PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2000-D74

PROVIDER -
Columbia/HCA 1984-1986 PPS Federal Rate/ Malpractice Group

Provider Nos. Various

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/ Blue Cross of Florida

DATE OF HEARING-
June 4, 1998

Cost Reporting Periods Ended -
December 31, 1984, 1985 and 1986

CASE NOs. 88-1494G, 88-1495G, and 88-1496G

INDEX

ISSUE:

Should the federal portion of the prospective payment system (APPS@) rate be adjusted because it was based on 1981 hospital cost report data which incorporated an invalid method of reimbursing malpractice costs, that is, the 1979 malpractice rule?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Under PPS, payments to hospitals for inpatient services provided to Medicare beneficiaries are based upon a Aprospective payment rate@ for each hospital discharge that is unrelated to an individual hospital=s costs. 42 U.S.C. ' 1395ww(d)(1). The Secretary was instructed to adopt a methodology for determining PPS using Adiagnosis-related groups@ (ADRGs@). 42 U.S.C. ' 1395ww(d)(2). In addition, the statute requires that PPS be calculated based on data from Athe most recent cost reporting period for which data are available.@ 42 U.S.C. ' 1395ww(d)(2)(A). The methodology for establishing the initial PPS rates were set on September 1, 1983. 48 Fed. Reg. 39752 (September 1, 1983) (interim rule) and 49 Fed. Reg. 234 (January 3, 1984) (final rule). The federal PPS rates were used beginning in federal fiscal year 1984, with a four year transition period. During the transition period, a portion of a hospital=s Medicare payments was based on the previous cost-based system. This portion was referred to as the Ahospital specific portion.@ The portion unrelated to the individual hospital=s costs is referred to as the Afederal portion.@ This case concerns only the federal portion. The Providers seek prospective relief, as well as additional reimbursement for their fiscal years (AFYs@) 1984, 1985 and 1986. After 1987, when the PPS was fully implemented, the relief sought pertains to the entire PPS rate.

The federal portion of the PPS rate was derived from Medicare cost reports for reporting periods ending in calendar year 1981. 48 Fed Reg. 39752, 39763 and 49 Fed Reg. 234, 251. Because hospitals were required to file cost reports consistent with regulations in effect at the time, the PPS rates are based on data derived from 1981 Medicare cost reports that were generally filed consistent with regulations applicable in 1981.

Once the base year amounts were determined, they were modified to update them for inflation and other factors, however, the basic building block of the federal rate, the data from the cost reports in 1981, have never been revised or updated. This 1981 base year data included malpractice costs calculated pursuant to the A1979 Malpractice Rule@ which was in effect at that time. This rule was invalidated by numerous courts, and eventually HCFA acquiesced to the court rulings. Subsequently, HCFA adopted a new methodology for calculating malpractice costs, the A1986 Malpractice Rule@ and attempted to apply it retroactively. The courts invalidated HCFA=s attempt to retroactively apply the 1986 Malpractice Rule and ultimately HCFA was required to return to the Apre-1979 methodology@ for the periods from 1979 through 1986. The correction, however, only pertained to the cost-based reimbursement portion and thus, only the hospital specific portion of the PPS rate was corrected

retroactively. The instant case challenges the incorporation of the illegal 1979 Malpractice Rule present in the 1981 base year data that it used to calculate the federal portion of the PPS rate.

The Providers in this group have appealed their notices of program reimbursement in accordance with the jurisdictional requirement of the Provider Reimbursement Review Board (ABoard@) at 42 C.F.R. '' 405.1835-.1841. The Medicare reimbursement in controversy for Case Nos. 88-1494G; 88-1495G; and 88-1496G are $134,459, $1,450,829, and $3,592,221, respectively.

The Provider was represented by John R. Hellow, Esquire, and Bryone J. Gross, Esquire, of Hooper, Lundy and Bookman, Inc. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER=S CONTENTIONS:

The Providers seek an upward adjustment to the federal portion of the payments they received pursuant to Medicare PPS for inpatient hospital services. This claim for additional payments is based on the Providers= contention that the standardized payment, the building block of the PPS rate, did not properly account for costs incurred by hospitals for malpractice insurance premiums. This occurred because the amount of malpractice costs in the PPS base year, used as a basis for all succeeding PPS payments, was calculated pursuant to an illegal regulation. The Providers contend that the failure to adjust the PPS rate to properly account for malpractice costs would illegally cement into place a policy which has unanimously been declared unlawful by the courts.

The Providers seek additional reimbursement for the fiscal years under appeal and/or for HCFA to prospectively adjust the PPS base rate to account for the proper inclusion of malpractice costs for fiscal years beginning after the date of the Board=s decision.

The Providers contend that the PPS rates incorporated an unlawful policy for the calculation of malpractice costs, and a correction can easily be made. The Providers reviewed how the PPS rate was constructed.[1] The Secretary chose a Abase period,@ pursuant to statutory instruction to calculate the PPS rates based on data from Athe most recent cost-reporting period for which data are available.@ 42 U.S.C. ' 1395ww(d)(2)(A). The Secretary used base year data from Medicare cost reports for hospital reporting periods ending in calendar year 1981. 48 Fed. Reg. 39,752, 39,772 (September 1, 1983). The standardized amount, the basic building block of the federal rate, remains to this day, based on cost data from the 1981 cost reports.

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[1] See Providers= Position Paper (APPP@) at 2-4 and Tr. at 49-64.

Under the methodology in effect prior to 1979, malpractice costs were included as Ageneral and administrative@ (AG&A@) costs.[2] Then, in accordance with standard cost-reporting methodology, they were allocated among cost centers along with other overhead costs, and then apportioned between Medicare and non-Medicare patients in proportion to their utilization of services. By contrast, under the 1979 Malpractice Rule, the Secretary reimbursed malpractice costs by directly apportioning hospitals= malpractice insurance premium costs based on the ratio of malpractice losses paid to Medicare patients compared to losses paid to all patients.[3] Under the 1979 Malpractice Rule, the calculation was based on the last five years of a hospital=s malpractice history. If the hospital had no malpractice losses over the five years, then a national rate would apply. If the hospital did have losses, but there were only non-Medicare claims, then the hospital would receive no reimbursement for malpractice costs.[4] The 1979 Malpractice Rule was eventually unanimously declared illegal by eight Circuit Courts of Appeal.[5] The Secretary=s attempt to impose another methodology, the 1986 Malpractice Rule was also struck down by the courts, and the pre-1979 methodology remains in effect today.

Because, the 1979 and 1986 Malpractice Rules were declared to be void ab initio, they were never properly or legally in effect. 5 U.S.C. ' 706(2). The only approved and legal rule for determining malpractice costs has always been the pre-1979 methodology, i.e., including malpractice costs in G&A and allocating them down to the various cost centers through the step-down allocation cost reporting process. Because, the PPS rate was based on cost reports from 1981, when the illegal 1979 Malpractice Rule was in effect, it incorporated improper data on malpractice costs. This is significant for hospitals, because the calculations in accordance with the 1979 malpractice Rule resulted in malpractice costs which were less than those actually incurred by hospitals. Thus, some correction must be made, so that the PPS rate will truly reflect average national hospital costs, as Congress originally intended.

The Providers= indicate that they have presented a methodology that can be used to correct the PPS rate which has not been challenged by the Intermediary. The Providers have presented a methodology for correcting the rate, which was developed by Dr. Michael L. Vaida, a renowned expert in Medicare payment policies and the use of complex health care data bases.[6] The Providers have presented a detailed report prepared by Dr. Vaida, which explains his recalculation of the PPS rates, to remove

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[2] See PPP at 4-11.

[3] Tr. at 64-68.

[4] Tr. at 67-68.

[5] See PPP at 7-8.

[6] Tr. at 41-49 and Providers= Exhibit 18.

malpractice costs as calculated by the illegal 1979 Malpractice Rule and replace those costs with malpractice costs calculated pursuant to the legal pre-1979 Rule.[7]

In addition to Dr. Vaida=s testimony, the Providers also presented testimony from Dr. Allen Dobson, a distinguished health care economist, and former Director of Research at the HCFA from 1982 to 1986, during the time when PPS was first implemented.[8] Dr. Dobson thoroughly reviewed Dr. Vaida=s methodology, and testified that the methodology was valid.[9] Dr. Dobson also specifically noted that the margin of error in Dr. Vaida=s recreation of the PPS rates was not significant.[10] Further, Dr. Dobson testified that it was reasonable for Dr. Vaida to use 1982-83 malpractice premium cost data as a proxy for 1981 data, since the actual 1981 data are unavailable.[11]

Several points about the data were made at the hearing. First, it was noted that the adjustments sought by the Providers are actually very small on a case-by-case basis.[12] However, when this adjustment is applied to all hospital discharges, it can amount to significant dollars. So, it is not a meaningless remedy that the Providers are seeking, especially in cases where Providers may have been operating very close to profit margins.[13] Moreover, regardless of the size of the per discharge adjustment which is being sought, the Providers are legally entitled to this remedy as long as the minimum jurisdictional requirements for the group appeal have been met, which is undisputed.

It was also noted that the data used by the Secretary in developing the PPS rates was unaudited data, because of Congress= instruction to use the most recent data available. In fact, the Secretary estimated that the use of unaudited data had about a 1 percent impact on the PPS rates, which was more than made up for when the Secretary decided to grant a zero market basket increase to the PPS rates for 1986, to account for this and for other reasons the Secretary believed the rates were overstated. 50 Fed. Reg. 35646, 35704 (September 3, 1985). Thus, at least beginning with 1986, the fact that unaudited base year data had been used no longer had an impact on the PPS rates. Moreover, while the data may have been unaudited, the fact is that a large proportion of the hospitals reported

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[7] See Providers= Exhibit 19, PPP at 22-26 and Tr. at 69-118.

[8] Tr. at 141-148 and Providers Exhibit 24.

[9] Tr. at 160.

[10] Tr. at 152-153.

[11] Tr. at 157-158.

[12] Tr. at 171-72.

[13] Tr. at 172.

malpractice costs in accordance with a regulatory policy that was declared to be illegal.[14] Inaccuracies in the data resulting from the fact that it was unaudited, or possibly for other unavoidable reasons, are quite different from inaccuracies resulting from an illegal policy. The courts have already noted that it would be highly improper to allow an unlawful policy of the Secretary to be cemented into place by failing to allow for retroactive corrections. Georgetown University Hospital et al. v. Bowen, 862 F.2d 323, 328 (D.C. Cir. 1988).

The Intermediary presented no testimony or other evidence critical of Dr. Vaida=s methodology, nor did they argue that the methodology was not valid. Accordingly, if the Board agrees with the Providers that it has the authority to order corrections to the PPS rate, then the Board should order that Dr. Vaida=s methodology be used to correct the PPS rates.

A preponderance of the Board=s hearing questions, and the entirety of the Intermediary=s argument at the hearing for this matter concerned itself with the statutory authority to correct this particular problem. The Providers= arguments address the Board=s statutory jurisdiction to address corrections to the PPS rate, the limitations on that jurisdiction, and the Board=s supposed authority to grant prospective relief in light of the decision in Methodist Hospital of Sacramento v. Shalala, 38 F.3d 1225 (D.C. Cir. 1994) (AMethodist@).

The Board=s jurisdiction and authority flow from the only provision of the Medicare Act which even mentions the Board, 42 U.S.C. ' 1395oo. It states that:

> [a]ny provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board . . . and (except as provided in subsection (g) (2) of this section) any hospital which receives payments in amounts computed under subsection (b) or (d) of ' 1395ww of this title and which has submitted such report within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such Payment by the Board, if (1) such provider - (A) . . . (ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of ' 1395ww of this title . . . .

42 U.S.C. ' 1395oo(A) (emphasis added).

Subsection (d) of 42 U.S.C. ' 1395ww is the statutory provision authorizing PPS, including subsection 1395ww(d)(2)(A) requiring that in establishing a national adjusted DRG prospective payment rate Athe

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[14] Tr. at 86.

Secretary shall determine the allowable operating costs per discharge of inpatient hospital services for the most recent cost-reporting period for which data are available.@ Id. The exclusions from review are addressed in subsection 1395oo(g)(2) and are addressed more fully below, but clearly do not apply to this case.

The legislation governing the Board=s jurisdiction could not be clearer on the issue of review of PPS payment determinations. Section 1395oo(A) specifically provides that any hospital which receives payment amounts under PPS may obtain a hearing with respect to such payment by the Board, if such provider is dissatisfied with a final determination of the Secretary as to the amount of that payment. The fact that Congress chose to exclude some aspects of PPS from review further supports the conclusion that Congress was unconcerned about corrections to other aspects of the PPS rate which may be necessary to otherwise comply with the law. In the instant case, such noncompliance with the definition of Aallowable@ costs is premised on the application of an unlawful regulation, the 1979 Malpractice Rule.

This grant of authority to consider the correction of errors in PPS payments is also supported by the PPS legislative history.[15] In brief, the Senate committee responsible for PPS expressed its position that the changes made by PPS would not impact administrative and judicial review, by indicating that the same conditions which now apply for review by the Board and the Court would continue to apply except in the Anarrow@ cases necessary to maintain budget neutrality and avoid adversely affecting the establishment of DRGs.[16] This view of the legislative history was confirmed by Dr. Dobson, present at the bill drafting, and who noted the exclusions from review were intended to be narrow, the same constraint contained in the legislative history.[17]

If there was any doubt regarding Congress= intent that the majority of payment provisions under PPS would be reviewable and correctable, in 1997, Congress created a PPS for skilled nursing facilities. See Balanced Budget Act of 1997, P.L. 105-33, '' 4431-4432. For example, in developing a PPS for skilled nursing facilities, and discussing administrative and judicial review, Congress provided that:

> [t]here shall be no administrative or judicial review under section 1869, 1878, or otherwise of -
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> (A) the establishment of federal per diem rates under paragraph (4), including computation of the standardized per diem rates under paragraph (4) (C),

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[15] See PPP at 13.

[16] Id.

[17] Tr. at 192 (there is a typographical error at p.192, line 7, the word Acouldn=t@ should read Acould.@)

> adjustments and corrections for case mix under paragraphs (4)(F) and (4)(G)(i), and adjustments for variations in labor-related costs under paragraph (4)(G)(ii);
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> (B) the establishment of a facility=s specific rates for January 1, 1999, (except any determination of costs paid under part A of this title; and
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> (C) the establishment of traditional amounts under paragraph (7). [42 U.S.C. ' 1395yy(e) (8).]

Id.

Thus, when Congress did not want the standardized amount under a PPS to be reviewed, it specifically so stated. Congress also could have used the opportunity under the Balanced Budget Act of 1997, P.L. 105-33, to amend the inpatient hospital service PPS appeal rights to correspond with those of the skilled nursing facility PPS system, but it didn=t do that either.

Thus, the very language of the Board=s authorizing legislation, 42 U.S.C. ' 1395oo, the legislative history accompanying the inpatient PPS changes in 1983, and Congress= recent visitation on PPS in the context of skilled nursing facilities all points to the inescapable conclusion that Congress did intend that the standardized amount under inpatient PPS be reviewable and correctable when aspects of it are inconsistent with the law. This clear statutory right of providers to procure such review and correction is not contradicted by any regulation of the Secretary. In fact, the Secretary has posited that corrections to the standardized amounts can be made. 50 Fed. Reg. 35646, 35704, col. 1 (last paragraph) (Sept. 3, 1985). One possible method is through negative update factors, or through no update factor when one otherwise would be appropriate. Id. Even if such regulation did exist, it would be contrary to the express terms of the statute.

The Intermediary=s position in this case eludes to a potential budget neutrality problem to argue for the lack of remedy in this case. That has no support under those PPS items precluded from review by the Board and the courts. Under 42 U.S.C. ' 1395oo(g)(2):

> [d]eterminations and other decisions described in ' 1886(d) (7) [42 U.S.C. ' 1395ww(d)(7)] shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) or otherwise.

The cross-referenced subsection, 42 U.S.C. '1395ww(d)(7), provides that there shall be no administrative or judicial review of the determination of the requirement, or the proportional amount of any adjustment affected pursuant to 42 U.S.C. ' 1395ww(e)(1), which concerns the budget neutrality

adjustment. The Providers here are not requesting a review of the determination of the requirement for a budget neutrality adjustment, nor are they requesting a revision to any portion of the budget neutrality adjustment, the only such requests that are foreclosed from review under 42 U.S.C. ' 1395ww(d)(7).

Additionally, the budget neutrality adjustment, which was designed to insure that aggregate payments in the first two years of PPS equal what would have been paid under the Tax Equity and Fiscal Responsibility Act of 1982, P.L. 97-248 (ATEFRA@), is completely unaffected by the kind of adjustment to the standardized amount that is being requested in this case.[18] The budget neutrality adjustment for the hospital-specific portion and the federal portion of the PPS rate are essentially the same calculation.[19] In HCFA Ruling 91-1, when the Secretary conceded the need for a change in the hospital-specific portion of the PPS rate to take into account the use of the invalid 1979 Malpractice Rule, she remained unconcerned that the budget neutrality adjustment would need to be modified to account for that change. This is because under TEFRA, the law required reimbursement under the pre-1979 methodology for reimbursing malpractice costs, which corresponds with the requested change in the PPS standardized amount. Indeed, such a change in the standardized amount would seem to be required to bring budget neutrality back into balance.[20]

The other matters excluded from review under PPS have not been raised as a concern in this case by the Intermediary or in questioning by the Board.

Only one case of significance has held that an aspect of PPS cannot be retroactively corrected. See Methodist. The Providers believe that they adequately distinguished that case from the current situation.[21] That case involved the wage index portion of the federal rate, wherein the Secretary had adopted a formal policy prohibiting retroactive corrections of the wage index.

However, several aspects of Methodist are relevant. First, the Methodist decision denying a retroactive correction to the wage index is based on a faulty premise, that the Board has the authority to provide prospective relief under 42 U.S.C. ' 1395oo. However, prospective relief has never been provided by the Board, nor could it provide such relief pursuant to the jurisdiction it maintains over providers under its operative authorizing legislation. In 42 U.S.C. ' 1395oo(a), Congress clearly provided that the Board only has jurisdiction over the cost report for which a hearing is sought in the case of cost reimbursed providers, and with respect to payment amounts under 42 U.S.C. ' 1395ww(d) the Board has jurisdiction over PPS payments already made by the Secretary for such reports. Clearly, the

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[18] Tr. at 161-164.

[19] Tr. at 162-63.

[20] Tr. at 162-164 and 189-191.

[21] See PPP at 18-20.

legislation does not authorize the Board or the courts to grant relief for periods not subject to the cost report or payments under appeal.

Moreover, Congress indicated that it was not changing the fundamental nature of review of available relief provided under 42 U.S.C. ' 1395oo, before PPS.[22] If the court in Methodist had realized that the Board lacked the authority to issue prospective relief, it would have been required to conclude that the review procedures available for PPS are meaningless unless retroactive relief, which is the only relief which the Board can provide, is available.

Second, the Intermediary argues that retrospective relief is inconsistent with the notion of a PPS. That issue was addressed in Georgetown at 329-330 wherein the court rejected similar arguments. Here, Dr. Dobson testified he was the HCFA representative assigned to address incentives under the new PPS system and that this requested correction would not disturb such incentives.[23]

For the foregoing reasons, the Board cannot limit its relief to a prospective remedy and should order a correction of the standardized amount for the fiscal years involved in this dispute.

INTERMEDIARY=S CONTENTIONS:

The Intermediary indicates that the federal portion of the PPS was calculated from cost reports which ended in FYE 1981. During that period, the controlling regulation required that the Medicare programs reimbursable costs for malpractice protection was based upon the hospital=s medical malpractice loss ratio or a nationally applicable statistic, the 1979 Malpractice rule. Generally, that would allow less malpractice costs than if malpractice costs were in A&G cost pool.

Subsequent litigation resulted in the Medicare program going back to the traditional A&G method for malpractice expense reimbursement. From that history, the Providers are arguing that the federal rate was always understated and should be revised upwards. The hearing was devoted to the Providers= presentation as to how the difference in malpractice reimbursement methodologies can be quantified so that the federal rate can be mathematically adjusted. The Intermediary contends that this highly technical discussion was premature. There is no legal basis to support changing the federal rate.

The Intermediary contends that the PPS for inpatient hospital operating costs is a product of '1886(d) of the Social Security Act, 42 U.S.C. Section 1395ww(d). PPS became effective for covered hospitals for the first fiscal years beginning on or after October 1, 1983, or FYE September 30, 1984. The

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[22] Id. at 13.

[23] Tr. at 164-168.

legislation was passed on April 20, 1983. For purposes of this appeal, the starting reference is 42 U.S.C. ' 1395ww(d)(2)(a):

> (2) The secretary shall determine a national adjusted DRG prospective payment rate, for each inpatient hospital discharge in fiscal year 1984 involving inpatient hospital services for a subsection (d) hospital in the United States, and shall determine a regional adjusted DRG prospective payment rate for such discharges in each region, for which payment may be made under Part A of this subchapter. Each such rate shall be determined for hospitals located in urban or rural areas within the United States or within each such region, respectively, as follows:
>
> (A) The Secretary shall determine the allowable operating costs per discharge of inpatient hospital services for the hospital for the most recent cost-reporting period for which data are available . . .

Id.

The controversy comes out of the use of the Amost recent cost reporting period for which data are available.@ Id. The statute goes on to describe a number of adjustments and deletions from the cost reporting data pool. There is no further directive as to what period data should be used leaving the choice to the Secretary=s discretion.

The interim final rule pertaining to the establishment of the federal rate, 48 Fed. Reg. 39752, 39763 (September 1, 1983), states the folloing concerning the base year cost report data.

> ' 1886(d)(2)(A) of the Act requires that, in determining allowable costs for the base period, the most recent cost reporting period for which data are available is used. Therefore, we have used Medicare hospital cost reports for reporting periods ending in 1981.
>
> In calculating standardized amounts, we gathered cost reports from nearly all hospitals participating in Medicare, manually extracted necessary information, and prepared the information in computer-readable form. Because this process required a great deal of staff time, there was considerable lag time between the filing of cost reports and the availability of complete data for use by HCFA. Thus, calendar year

> 1981 cost data were the most recent cost reporting period data available for use.

Id.

Because of the short window between the passage of the legislation and the implementation of the PPS system for hospitals that started new fiscal periods on and after October 1, 1983, the choice of 1981 data was clearly reasonable. The rule goes on to describe the types of costs which were to be excluded from the data pool and described the arithmetic which produced the standardized amount. The interim final rule is the most detailed description of the mechanics of establishing the federal rate that exists. There was little relevant discussion in the final rule published on January 3, 1984. The implementing regulation at 42 C.F.R. ' 412.62 did not flesh out the computation of the rate in any more detail.

The testimony of the Provider witness was to describe how the Providers would mathematically extrapolate what it believed the erroneous malpractice reimbursement was and adjust the federal rate accordingly. Although the Intermediary views this testimony as premature, it notes that cost reports from 5,631 providers were included in the core data used to set the federal rate. Only 61 cost reports out of that total were audited. It is common knowledge that the results of an audit are typically less allowable cost and less Medicare reimbursement than an unaudited report.

To review, the PPS was passed giving the Secretary and HCFA a very short turnaround to get the system up and running. A key component of the PPS was the federal rate. By necessity, the federal rate was calculated off of a database in which 99 percent of over 5,600 hospitals information was unaudited. The fact that such a high percentage of cost reports were unaudited would intuitively produce an inflated Federal rate to begin with.

The Intermediary is certainly not second guessing HCFA=s approach, since it was in the Secretary=s realm to use raw or unaudited data out of necessity. What the Providers want to do is to retroactively perfect the data pool for one issue based upon the outcome of subsequent litigation over how one cost should be reimbursed.

The underlying question in this case is whether the Board has any legal basis for determining that the federal rate used to settle the cost reports covered by this appeal were erroneous. The Providers refer to 42 U.S.C. ' 1395ww(d)(7) that specifically eliminates administrative or judicial review of the budget neutrality adjustment or the establishment of DRGs. From that limitation, there is a leap to the conclusion that the Board has unbridled authority to change all other elements of the PPS system if a provider can articulate a complaint.

Even if the Board can review the accuracy of the federal rate, it does not help the Providers case because they must show that the statutory and regulatory implementation of the federal rate was wrong.

That has not been done. The federal rate was established off specific 1981 cost reports that were largely unaudited. Given the timing of the PPS implementation and the broad discretion of the Secretary, using that raw data pool was correct. Therefore, the Providers cannot establish a right to adjust the data pool for one small component.

The Intermediary also asserts that the retroactive correction to the federal rate upsets the budget neutrality portion of the statute. TEFRA, was intended by Congress to control the allowable rate of increase in hospitalÍs inpatient operating costs on a per discharge basis. The Medicare PPS was more sophisticated, because the PPS payments were to be adjusted for the relative weights of each patientÍs diagnosis. As explained in the rule, 48 Fed. Reg 39755 (September 1, 1983), the basis of the federal PPS rates:

> are determined based on the mean urban or rural standard amount per discharge. This amount is then adjusted to account for area differences in hospital wages. The standard amounts per discharge will be updated annually. For FY 84 and FY 85, the prospective payment system must be Abudget neutral.@ That is, payments may not be greater than, nor less than, the payments that would have been paid under the law previously in effect. Beginning with FY 86, the Secretary will determine the update factor taking into consideration recommendations made by a commission of independent experts appointed by the Director of the Office of Technology Assessment.

Id.

The Abudget neutrality@ was mandated by ' 1886(e)(1) of the Act, codified at 42 U.S.C. ' 1395ww(e). It requires that the Medicare PPS payments result in aggregate program reimbursement equal to A[w]hat would have been payable@ under the reasonable cost provisions of prior law. 42 C.F.R. '' 412.62(i), 412.63(c)(2)(iv) and 412.63(q). Thus, for FYs 1984 and 1985, PPS should be Abudget neutral.@ The budget neutrality adjustment to the Federal payments was determined by comparing the estimated total payments for inpatient hospital operating costs for FY 84 and FY 85 that would have been made on a reasonable cost basis under Medicare prior to the Social Security Amendments of 1983, P. L. 98-21. The resulting adjustment factor for the FY 84 federal portion was .969. Therefore, any costs which would have been added to the federal portion of the total PPS rate would have been eliminated by the budget neutrality adjustment factor. If the additional costs would have been included in the original FY 1981 Medicare cost report data, the budget neutrality factor would have been proportionately reduced to compensate for the increase in the estimated federal portion of the total PPS payments.

There is a preponderance of evidence regarding the intent of Congress to control the increase in the growth of Medicare spending, especially in Medicare hospital inpatient services. In order to address those concerns, Congress changed the payment method to a prospective basis in order to control spending and to balance the federal budget. They also intended that the total PPS payments for inpatient hospital services did not exceed what would have been paid out in FYs 1984 and 1985 under previous laws. There was no guarantee that hospitals would be paid Medicare=s share of their actual inpatient operating costs. In FY 1986 and future periods there was further pressure to control spending via the various Omnibus Budget Reconciliation Acts and the Deficit Reduction Act. All of this indicated that there was a fixed pool of money available to pay Medicare providers. If any payment method for Medicare inpatient services had been increased, it would have been taken out of some other payment for Part A services. Congress was not depriving any provider of its share of the total Medicare reimbursement, because there was only so much to go around.

The Intermediary indicates that its position is supported by Methodist, supra. The specific issue in Methodist was HCFA=s rejection of a retroactive correction to the wage index. The wage index is used to adjust the federal rate for a specific hospital locale. The Intermediary sees the wage index as an inseparable element of computing the actual federal rate for any given hospital. Therefore, the rationale the court used to deny a retroactive correction to the wage index applies to the federal rate as a stand-alone element of PPS. The Providers argued that the same rationale for allowing a retroactive correction to the HSR should apply to the wage index used to adjust the federal rate for a specific geography. However, the Methodist case preserved the prospectivity of the federal rate and refused a retroactive correction to the wage index. The same rationale applies to preserving the federal rate.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.:

' 1395oo et seq.	-	Provider Reimbursement Review Board
' 1395ww(d) et seq.	-	PPS Transition Period; DRG Classification System; Exceptions and Adjustments to PPS
' 1395ww(e) et seq.	-	Adjustments to Payments under PPS; Prospective Payment Assessment Commission
' 1395yy et seq.	-	Payment to SNFs for Routine Service Costs

2. Regulations - 42 C.F.R.:

' 405.1804	-	Matters Not Subject to Administrative and Judicial Review Under Prospective Payment
' 405.1835-.1841	-	Board Jurisdiction
' 412.62 et seq.	-	Federal Rates for Inpatient Operating Costs for Fiscal Year 1984
' 412.63 et seq.	-	Federal Rates for Inpatient Operating Costs for Fiscal Years After Federal Fiscal Year 1984

3. Cases:

Georgetown University Hospital et al. v. Bowen, 862 F.2d 323 (D.C. Cir. 1988)

Methodist Hospital of Sacramento v. Shalala, 38 F.3d 1225 (D.C. Cir. 1994)

4. Other:

Administrative Procedure Act - 5 U.S.C. ' 706(2).

Balanced Budget Act of 1997, P.L. 105-33, '' 4431-4432.

Tax Equity and Fiscal Responsibility Act of 1982, P.L. 97-248.

Social Security Amendments of 1983, P.L. 98-21.

48 Fed. Reg. 39752 (September 1, 1983).

49 Fed. Reg. 234 (January 3, 1984).

50 Fed. Reg. 35646 (September 3, 1985).

HCFA Ruling 89-1.

HCFA Ruling 91-1.

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND DISCUSSION:

The Board, after consideration of the facts, parties= contentions, and evidence presented finds and concludes as follows:

The Board finds that the limitation on review of PPS cases do not apply to this case. The Board recognizes that the 1981 data used to develop the PPS rates contained malpractice costs apportioned under the 1979 Malpractice Rule which was later overturned. Although the Provider requests that the PPS rate be retroactively revised, the Board finds that there is no authority to make a retroactive correction. In addition, the Board notes that the decision in the Methodist, case supra, supports the Intermediary=s position that there should not be retroactive adjustments.

The Board notes that the PPS statute placed limitations on the Board=s jurisdiction to review disputes concerning PPS. 42 U.S.C. ' 1395ww(d)(7). These exceptions prohibit the review of Abudget neutrality@ requirements contained in 42 U.S.C. ' 1395ww(e)(1) and disputes concerning the Aestablishment of diagnostic-related groups, of the methodology for classification of discharges within such groups, and of the appropriate weighting factors thereof . . .@ 42 U.S.C. ' 1395ww(d)(7). These exceptions are cross referenced in the statute on Board jurisdiction. 42 U.S.C. ' 1395oo. It states that Board review procedures are available to hospitals receiving PPS payments, except as provided in subsection (g)(2) which pertains to the above noted exceptions from the PPS statute at 42 U.S.C. ' 1395ww(d)(7). The Board finds that the issue in this case, whether the federal portion of the PPS rates should be adjusted because it was based on 1981 hospital cost report data which incorporated an invalid 1979 Malpractice Rule, does not fall into either limitations on Board jurisdiction. The Board finds that it can determine whether the existing statute and regulations concerning the establishment of the federal portion of the PPS rate require or permit retroactive adjustments.

The Board notes that both parties indicate that the 1981 cost reports used to develop the federal portion of the PPS rates were filed by providers using the 1979 Malpractice Rule. The Board notes that the 1979 Malpractice Rule was subsequently found to be improper and with HCFA Ruling 89-1, cost reports were revised to revert the allocation of malpractice costs to the pre-1979 rule. The Board notes that HCFA adjusted the HSP which was still subject to the old reimbursement rules but that the federal portion of the PPS rate was not adjusted.

The Board notes that when Congress mandated the creation of PPS for each hospital discharge that is unrelated to an individual hospital=s costs. 42 U.S.C. ' 1395ww(d)(1). The statute instructs the Secretary to adopt a methodology for determining the PPS rates based on a system for classifying all patient cases upon discharge from the hospital into DRGs. 42 U.S.C. ' 1395ww(d)(2). The statute also requires that the PPS rates be calculated based on data from Athe most recent cost reporting period from which data are available.@ 42 U.S.C. ' 1395ww(d)(2)(A). The Secretary established the PPS rates by appropriate rulemaking. 48 Fed. Reg 39752 (September 1, 1983) and 49 Fed. Reg. 234

(January 3, 1984). As previously noted, the Secretary used aggregate hospital data derived from Medicare cost reports for reporting periods ending in calendar year 1981. Id. at 39763 and 251. Since hospitals were required to file cost reports in accordance with the regulations at that time, the PPS rates are based on data that contained the 1979 Malpractice Rule costs. Once the base year rates were determined, they were modified for inflation, standardized to remove the effects of certain variations and adjustments according to certain groupings and to take into account certain other factors, such as outlier payments and budget neutrality requirements. 42 U.S.C. ' 1395ww(d)(2)(B); 48 Fed. Reg. 39752, 39763 (September 1, 1983); 49 Fed. Reg. 234, 251 (January 3, 1984) and See also 42 C.F.R. '' 412.62 and 412.63. The Board notes, however, that the basic building block of the federal rate - the 1981 data - was never revised or updated.

The Board notes that the Secretary was given broad discretion to establish a methodology for establishing the PPS. The Board notes that the Secretary promulgated complex regulations to carry out this task. The Board has reviewed the regulations in which the Secretary proposed to use 1981 data and the numerous adjustments that would be made to the data to achieve the most accurate as possible result. As pointed out by the Intermediary, the data was largely unaudited and as a result, it contained costs that could later be determined to be unallowable through actions such as audit adjustments and appeals of audit adjustments. The Board has reviewed the statute and regulations and finds that they do not specifically provide for any retroactive adjustment of the federal portion of the PPS. Since the Secretary was afforded the latitude to develop the methodology, it was permissible not to provide for retroactive adjustment.

The Board also believes that the decision in Methodist, supra, is relevant to the issue in this case. The underlying facts are similar, an error resulted in a lower PPS rate - in Methodist, it was an incorrect wage rate, and in the instant case, malpractice costs were improperly allocated. In both cases, the providers seek to have the PPS rates retroactively adjusted. In Methodist, the court found that Congress did not directly speak on the issue of retroactive adjustments and gave deference to the Secretary=s permissible interpretation of the statute. In the instant case, the Board does not find any requirement or provision allowing for retroactive adjustments to the PPS rate. In addition, the court in Methodist found that allowing for retroactive correction of errors would undercut the objective of the PPS statute which was to provide predictable Medicare reimbursements. The Board finds that the same finding applies to the instant case. In addition, the Board reasons that many retroactive adjustments to the PPS rate could be made to correct errors and that these corrections might either raise or lower the PPS rates. Finally, the Board finds that the methodology used by the Secretary to develop the PPS rates as a whole was reasonable and that it should not be disturbed because the data was not perfect and because retroactive adjustments are inconsistent with the underlying prospective nature of the PPS statute.

The Board notes that it is not inconsistent for the Secretary to permit a retroactive adjustment to the HSP portion of the PPS and not allow it for the federal portion. In Georgetown, supra, the court found

a clear congressional intention to provide retroactive adjustments to Aallowable costs@ because the HSP provisions retained and incorporated the previous reasonable cost regime into the PPS rate during the transitional period. Id. 862 F.2d at 326-7 and n.9. The court in Methodist did not find comparable intent to permit retroactive adjustment for the federal portion of PPS.

Finally, the Board agrees with the Intermediary=s assertion that the retroactive adjustment proposed by the Provider would increase the federal portion of the PPS rates and therefore require some adjustment to be made to maintain budget neutrality. 42 U.S.C. ' 1395ww(e) and 42 C.F.R. ' 412.63(j). Because the Board has determined that the adjustments are not required, how those adjustments would be made are moot, and in any event would not be subject to review by the Board. 42 C.F.R. ' 405.1804(a).

In summary, the Board finds that the statute and regulations pertaining to the federal portion of the PPS does not require or provide for retroactive adjustments. The Board finds that the Secretary=s methodology was reasonable and should not be changed because the cost data was not perfect and because retroactive adjustments are inconsistent with the underlying prospective nature of the PPS statute.

DECISION AND ORDER:

The Board finds that the statute and regulations pertaining to the federal portion of the PPS does not require or provide for retroactive adjustments. The Board finds that the Secretary=s methodology was reasonable and that permitting retroactive adjustments is inconsistent with the underlying prospective nature of the PPS statute.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire
Martin W. Hoover, Jr., Esquire
Charles R. Barker
Stanley J. Sokolove

Date of Decision: August 18, 2000

FOR THE BOARD:

Irvin W. Kues
Chairman