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Determining Reasonable Charges: A Teaching Hospital Takes on the Federal Government Over Recalculated Graduate Medical Education Expenses (96-1375) Administrative Law

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Case at a Glance

Teaching hospitals rely heavily on Medicare reimbursements to support their graduate medical teaching programs. Current reimbursements are controlled by a formula based on 1984 costs, indexed for inflation. Now the Medicare program wants to reaudit the 1984 cost figures to ensure accuracy, but a hospital asserts that Medicare lacks the authority to re-examine the old figures. Enter the Supreme Court to decide who is correct and whether taxpayers or teaching hospitals will bear the cost of excessive reimbursements.

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by William L. Andreen

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Teaching hospitals in the United States are reimbursed by the Government for the services they provide to Medicare patients, the elderly and disabled, through their training programs for resident doctors. Reimbursement for graduate medical education ("GME") costs is based on a formula that is heavily dependent on 1984 cost figures. The formula takes the average cost incurred in 1984 on a per-resident basis, adjusts the number for inflation, and multiplies it by the total number of residents in the current year.

By the late 1980s, the Medicare program became concerned that a large number of errors had been made in the cost figures used to calculate GME reimbursements for 1984. Unless reaudited and corrected, those mistakes would lead to overpayments for many years to come. Responding to this problem, the Secretary of Health and Human Services (the "Secretary") promulgated a rule in 1989 (the "reaudit rule"), 42 C.F.R. § 413.86 (1996), that required a reaudit of all the 1984 reimbursement determinations.

St. Paul-Ramsey Medical Center (the "Medical Center" or the "Center") claims that the Secretary cannot re-examine its 1984 determinations because they are final and no longer subject to being reopened. *See* 42 C.F.R. §§ 405.1807(b), 405.1885(a), (b), and (d) (a reimbursement determination is final and not subject to reaudit after three years unless fraud contributed to the determination). Accordingly, the Center maintains that the reaudit rule is invalid.

The Secretary, on the other hand, claims that the reaudit rule is not intended to recoup overpayments for years in which there is a final reimbursement decision. The reaudit rule, therefore, is a reasonably crafted effort to prevent future overpayments and to recoup overpayments for years in which reimbursement determinations are not yet final.

ST. PAUL-RAMSEY MEDICAL CENTER, INC. V. DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES
DOCKET NO. 96-1375

ARGUMENT DATE:
DECEMBER 1, 1997
FROM: THE EIGHTH CIRCUIT

ISSUE

Is the Secretary's reaudit rule a reasonable interpretation of Congress' mandate to reimburse only the "average amount [of GME costs] recognized as reasonable"?

FACTS

Congress in 1965 created Medicare, a federally funded program providing health insurance for older and disabled Americans. Under Part A, the Secretary reimburses hospitals for certain covered services. Among the allowable costs for which a hospital may be reimbursed are the costs of training programs for healthcare professionals, including GME programs.

At the end of each fiscal year, a hospital seeking Medicare reimbursement must file a cost report with a "fiscal intermediary," generally an insurance company designated by the Secretary. The report — setting forth the hospital's costs related to Medicare services — is reviewed and, if necessary, audited by the fiscal intermediary that then makes a determination of the hospital's Medicare payment. These determinations may be reopened, as noted, during a three-year period in order to re-examine the findings of the intermediary.

Until 1985, GME costs were reimbursed on a reasonable-cost basis, which included, for example, resident stipends and teaching-physician compensation attributable to the education of residents. In 1986, however, Congress amended Medicare to change the way in which reimbursable GME costs are to be calculated. Under the changes, GME costs would no longer be subject to detailed cost accounting on an annual basis; instead, future annual reimbursements would be based on the costs allowed for the 1984 fiscal year, the baseline year. More specifically, Congress directed the Secretary to determine an "average amount recognized as reasonable" for each resident in the baseline year of 1984. 42 U.S.C. § 1395ww(h)(2)(A) (1994). All reimbursements for GME costs, beginning with Medicare cost reports filed by hospitals after July 1, 1985, would be calculated by multiplying the hospital's average cost per resident from the baseline year, adjusted for inflation, by the number of full-time-equivalent residents for the year in question.

In late 1988, the Secretary proposed the reaudit rule to implement Congress' new GME reimbursement scheme. The rule as proposed would authorize fiscal intermediaries to re-examine 1984 baseline costs and to reaudit those costs if they appeared to be unreasonably high or appeared to include misclassified or nonallowable costs. Reauditing was thought necessary to prevent perpetuation of past mistakes.

The final reaudit rule, promulgated in late 1989, retained this general approach. Fiscal intermediaries were required to reaudit teaching hospitals to determine average per-resident cost. In making this recalculation, the intermediaries were to exclude any nonallowable or misclassified costs even if such costs had previously been allowed.

The reaudit rule recognized, however, that prior cost determinations might not be subject to reopening under the Secretary's three-year rule of repose. In those cases, the reaudit rule provided that any modification in 1984 GME costs would affect only the computation of average per-resident costs to be used in the future and in any period subject to reopening under the three-year rule.

The Medical Center originally received $9.9 million for its 1984 GME expenses. After reauditing in late 1990 and early 1991, the fiscal intermediary concluded that the total allowable GME costs for 1984 were $5.5 million (later raised to $5.9 million). No recoupment was sought for that particular overpayment because the three-year reopening period for 1984 had already run. However, the new average per-resident amount of $49,805.29 would be used to determine total GME reimbursement for future years as well as in years still subject to reopening.

The Center filed suit in federal district court challenging the validity of the reaudit rule. The district court, in an unpublished opinion, upheld the regulation and was affirmed by the Eighth Circuit. 91 F.3d 57 (8th Cir. 1996). Both courts concluded that the Secretary's reaudit rule was a reasonable interpretation of an ambiguous congressional mandate.

That reasoning is now before the Supreme Court, which granted the Medical Center's petition for a writ of certiorari. 117 S. Ct. 2406 (1997).

CASE ANALYSIS

The Medical Center contends that the reaudit rule violates the plain meaning of the 1986 amendment that changed the way in which GME costs are calculated. The amendment provides that "the Secretary shall determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident." 42 U.S.C. § 1395ww(h)(2)(A).

(Continued on Page 134)

The Center maintains that the words "amount recognized as reasonable" direct the Secretary to use only the amount originally recognized and paid as reasonable by the fiscal intermediary for the baseline year 1984 — $9.9 million in this case. Here the Center stresses that under the Secretary's own regulations, its original GME reimbursement for 1984 is final and binding because the three-year reopening period has long since passed.

The Center argues that since Congress is presumed to know the law in an area when it legislates, the language "amount recognized as reasonable" can mean only the amount established as reasonable in the normal administrative process. In the absence of an agency appeal or a timely reopening, that amount is the amount originally set by the fiscal intermediary.

The Secretary, in contrast, argues that the statutory language is ambiguous with regard to the way in which she may calculate the average GME per-resident cost. According to the Secretary, the "amount recognized as reasonable" could mean the baseline GME costs that are recognized as reasonable through the reauditing process, or it could refer to costs that were recognized as reasonable at the time of the original determination.

The ambiguity, says the Secretary, stems from use of the past participle "recognized," which does not itself necessarily express time and may be used in the passive voice to refer to the present. Therefore since Congress did not speak directly to the point, the Secretary argues that courts must uphold the interpretation as long as it is reasonable. *See Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984).

Not surprisingly, the Secretary contends that her interpretation is plainly reasonable. Congress, after all, had created a new methodology for determining all future GME reimbursements, which, rather than relying on actual costs in future years, would be strongly influenced by the GME costs incurred during the baseline year. Consequently, says the Secretary, it is altogether appropriate to put into place an approach that minimizes the possibility that past errors — errors made in originally calculating reasonable GME costs for the baseline year — would distort future reimbursements. The Secretary argues, moreover, that her interpretation is consistent with both her responsibility to implement the Medicare program in a prudent manner and her statutory authority to issue regulations defining reasonable costs.

The Medical Center, however, argues that Congress' grant of general rule-making authority to the Secretary does not overcome Congress' clear expression of intent. Here, says the Center, Congress did not intend for the Secretary to ignore the original determination process and substitute a new one.

The Center insists that if Congress had intended to upset the settled way of determining GME reimbursement, it would have said so in the amendment itself or at least would have mentioned it in the legislative history. That history, observes the Center, is silent on this matter.

Even if the Court finds that the amendatory language is ambiguous, the Center argues that the reaudit rule still fails to satisfy the *Chevron* analysis because it is unreasonable. The rule sets aside final determinations that were completed when documentation was readily available and memories were fresh concerning the events of 1984.

The Center adds that the reaudit rule also conflicts with the Secretary's own three-year reopening period which is intended to ensure accuracy, not impede it. In short, the Center contends that it makes no sense to argue that a reaudit performed in 1991 of 1984 GME costs will be more accurate than the audit performed in 1986.

The Secretary replies that there was ample reason to believe at the time the reaudit rule was promulgated, and even before, that baseline GME determinations reflected significant overpayments. Moreover, GME costs were not being scrutinized adequately at the time because of a number of other major changes that were being implemented in Medicare. The reaudit in this case, in fact, proves that the original determination had been erroneously and substantially overstated by misclassified or nonallowable costs.

The Secretary also denies that the reaudit rule is unfair because it undertakes a re-examination of past GME determinations that are final under her own regulations. The reaudit rule, according to the Secretary, will not displace any legitimate expectation held by any hospital with regard to the finality of reimbursement decisions since the rule does not extend the three-year reopening period. Therefore even though the reaudit rule may authorize re-examination of an administratively final determination, the purpose is not to reopen that decision and seek recoupment of any erroneous payments. To the contrary, the purpose is to establish an accurate cost basis with respect to the baseline year to be applied in future years and to years still within the reopening period.

SIGNIFICANCE

Teaching hospitals have a great deal at stake in this case. If they lose, Medicare's fiscal intermediaries will be free to recalculate the GME reimbursement baseline. Any recalculation may well affect adversely all future GME reimbursements, dependent as they are on the baseline figure. Perhaps more devastating from the hospitals' perspective is the fact that the readjusted baseline figure may be used to demand repayment of some considerable sums that have been paid to the hospitals during the last three years subject to reopening. In this case, the Medical Center could be required to repay more than $33,000 per year, per resident.

Should the Secretary lose, however, any errors that may have been made in originally calculating GME costs during the baseline year of 1984 will be set in stone, never to be re-examined. Under the lock-step formula Congress enacted for GME costs, the Medicare program would be required to compound those errors, year after year, by making perpetual overpayments to teaching hospitals.

ATTORNEYS OF THE PARTIES

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