years after a statutory cap on reimbursement expired, but before psychiatric hospitals were moved to the prospective-payment system. The Court of Appeals found that HHS acted reasonably in allowing the cap to "echo" into the reporting periods for 2003 and 2004, beyond its expiration.

Background

In 1982, Congress directed HHS to develop a legislative proposal for a prospective-payment system (PPS) whereby hospitals would receive a fixed amount for services, rather than receiving reimbursement for the hospital's actual costs (which were rapidly rising nationwide). This was known as the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), and HHS developed associated regulations to implement the same. In the interim, Congress established limits on the annual rates of increase to cap hospital reimbursement based on actual costs, which tied reimbursement to a "target amount" for the relevant cost year. Essentially, the previous 12-month period for a hospital, as adjusted by an applicable percentage increase, was used to set the following year's reimbursement.

Most hospitals used the PPS starting in 1983, but certain hospitals, including psychiatric hospitals, were initially excluded from the PPS system. HHS continued to reimburse such hospitals based on actual costs so long as those costs did not exceed the limits set by TEFRA. However, significant variation occurred among exempt hospitals nationwide, so Congress imposed an additional cap for these hospitals under the Balanced Budget Act of 1997 (BBA). Under the BBA, the target amounts for fiscal years 1998-2002 could not exceed the 75th percentile of target amounts for all hospitals in the same class for cost reporting periods ending during fiscal year 1996, adjusted annually during the 5-year period. Finally, Congress directed HHS to migrate psychiatric hospitals to the PPS on or after October 1, 2002. In amending its regulations to bring them in line with the BBA cap, and recognizing the mandate to migrate the exempt hospitals to PPS by October 1, 2002, HHS specified that its changes applied to cost reporting periods beginning on or after October 1, 1997, through September 30, 2002.

HHS, however, was unable to migrate psychiatric hospitals to PPS until January 1, 2005. During this gap, HHS continued to calculate psychiatric target amounts under the TEFRA methodology. Thus, the 2003 target amount was calculated by adding the applicable percentage increase to the 2002 target amount (which had been subject to the BBA cap), and the 2004 target amount was calculated by adding the applicable percentage increase to the 2003 target amount.

Fayetteville's 2003 and 2004 Reimbursement

Initially, the fiscal intermediary informed Fayetteville that it would be reimbursed based on its hospital-specific target amount (which relies on net allowable costs, not the previous year's target amount) for 2003 and 2004. The fiscal intermediary, however, subsequently revised its calculation to reflect the previous year's target amount, resulting in reduced reimbursement for both years at issue because the 2003 reimbursement was affected by the 2002 BBA cap in place, and by extension, the 2004 reimbursement was similarly affected based on the 2003 target amount. Fayetteville appealed, arguing that this calculation improperly extended the BBA cap beyond its expiration on September 30, 2002 and contravened Congress's plain language. In response, HHS argued that the plain language of TEFRA's 12 month cost reporting calculation required its treatment of the 2003-2004 reporting periods for Fayetteville, as affected by the 2002 BBA cap.

The Rulings

The District Court for the District of Columbia, applying the two-step *Chevron* analysis, found that the statute unambiguously required HHS to calculate the reimbursement as it had and, in the alternative, that even if the statue was ambiguous, HHS's interpretation of the statute and its implementing regulations was reasonable, and not an improper retroactive change because HHS did not alter its method of calculating target amounts.

The D.C. Circuit affirmed, stating: "insofar as there is any ambiguity in the statute, we would uphold HHS's interpretation with or without *Chevron* deference because HHS's interpretation is not only reasonable but also the best interpretation of the statute." Essentially, the court found that Congress mandated that psychiatric hospitals migrate to the PPS immediately after the expiration of the BBA caps. According to the court, Congress did not anticipate any gap between the two systems of reimbursement, and therefore did not speak to how HHS would handle the target amounts during any subsequent gap. As such, HHS's interpretation was not against the plain language of the statute, but instead was a reasonable interpretation in the absence of any direction.

The court had little doubt that reverting to the pre-PPS method of calculating reimbursement perpetuated the effect of the BBA cap beyond September 30, 2002, but found that such "echo effect" was not contrary to the statute. Further, the court concluded, HHS's action was consistent with Congress's progressive effort to move hospitals from an actual cost system to a system based on national standards and objective characteristics. Congress did not intend to reverse the effects of TEFRA and the BBA and have HHS return to an actual cost system for psychiatric hospitals. HHS's own regulations, too, which limited the BBA cap to a 5 year period, were consistent with the best reading of the statute. Congress clearly meant to put a cap on reimbursement which would not necessarily result in hospitals receiving reimbursement for all reasonable operating costs incurred during a given reporting period. HHS's method was consistent with this purpose, even with the BBA cap echoing into 2003 and 2004.

Ober|Kaler's Comments

The D.C. Circuit's decision is at odds with a decision from the Fifth Circuit that reached the opposite conclusion. *See Hardy Wilson Mem'l Hosp. v. Sebelius*, 616 F.3d 449, 457-61 (5th Cir. 2010). Nonetheless, the D.C. Circuit's decision is consistent with a line of cases favoring HHS's discretion to interpret congressional intent when implementing reimbursement legislation.