

HEALTH CARE LAW

Hospitals want bigger piece of Medicare pie

There is growing litigation over the federal "disproportionate share hospital" adjustment supplement.

By John R. Jacob

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THE DISPROPORTIONATE share hospital (DSH) adjustment, the largest Medicare payment supplement to the reimbursements that hospitals receive for in-patient services, is given to hospitals that treat a significant number of low-income patients. Its intent is to compensate hospitals for the high costs of providing health care to these patients and to ensure access to high-quality care for the poor and uninsured populations. These goals are being thwarted, however, by continuous disagreements and litigation between hospitals and the government.

Medicare DSH payments represent a critical source of hospital revenues. The Medicare Payment Advisory Commission has estimated that DSH payments comprise 6.5% of hospitals' total Medicare in-patient payments, with significantly higher percentages at urban and major teaching hospitals. Moreover, according to the Congressional Budget Office, DSH payments, which totaled approximately \$4.8 billion in 1998, are expected to reach \$6.1 billion by 2008.

From the day that Congress mandated the creation of the DSH adjustment, the Centers for Medicare & Medicaid Services (CMS) has shown a great reluctance to implement the adjustment. (CMS is the federal agency within the U.S. Department of Health and Human Services that is responsible for running the Medicare and Medicaid programs. It maintains a Web site at www.cms.gov.) As a result, given the significance of these payments to hospitals, the history of the DSH adjustment is peppered with litigation. Over the past 20 years, hospitals have been fighting for their right to receive DSH payments and challenging the calculation of their DSH adjustments. In light of the history of the adjustment, and the fact that many hundreds of cases regarding the adjustment continue to this day before the Department of Health and Human Services' Provider



John R. Jacob

Reimbursement Review Board, an administrative tribunal that hears significant Medicare payment disputes, and in federal courts across the country, such litigation is not likely to end anytime soon.

Under the Medicare in-patient prospective payment system, hospitals are reimbursed on the basis of prospectively determined rates for each inpatient, which are based upon the patient's diagnosis. When Congress enacted the prospective-payment system as part of the Social Security Amendments of 1983, Pub. L. No. 98-21, § 601(e), it authorized CMS to provide for a DSH adjustment to the prospective-payment-system payments for hospitals that serve a disproportionate share of low-income patients. This reflected a congressional judgment that such patients are usually in poorer health and cost more to treat than other patients and that this unavoidable cost differential should be reflected in the prospective-payment-system rates. Without this adjustment, Congress found that hospitals treating a significant number of poor patients would be severely disadvantaged under the prospective-payment system.

Since the beginning of the prospective-payment system, however, CMS has shown an institutional antipathy to the concept of the adjustment. Despite the express congressional authorization to develop the DSH adjustment, CMS has declined to promulgate implementing regulations. At the time, CMS supported this decision by noting that its current data did not show that an adjustment was warranted.

See 49 Fed. Reg. 234, 276 (Jan. 3, 1984).

Displeased with this lack of administrative action, in the Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2315(h), Congress again directed CMS to publish a definition of disproportionate low-income hospitals and identify which hospitals met that definition by Dec. 31, 1984. CMS still refused to act on this congressional mandate.

Frustrated with CMS' continued disregard for Congress' directives, in *Samaritan Health Center v. Heckler*, 636 F. Supp. 503 (D.D.C. 1985), a group of hospitals obtained a court order from the U.S. District Court for the District of Columbia directing CMS to promulgate rules implementing the DSH adjustment. Consequently, tired of waiting for CMS to act, and seemingly unable to compel any action, Congress took the issue into its own hands, and in the Comprehensive Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-272, § 9105, amended the Medicare Act to prescribe a statutory definition of disproportionate-share hospitals and the formula for calculating the DSH adjustment.

The DSH adjustment (found at 42 U.S.C. 1395ww(d)(5)(F)(vi)) is calculated according to a formula that is based upon the determination of a hospital's "disproportionate patient percentage," which is an estimate of the amount of care provided to poor patients. This percentage is defined as the sum of two proxies for low-income patients. The first proxy, known as the Supplemental Security Income (SSI) Percentage, accounts for those patients who are Medicare beneficiaries entitled to SSI, a federal, low-income welfare program. The second proxy, the so-called Medicaid Proxy, covers those patients eligible for medical assistance under a Title XIX state plan, but not entitled to Medicare.

Most of the DSH litigation to date involves these proxies. For instance, a growing number of cases is currently being brought before the Department of Health and Human Services' Provider Reimbursement Review Board, challenging the SSI percentages used in calculating hospitals' DSH adjustments. Notably, CMS annually calculates every hospital's SSI percentage. While hospitals have long believed that these percentages were improperly low, CMS has consistently denied hospitals' attempts to obtain the data supporting them. It

John R. Jacob is senior counsel in the health industry practice in the Washington office of Akin Gump Strauss Hauer & Feld. Jacob was designated one of the plaintiffs' coordinating counsel in the *In re Medicare Reimbursement Litigation* cases. He can be reached at jjacob@akingump.com.

will be quite some time before these cases make their way into the federal courts, but the reimbursements at issue are substantial and their significance cannot be underestimated.

The vast number of cases regarding the DSH adjustment pertains to the Medicare program's interpretation of the types of days to be included in the Medicaid Proxy. Most of these cases involve CMS' narrow interpretation of Congress' DSH adjustment in its implementing regulations. In that regard, to implement the DSH adjustment created by Congress, the centers finally issued 42 C.F.R. 412.106. However, through its regulation, CMS once again attempted to minimize the DSH adjustment.

Even though the Medicare Act requires that the Medicaid Proxy include all days for which patients "were eligible for medical assistance under a State plan approved under title XIX," under CMS' rule, whether the patient's day of care was counted turned upon whether a state's Medicaid program paid for that day, and not whether the patient was eligible for medical assistance under a state Title XIX plan on that day. As intended, this policy significantly understated hospitals' DSH adjustments.

A flood of suits over 'days'

Thereafter, hospitals brought hundreds of cases before the Provider Reimbursement Review Board, and this issue was litigated extensively in courts across the country, leading to the conclusion that CMS' DSH policy was unlawful. Indeed, every court to consider the issue rejected CMS' interpretation of the Medicare Act. See, e.g., *Legacy Emanuel Hosp. & Health Ctr. v. Shalala*, 97 F.3d 1261 (9th Cir. 1996); *Deaconess Health Servs. Corp. v. Shalala*, 83 F.3d 1041 (8th Cir. 1996); *Cabell Huntington Hosp. Inc. v. Shalala*, 101 F.3d 984 (4th Cir. 1996); *Jewish Hosp. Inc. v. Health and Human Services*, 19 F.3d 270 (6th Cir. 1994).

Given the universal rejection of its position, on Feb. 27, 1997, CMS issued Ruling 97-2. In it, the CMS conceded that all days of inpatient care to patients eligible for medical assistance under a state Title XIX plan (who are not eligible for Medicare Part A) should be counted in the Medicaid Proxy regardless of whether a state actually paid for the day. Thus, CMS finally admitted that all days for patients eligible for medical assistance under a state Title XIX plan should be included in a hospital's DSH adjustment calculation.

Moreover, after admitting that its DSH payment guidance "was not sufficiently clear," in December 1999, CMS issued Program Memorandum A-99-62, which purported to clarify the types of days to be included in the Medicaid Proxy. Not surprisingly, hospitals have since brought numerous challenges to the validity of the program memorandum, which was not issued pursuant to notice and comment

rule-making, as well as to CMS' categorization of days that are properly includable in the Medicaid Proxy of the DSH calculation.

Even after CMS acknowledged that its prior DSH policy regarding Medicaid eligible but unpaid days was wrong, it refused to reopen

Most cases pertain to types of days in Medicaid Proxy.

hospitals' cost reports to correct past DSH payments. Ruling 97-2 was applicable to hospitals' unsettled cost reports and cases in which appeals on this DSH issue were still pending. Significantly, however, CMS stated that intermediaries would not reopen settled cost reports based upon this issue. As a result, hospitals serving a significant number of low-income patients were deprived of hundreds of millions of dollars in DSH payments to which they would have otherwise been entitled under the CMS' new DSH policy.

The 'Monmouth' case

In 2001, in *Monmouth Medical Center v. Thompson*, 257 F.3d 807 (D.C. Cir. 2001), the U.S. Circuit Court for the District of Columbia declared this reopening prohibition unlawful. The court found that the hospitals were entitled to equitable mandamus relief because the hospitals had exhausted all of their administrative remedies. The court also held that Ruling 97-2 provided notice that CMS' prior interpretation of the Medicare Act was inconsistent with the law. Therefore, 42 C.F.R. 405.1885(b) of the Medicare regulations imposed a clear duty on the intermediaries to reopen the hospitals' DSH payment determinations that were made in the three years prior to Ruling 97-2. Id. at 814-15.

By early 2003, hospitals had filed approximately 260 cases in the U.S. District Court for the District of Columbia seeking relief under an extension of the *Monmouth* doctrine. These cases, representing more than 2,500 hospital fiscal years, were consolidated by the court into an action captioned *In re Medicare Reimbursement Litigation*, Misc. No. 03-0090. Under the case-management plan filed by the parties, all of the cases in the consolidated litigation were stayed pending the outcome of its lead case, *Baystate Health System v. Thompson*.

The hospitals in *Baystate*, unlike those in *Monmouth*, had not filed in a timely fashion reopening requests on the DSH issue. Nonetheless, the hospitals argued that based upon the *Monmouth* decision, such requests were not necessary and that mandamus relief was appropriate to correct their erroneous DSH adjustment determinations that were issued in

the three years preceding Ruling 97-2.

In a March 2004 decision, *Baystate Health System v. Thompson*, 309 F. Supp. 2d 89 (D.D.C. 2004), the U.S. District Court for the District of Columbia ruled overwhelmingly in the hospitals' favor and found that mandamus relief was indeed appropriate. The court ruled that *Monmouth* had established that Ruling 97-2 sufficed to serve as clear notice to intermediaries that CMS' previous interpretation of the Medicaid Proxy was inconsistent with the Medicare Act. Moreover, the court found that it would have been futile for the hospitals to have submitted reopening requests to their intermediary or to have pursued appeals before the Provider Reimbursement Review Board. Finally, under 42 C.F.R. 405.1885(b), intermediaries had a mandatory duty to reopen cost reports issued within the three years before Ruling 97-2 to correct the hospitals' DSH adjustments, even absent a timely reopening request by the hospitals to do so. Id. at 96-98.

As expected, the government has appealed this decision to the D.C. Circuit. Given the number of hospital fiscal years at issue in these consolidated cases, if the D.C. Circuit also rules in the hospitals' favor, this may be the most significant Medicare reimbursement litigation since the inception of the Medicare program. However, even then the story may not be over. In *Bartlett Memorial Medical Center Inc. v. Thompson*, 347 F.3d 828 (10th Cir. 2003), the 10th Circuit recently declined to follow the *Monmouth* doctrine and grant the hospitals mandamus relief. In the event that the hospitals are victorious on appeal in *Baystate*, it is likely that the U.S. Supreme Court will resolve this split between the circuits and provide the last word on the application of Ruling 97-2.

To be sure, the outcomes of the *In re Medicare Reimbursement Litigation* cases, the SSI percentage challenges, claims regarding Program Memorandum A-99-62 and the other DSH issues that are making their way through the Provider Reimbursement Review Board and the federal courts are anything but certain. As long as the adjustment remains a significant part of hospitals' Medicare payments, and CMS attempts to limit these payments, the litigation will surely continue. In the meantime, both hospitals and the government are expending valuable resources in their fight, and the aim of the adjustment—to compensate for the high costs of providing care to low-income patients and to ensure access to quality care—remains unfulfilled.

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