UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
NORTHERN DIVISION

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH, CARO CENTER, KALAMAZOO PSYCHIATRIC HOSPITAL, and NORTHVILLE PSYCHIATRIC HOSPITAL,

Plaintiffs,

v.

Case Number 10-12914-BC
Honorable Thomas L. Ludington

KATHLEEN SEBELIUS and CENTER FOR MEDICARE & MEDICAID SERVICES,

Defendants.
_____/

ORDER GRANTING DEFENDANTS' MOTION FOR SUMMARY JUDGMENT, DENYING PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT, AND DISMISSING PLAINTIFFS' COMPLAINT WITH PREJUDICE

Plaintiffs, led by the Michigan Department of Community Health ("MDCH"), contend that they were not fully reimbursed by the federal government for psychiatric hospital services provided to medicaid and medicare patients during fiscal years 2003 through 2006. In an attempt to recover nearly $10 million in costs, Plaintiffs MDCH, Caro Center, Kalamazoo Psychiatric Hospital, and Northville Psychiatric Hospital, sued Defendants Kathleen Sebelius, the Secretary of the Department of Health and Human Services, and Centers for Medicare & Medicaid Services ("CMS" or "the agency"), seeking an injunction directing Defendants to recalculate payments in accordance with Plaintiffs' interpretation of the applicable statutes and regulations. In March and April 2011, the parties filed cross-motions for summary judgment. For the reasons explained below, Plaintiffs' motion will be denied, Defendants' motion will be granted, and Plaintiffs' complaint will be dismissed with prejudice.

I.

Plaintiffs, MDCH and three hospitals that it operates, provide psychiatric care to medicare and medicaid patients. Generally, inpatient hospital services are reimbursed at predetermined rates under the Prospective Payment System or PPS, which was implemented by Congress in 1982 with the passage of the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"). *See* TEFRA, Pub. L. No. 97-248, 96 Stat. 324 (1982); 42 U.S.C. § 1395ww(d)(1)–(4). With the passage of TEFRA and the implementation of the PPS, Congress largely ended CMS's historic compensation system, which was based on hospitals' actual cost, which varied widely for different hospitals. TEFRA imposed a standardized reimbursement system based on specific patient characteristics. TEFRA, however, exempted a small percentage of services, including the in-patient psychiatric services Plaintiffs provide, from the PPS because those services were difficult to define based on patient characteristics and because there was little consensus about a national standard of care for in-patient psychiatric services. *See* 42 U.S.C. § 1395ww(a)–(b) (outlining payment plans for certain types of facilities). Plaintiffs and other PPS exempt providers continued to be reimbursed for their actual "operating costs" as long as those costs did not exceed a defined "target amount." 42 U.S.C. § 1395ww(b)(1)(A). In the first fiscal year after TEFRA was enacted, the "target amount" was defined as the "allowable operating costs . . . for the preceding 12-month cost reporting period." 13 U.S.C. § 1395ww(b)(3)(A)(i). Thus, the initial target amounts were based on each hospital's actual operating costs. In later years, the "target amount" was defined as "the target amount for the preceding 12-month cost reporting period" plus a standard percentage increase identified by the statute and regulations. 13 U.S.C. § 1395ww(b)(3)(A)(ii); 42 C.F.R. § 413.40(c)(4)(ii). The regulations refer to the annual increase as an "update factor."

In 1997, Congress amended the statute in response to criticism of the widely varying compensation psychiatric hospitals and other PPS-exempt providers received for similar services. The variations resulted from a compensation system that was based on "operating costs" of individual hospitals rather than a defined compensation rate based on the characteristics of the patients. Congress placed a cap on payments to providers of psychiatric services. Balanced Budget Act of 1997 ("BBA"), Public Law 105-33, 111 Stat. 251 (1997); Defs.' Br. at 3 (discussing legislative history). The statute provided that the "target amount" for such providers during fiscal years 1998 through 2002 "may not exceed" the seventy-fifth percentile of target amounts for hospitals in the same class for fiscal year 1996. 13 U.S.C. § 1395ww(b)(3)(H)(i)–(ii). Congress also directed the Secretary to adjust the seventy-fifth-percentile cap annually. 42 U.S.C. § 1395ww(b)(3)(H)(ii). Under the revised statute and accompanying regulations, for fiscal years 1998 through 2002, the target amount equaled the lesser of the hospital's actual operating costs, 42 U.S.C. § 1395ww(b)(3)(A)(i), the allowable operating costs for the previous fiscal year multiplied by the update factor, 42 U.S.C. § 1395ww(b)(3)(A)(i); 42 C.F.R. § 413.40(c)(4)(iii)(A), and the seventy-fifth percentile of target amounts for hospitals in the same class, 42 U.S.C. § 1395ww(b)(3)(H)(ii); 42 C.F.R. § 413.40(c)(4)(iii)(B). Passage of the BBA led to a significant funding reduction for many hospitals with historically higher-than-average costs per patient.

In 1999, Congress again altered the payment system for psychiatric hospitals with the passage of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 ("BBRA"), Pub. Law. 106-113, 113 Stat. 1501 (1999). Pursuant to the BBRA, providers of psychiatric hospital services were to join the majority of other medical care providers in the PPS in fiscal year 2003. The BBRA provided for PPS payments for in-patient psychiatric care to begin in

fiscal year 2003, the year after the seventy-fifth-percentile cap expired at the end of fiscal year 2002. Notwithstanding the congressional directive, the Secretary did not begin to implement the PPS for psychiatric hospitals until fiscal year 2006, three years after the BBA's seventy-fifth-percentile cap expired. CMS phased the PPS for psychiatric services in over four years. As a result, 2010 was the first year that payments for psychiatric services were based only on a PPS.

The BBRA also required that the Secretary submit a report to Congress by October 1, 2001, explaining the development and implementation of the PPS for psychiatric hospitals. Although the Secretary and CMS did not implement the PPS for psychiatric hospitals, they still submitted the report. *See* Tommy G. Thompson, Prospective Payment System for Inpatient Services in Psychiatric Hospitals and Exempt Units (2002) (hereinafter "Thompson Report"). The report explained that a PPS requires classification of each patient into a "diagnosis related group," or DRG. Thompson Report at 6. Each patient in any given DRG will have a similar illness or disorder which, in theory, will require similar treatment at "relatively similar cost." *Id.* The implementation of the original PPS for acute care hospitals in 1983 followed ten years of research and study concerning the appropriate way to classify patients and resulted in nearly 500 distinct DRGs. *Id.* at 4–6. The report explained that the goal of PPS is to define payments to hospitals based on patient characteristics rather than the historical practices and expenses of the hospital, but that defining patient characteristics with regard to psychiatric hospitals is more difficult than it is with regard to acute care hospitals. *Id.* at 24. Psychiatric disorders are more difficult to define and classify, and any specific definition does not always explain the full reason for a patient's admission. *Id.* The report concluded that the development of a comprehensive PPS for psychiatric hospitals would require

additional research. *Id.* at 44–47. The report noted that CMS would miss the BBRA's implementation deadline, but endeavored to "proceed as quickly as possible." *Id.* at 47.

II.

The question raised in this case is how payments to psychiatric hospitals should be addressed between fiscal year 2002—when the seventy-fifth-percentile cap expired—and fiscal year 2010—when the PPS was fully implemented. The Fiscal Intermediary, now called an administrative contractor, 42 U.S.C. § 1395(k), that was responsible for Plaintiffs' medicare billing calculated Plaintiffs' target amounts for fiscal year 2003 based on Plaintiffs actual expenditures, disregarding the effect of the seventy-fifth-percentile cap or the previous year's target amount. After an audit, however, CMS disagreed with the Intermediary and recalculated Plaintiffs' target amount for 2003 based on the previous fiscal year's target amount, which had been significantly reduced by the seventy-fifth-percentile cap in that year. The result was a substantial discrepancy between what Plaintiffs actually spent on psychiatric services in fiscal year 2003 and the amount CMS would reimburse.

In this lawsuit, Plaintiffs maintain that they should be reimbursed for their actual costs in fiscal years 2003, 2004, 2005, and 2006 without regard to the 2002 target amount, which was capped by the BBA. Plaintiffs contend that the plain language of TEFRA provides for such a result. Defendants agree that the TEFRA provisions control, but contend that the fiscal year 2003 payment should be based on fiscal year 2002's target amount multiplied by the applicable update factor. The target amount in fiscal year 2002 was subject to the seventy-fifth-percentile cap. Thus, even though the seventy-fifth-percentile cap expired at the end of fiscal year 2002, it still affects the payments to Plaintiffs because 2002's target amount, as limited by the cap, was the starting point for

calculating new target amounts going forward. The parties agree that there are no material facts in dispute. They filed cross-motions for summary judgment, explaining their positions on the law. *See* Fed. R. Civ. P. 56(a).

A motion for summary judgment should be granted if the "movant shows that there is no genuine dispute as to any material fact and that the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). The moving party has the initial burden of informing the Court of the basis for its motion, and identifying where to look in the record for relevant facts "which it believes demonstrate the absence of a genuine issue of material fact." *Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986). The burden then shifts to the opposing party who must "set out specific facts showing a genuine issue for trial." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 250 (1986) (citation omitted). If the opposing party does not raise genuine issues of fact and the record indicates the moving party is entitled to judgment as a matter of law, the court shall grant summary judgment. *Anderson*, 477 U.S. at 250.

The Court must view the evidence and draw all reasonable inferences in favor of the non-moving party and determine "whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law." *Anderson*, 477 U.S. at 251–52. The party opposing the motion may not "rely on the hope that the trier of fact will disbelieve the movant's denial of a disputed fact" but must make an affirmative showing with proper evidence in order to defeat the motion. *Street v. J.C. Bradford & Co.*, 886 F.2d 1472, 1479 (6th Cir. 1989). A party opposing a motion for summary judgment must designate specific facts in affidavits, depositions, or other factual material showing "evidence on which the jury could reasonably find for the plaintiff." *Anderson*, 477 U.S. at 252.

III.

In *Chevron v. Natural Resources Defense Council, Inc.*, the Supreme Court provided for a two-step inquiry when district courts are confronted with a challenge to an agency's interpretation of a statute or rule. "First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." 467 U.S. at 842–43. If, on the other hand, Congress's intentions with respect to the question before the Court are not clear from the language of the statute, "the court does not simply impose its own construction on the statute, as would be necessary in the absence of an administrative interpretation. Rather, . . . the question for the court is whether the agency's answer is based on a permissible construction of the statute." *Id.* at 843. That is, in most circumstances, the district court should defer to the agency's interpretation of the statute as long as that interpretation is reasonable. *Id.* at 844.

"[A]dministrative implementation of a particular statutory provision qualifies for *Chevron* deference when it appears that Congress delegated authority to the agency generally to make rules carrying the force of law, and that the agency interpretation claiming deference was promulgated in the exercise of that authority." *United States v. Mead Corp.*, 533 U.S. 218, 227–28 (2001). An agency can demonstrate its decision warrants deference if it resulted from a formal process, such as notice-and-comment rulemaking. *Id.* at 227. Where an agency's decision is entitled to deference, the "ensuing regulation is binding in the courts unless procedurally defective, arbitrary or capricious in substance, or manifestly contrary to the statute." *Id.* (citing Administrative Procedures Act, 5 U.S.C. § 706(2)(A), (D) (additional citations omitted)).

A.

The first inquiry under *Chevron* directs the Court to the statute itself: Does it provide a clear answer to the specific question? *Chevron*, 467 U.S. at 842. If it does, as both parties suggest, the inquiry is complete. *Id.* at 842–43. In 42 U.S.C. § 1395ww(b)(3)(A), Congress defined the "target amount":

> [F]or purposes of this subsection, the term "target amount" means, with respect to a hospital for a particular 12-month cost reporting period—
>
> (i) in the case of the first such reporting period for which this subsection is in effect, the allowable operating costs of inpatient hospital services . . . recognized under this subchapter for such hospital for the preceding 12-month cost reporting period, and
>
> (ii) in the case of a later reporting period, the target amount for the preceding 12-month cost reporting period,
>
> increased by the applicable percentage increase under subparagraph (B) for that particular cost reporting period.

42 U.S.C. § 1395ww(b)(3)(A).

According to Defendants, subsection (i) is inapplicable because this is not the "first such reporting period" that the provision is in effect. Indeed, the provision has been in effect for nearly thirty years. Thus, under subsection (ii), the target amount for fiscal years 2003, 2004, 2005, and 2006, is "the target amount for the preceding 12-month cost reporting period" increased by the applicable update factor. Beginning with fiscal year 2003, the critical year in this analysis, the target amount for the previous 12-month reporting period—fiscal year 2002—was governed by the BBA. Under the BBA, the target amount for fiscal year 2002 was also governed by § 1395ww(b)(3)(A), but it was capped at the Secretary's "estimate [of] the 75th percentile of the target amounts for such hospitals within such class for the" most recent cost reporting period with available data. 42 U.S.C. § 1395ww(b)(3)(H). The 2003 target amount, according to the secretary, is based on the capped 2002 target amount increased by the applicable update factor. 42 U.S.C. § 1395ww(b)(3)(A)(ii).

Plaintiffs, by contrast, argue that Defendant's interpretation of the statute subverts Congress's intent with regard to the seventy-fifth-percentile cap. Plaintiffs emphasize that the statute must be considered as a whole, and contend that Defendant's interpretation focuses too closely on a particular subsection. *See Walker v. Bain*, 257 F.3d 660, 666–67 (6th Cir. 2001) (quoting *K Mart Corp. v. Cartier, Inc.*, 486 U.S. 281, 291 (1988)). Plaintiffs argue that Defendant's focus on paragraph (ii) of § 1395(b)(3)(A) impermissibly ignores paragraph (i), which was intended to provide a specific "base year" for each provider.

Plaintiff's emphasize that the definition of "target amount" was in place long before Congress imposed the BBA cap, and that, as originally enacted, Congress intended the target amount to be based, initially, on each individual hospital's operating costs rather than an artificially imposed ceiling. Moreover, Plaintiffs argue, the cap that Congress adopted was limited to five fiscal years—1998 through 2002—and by basing the 2003 target amounts on the 2002 target amounts the government artificially extended the cap without congressional action. Plaintiffs also note that other subparts of § 1395(b)(3) distinguish between the "target amount" and what is referred to as "the limiting or cap amount." 42 U.S.C. § 1395(b)(3)(J). Thus, according to Plaintiffs, Congress clearly distinguished between the "target amount" defined in subpart (A) and the "cap amount" defined in subpart (H). Finally, Plaintiffs emphasize that the time limitation on the cap imposed by subsection (H), as well as the BBRA's implementation of the PPS system beginning in 2003, establish Congress's intention to end the artificial cap after fiscal year 2002.

Although Plaintiffs' argument is not without merit, *see Hardy Wilson Mem'l Hosp. v. Sebelius*, 616 F.3d 449, 455–57 (5th Cir. 2010) , it is insufficient to overcome the plain and obvious meaning of the statute itself. " 'When [the court] can discern an unambiguous and plain meaning

from the language of a statute, our task is at an end.' " *Walker*, 257 F.3d at 667 (quoting *Bartlik v. U.S. Dep't of Labor*, 62 F.3d 163, 166 (6th Cir. 1995) (en banc)). Plaintiffs persuasively argue that Congress intended that the cap imposed by the BBA would expire following fiscal year 2002, and that the PPS for psychiatric hospitals would be implemented in fiscal year 2003. When implementation of the PPS was delayed, however, the agency was required to reimburse the hospitals in accordance with the statutory language that was in place.

The statutory language that was in place provided two options: either Plaintiffs could be reimbursed for their actual costs under paragraph (i) or they could be reimbursed based on the previous year's target amount under paragraph (ii). 42 U.S.C. § 1395(b)(3)(A). Paragraph (i) applies only in the "first such reporting period" for which TEFRA was in effect—which occurred in the early 1980s and not 2003. Thus, by its own terms, paragraph (i) did not apply in fiscal year 2003. *See Ancora Psychiatric Hosp. v. Sec'y of the U.S. Dep't of Health & Human Servs.*, No. 10-2016, 2011 WL 547733, at *4–5 (3d Cir. Feb. 17, 2011); *Chalmette Med. Ctr., Inc. v. U.S. Dep't of Health & Human Servs.*, No. 08-4027, 2009 WL 2488265, at *5 (E.D. La. Aug. 11, 2009); *but see Hardy Wilson Mem'l Hosp.*, 616 F.3d at 455–57 (concluding the statute is ambiguous).

Because paragraph (i), by its own terms, applied only in the first year that the statute was in effect, the agency was required to look to paragraph (ii). Under paragraph (ii), the target amount for 2003 was based on the previous year's target amount multiplied by the applicable update factor. The "literal language of the statute" does not "lead to absurd results or an interpretation which is

inconsistent with the intent of Congress." *Walker*, 257 F.3d 667 (citations omitted). As a result, that language must be followed. [1]

Importantly, TEFRA was enacted in 1983 and has remained in place since. *See* Thompson Report at 2. Later legislation, including the BBA and the BBRA, supplemented and amended TEFRA, but the original statute was never replaced or repealed. TEFRA's reimbursement scheme was based in the first year of enactment on each individual hospital's actual costs, but the rate of increase was limited by the update factor. The reimbursement rates were further limited by the BBA, which placed a national cap on the total reimbursement rate, and the BBRA, which compensated hospitals based on patient characteristics rather than historical practices. If, as Plaintiffs contend, the reimbursement rate for fiscal year 2003 were based on each hospital's actual costs, rather than the previous year's target rate multiplied by an update factor, it would turn Congress's intent on its head. The legislation demonstrates a progressive effort to reimburse psychiatric hospitals based on objective patient characteristics and consistent national standards, and to rein in the disproportionately expensive treatment provided by certain hospitals. If Plaintiffs' interpretation of the statute were to prevail, it would reward hospitals for providing expensive treatment regardless of its effectiveness or the specific characteristics of its patients. In short, if Plaintiff's interpretation were to prevail, the highest-cost providers would receive a windfall merely

[1] Plaintiffs suggest that Defendant's interpretation of the statute renders the time limitation imposed by the cap provision in subsection (H) "meaningless." *See Walker*, 257 F.3d at 667 ("Every word in the statute is presumed to have meaning, and we must give effect to all the words to avoid an interpretation which would render words superfluous or redundant."). The government's interpretation of the statute recognizes the time limitation. The government does not apply the cap in 2003. Rather, it uses the 2002 target amount, which was capped, to calculate the 2003 target amount.

for providing high-cost services. Nothing about Congress's legislative changes would remotely suggest such an intention.

Accordingly, because fiscal year 2003 was not "the first such reporting period" for which TEFRA was in effect, reimbursement rates must be based on the capped target amount for the previous fiscal year multiplied by the applicable update factor. 42 U.S.C. § 1395ww(b)(3)(A)(ii).

IV.

Because the plain language of the statue controls the outcome of this case, it is unnecessary address the agency's interpretation of the regulations. Nevertheless, the Agency's regulations were the result of a formal decision making process and are reasonable. *See Mead Corp.*, 533 U.S. at 227–28. As such, they would be entitled to *Chevron* deference. Thus, even if the statute were ambiguous, it is likely that Defendants would prevail.

Accordingly, it is **ORDERED** that Defendants' motion for summary judgment [Dkt. # 26] is **GRANTED**.

It is further **ORDERED** that Plaintiffs' motion for summary judgment [Dkt. # 24] is **DENIED**.

It is further **ORDERED** that Plaintiffs' complaint is **DISMISSED WITH PREJUDICE**.

s/Thomas L. Ludington
THOMAS L. LUDINGTON
United States District Judge

Dated: June 21, 2011

PROOF OF SERVICE

The undersigned certifies that a copy of the foregoing order was served upon each attorney or party of record herein by electronic means or first class U.S. mail on June 21, 2011.

s/Tracy A. Jacobs
TRACY A. JACOBS