Medicare Cost Report Appeals: Is Your Hospital Leaving Money on the Table?

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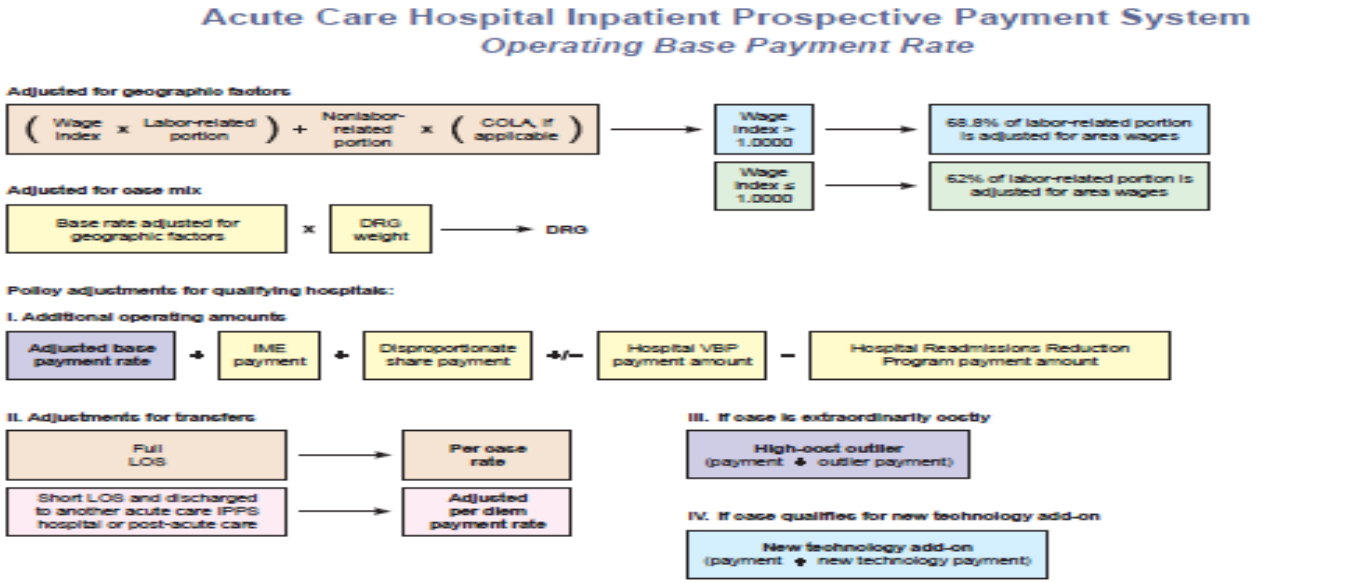
AGENDA

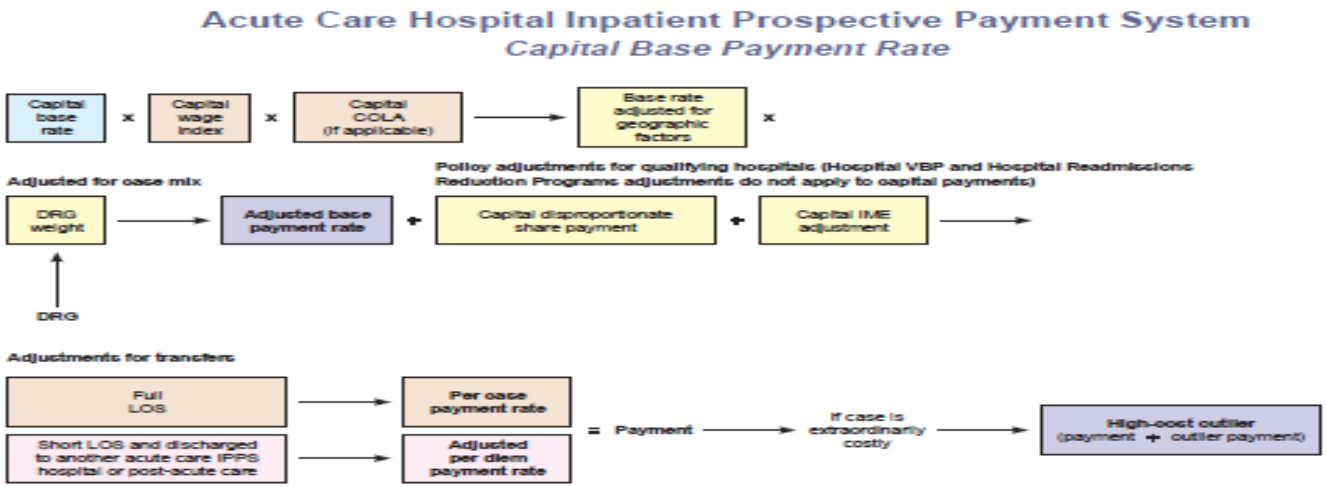
- **DSH Litigation Update: What You Need to Know**

- **Update -- DSH S-10 Worksheet Strategies to Enhance Payment**

- **“Tips”**

Medicare Hospital Reimbursement





Update – Medicare DSH Litigation
The Saga Continues

Allina Health Services cases
The Saga Continues

- Where do M+C days belong in the Disproportionate Share Hospital Payment (DSH)?
- Are Medicare beneficiaries who are enrolled in Part C Plans "entitled to benefits under Part A?"
- D.C. Circuit vacated the 2004 Rule placing M+C days in Medicare fraction – Allina I
- Plaintiffs challenge a 2013 Rule placing M+C in Medicare fraction 2014 and beyond and alleged effort to apply "vacated 2004 rule" to subsequent years

Allina Health Services v. Price

2017 WL 3382055 (Aug. 4, 2017)

The Saga Continues

- Challenge to the agency's post remand interpretative rule placing M+C days in the Medicare fraction, *Allina I*, 746 F.3d 1102, 1111 (D.C. Cir. 2014); *affirmed in part and reversed in part*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012)
- Court of Appeals had held that the agency failed to engage in adequate notice and comment but district court erred in directing placement of M+C days in the Medicaid fraction
- Agency might reach the same result (placing days in Medicare fraction) by "adjudication" (issuing an order)
- December 1, 2015, agency issued an order placing M+C days in the Medicare fraction "based on statute"
- Meaning "not entitled to benefits under Part A" remains unresolved
- Agency's motion to dismiss denied by the district court

Allina Health Services v. Price

863 F.3d 937 (D.C. Cir. 2017)

The Saga Continues

- Plaintiffs challenge a 2014 Rule placing M+C in Medicare fraction for 2012 and beyond and alleged effort to apply "vacated 2004 rule" to subsequent years – Allina II (Allina I consolidated with Allina II, Order, September 29, 2014)
- District Court, 201 F. Supp. 3d 94 (D.D.C. 2016), upheld agency's placement of M+C days in the Medicare fraction – finding the rule to be an "interpretative rule" based on the statute – no notice and comment required
- Circuit Court reversed, 863 F.3d 937 (D.C. Cir. 2017), finding notice and comment required
  - Rule applies to all providers (not just plaintiff hospitals)
  - Medicare Act contains no exception for "interpretative rules" unlike the APA
  - Even under the APA, hospitals prevail because final regulation is not a "logical outgrowth" of the proposed rule – here proposed 2004 Rule placed M+C days in Medicaid fraction – Final Rule in the Medicare fraction
- Result – agency has no rule for placement of M+C days from 2004 to 2013. 863 F. 3d at 939

Allina Health Services v. Azar
Docket No. 17-1484
Cert. Granted September 27, 2018

Issue limited to:

Whether Medicare statutes (42 USC §1395hh(a)(2) or 42 USC § (a)(4)) require notice and comment rule making prior to the issuance of instructions to MAC?

- Decision will not address placement of M+C days in the DSH calculation
- Limited to requirements placed on HHS by the Medicare statute
- Argument – January 15, 2019

Allina – *Looking for Clues*

Impact of Different Treatment in D.C. Circuit

- Case is on a “different course”
- Issue is the need for notice and comment v. meaning of “entitled to benefits under Part A?”
- New issue does not moot the issue of the meaning of “entitled to benefits under Part A?”

Impact of earlier precedents

DSH – *A Raging Controversy*

Northeast Hospital v. Sebelius, 657 F.3d 1 (D.C. Cir. 2011)

District Court reversed district court decision

- Congress has not "unambiguously" foreclosed agency's interpretation of "entitled to benefits under Part A" includes M+C beneficiaries – other sections of statute assume Part C beneficiaries are entitled to Part A benefits, *e.g.*, mailing open enrollment information to permit plan changes would not be required – Part A only? "Make no sense" for Congress to require information to be sent to Part A and not Part C [other examples]
- Subsequent provisions confirm that Part C enrollees are "entitled to benefits under part A"
- Amidst conflict, court cannot conclude that agency's interpretation is "unambiguously foreclosed"

DSH – *A Raging Controversy*

Catholic Health Initiatives v. Sebelius, 841 F.Supp.2d 270 (D.D.C. 2013),

718F.3d 914 (D.C. Cir. 2013)

Issue: Whether days of dual eligible beneficiaries who have exhausted their Part A benefits must be included in the Medicaid fraction of the Medicare DSH calculations as individuals no longer eligible for benefits under Part A? District Court held "Yes"

Reversed

- Phrase "entitled to benefits under Part A" **ambiguous**
- "We, of course, defer to the agency's interpretation"
- No retroactivity – agency enunciated the rule by adjudication in the *Edgewater* decision
- Even if retroactive, not the kind of retroactivity that renders an agency action arbitrary, capricious or contrary to law
- Adjudications are inherently retroactive

DSH – A Raging Controversy Any "Hints" from the Supreme Court?

Sebelius v. Auburn Regional Medical Center, 568 U.S. 145 (2013)

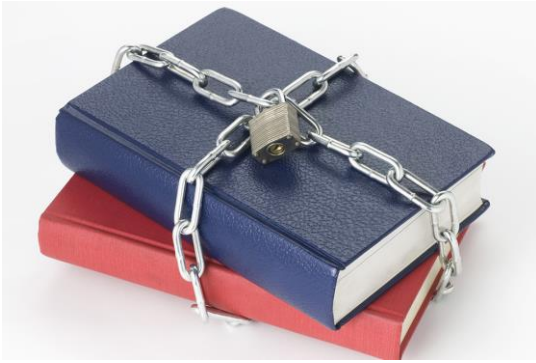
- Post *Baystate* effort to appeal "old" NPRs after court finding of "systematic errors" in the SSI/Medicare fraction of DSH to obtain the benefit of the decision
- Doctrine of "equitable tolling," *i.e.,* 180 day deadline for filing appeal not apply since providers were unaware of errors
- Equitable tolling not apply
- "the statutory scheme before us is not designed to be 'unusually protective' of claimants."
- Continuing strength of deference to agency decision making

Medicare Hospital Reimbursement

One Important "Take-away"

- Protect and safeguard any pending DSH appeals
- Abeyance – generally one year

The "New" DSH Payment – "Unreviewability"



- *Florida Health Services Center* (Tampa General Hospital) *v. Sebelius*, 89 F. Supp. 3d 121 (D.D.C. 2015), *aff'd*. 830 F. 3d 515 (D.D.C. 2016)
- "There shall be no administrative or judicial review under section 1395ff of this title, section 1395*oo* of this title, or otherwise of the following: (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2), (B) Any period selected by the Secretary for such purposes."
- Estimates and methods not subject to administrative/judicial review
- Accord, *DCH Regional Medical Center v. Price*, 257 F. Supp. 3d 91 (D.D.C. 2017)
- PRRB following this holding broadly and dismissing appeals
- Providers seeking EJR – therefore, another round is in the offing

Impact of Government Shutdown
The PRRB is **CLOSED**

When are filings due?

PRRB Rule 4.4.3

Due Date Exception When Board's Offices Are Closed

If the due date falls on a Saturday, a Sunday, a Federal legal holiday, (as enumerated in Rule 6(a) of the Federal Rules of Civil Procedure), or a day on which the Board is unable to conduct business in the usual manner, the deadline becomes the next day that is not one of the aforementioned days. *See* 42 C.F.R. § 405.1801(d)(3).

PRRB New Rules Effective 8/2018 (mostly)

- Electronic Filing System (long awaited)
  - Office of Hearings Case and Document Management System (OH CD
  - Web-based portal similar to that used by the federal courts
  - Transition period – not mandatory
  - Preliminary Position Paper with all exhibits – more prominent role
  - “SIGN UP” AHEAD of TIME
- Final Papers optional for appeals after 8/29/18; mandatory before
- Post-Hearing Papers only at request of Board
- READ and REFER to the Rules OFTEN

2018 Final Medicare IPPS Rule: Use of S-10 Worksheet

S-10 worksheet

Hospital Medicare Reimbursement – S -10

Historically, DSH Payment calculated individually for each hospital – the more needy patients the hospitals served, the the higher the DSH payment; no comparison to other hospitals

New DSH Payment/Uncompensated Care Payment enacted by ACA

- 25% of the traditional amount
- 75% an additional payment reduced by change in percentage of the uninsured population
- Each DSH hospital receives a payment based on its share of the total amount of uncompensated care for all Medicare DSH in a given period (Factor 3)
- Individual hospital's payment based on a comparison of its uncompensated care for the period selected to the national estimated amount
- Methodology produces a "zero sum game:" if hospital A's factor 3 increases; hospital; B's factor 3 payment necessarily decreases

Medicare Hospital Reimbursement – S-10

CMS Q & As – September 29, 2017 – Takeaways

- Any discount not part of the hospital's written charity or financial assistance policy (FAP) cannot be included; defines courtesy discounts, which are not included as uncompensated care
- Notes that a hospital's written charity care or (FAP) must explicitly include self-pay discounts to be written off as charity care, even if state law requires self-pay discounts
- Defines when a bad debt is considered to be "written off;" see, hospital bad debt policy
- Charges for non-covered services to Medicaid patients and for patients that have insurance plans that do not have a contractual relationship with the hospital must be specified in/meet requirements of hospital's written charity care policy or (FAP)
- Discusses how to treat unpaid coinsurance and deductible amounts for Medicare Advantage patients
- States that charges for Medicaid non-covered services must be specified in the charity care policy or FAP
- Details the procedure for revising worksheet S-10 of cost reports that already have been settled (through a request for reopening to the Medicare administrative contractor) and
- Reiterates that revisions to FY 2014 and FY 2015 cost reports are limited to lines 20, 22, 25, and 26 of worksheet S-10.

Hospital Medicare Reimbursement – S-10

Transmittal 11

September 29, 2017

- Revised instructions for line 20 for subsection (d) Puerto Rico hospitals, charity care and uninsured discounts.
- Modified the calculation and clarified the instructions on line 21, column 2, for insured patients and non-covered charges for insured patients for days exceeding a length-of-stay limit.
- Clarified the instructions for line 22.
- Clarified that the amount reported on line 26 is net of recoveries.
- Added line 27.01 to capture Medicare allowable bad debt for the entire facility.
- Modified the instructions for line 28 to only capture the non-Medicare bad debt expense.
- Modified the calculation for line 29.
- Clarify that “full or partial discounts given to uninsured patients who meet the hospital’s charity care policy or financial assistance policy/uninsured discount policy may be included on line 20, column 1 of Worksheet S-10.”

Medicare Hospital Reimbursement – S-10

Qs and As – December 27, 2018- Some Further Detail

- defines courtesy discounts, which are not included as uncompensated care, and clarifies the difference between self-pay/uninsured discounts and courtesy discounts
- notes that a hospital's written charity care or financial assistance policy (FAP) must explicitly include self-pay discounts to be written off as charity care, even if state law requires self-pay discounts
- defines when a bad debt is considered to be "written off"
- clarifies when unpaid coinsurance and deductible amounts can be reported as charity care instead of bad debt
- discusses how to treat unpaid coinsurance and deductible amounts for Medicare Advantage patients
- states that charges for Medicaid noncovered services must be specified in the charity care policy or FAP
- details the procedure for revising worksheet S-10 of cost reports that already have been settled (through a request for reopening to the Medicare administrative contractor) and
- reiterates that revisions to FY 2014 and FY 2015 cost reports are limited to lines 20, 22, 25, and 26 of worksheet S-10.

Hospital Medicare Reimbursement S-10

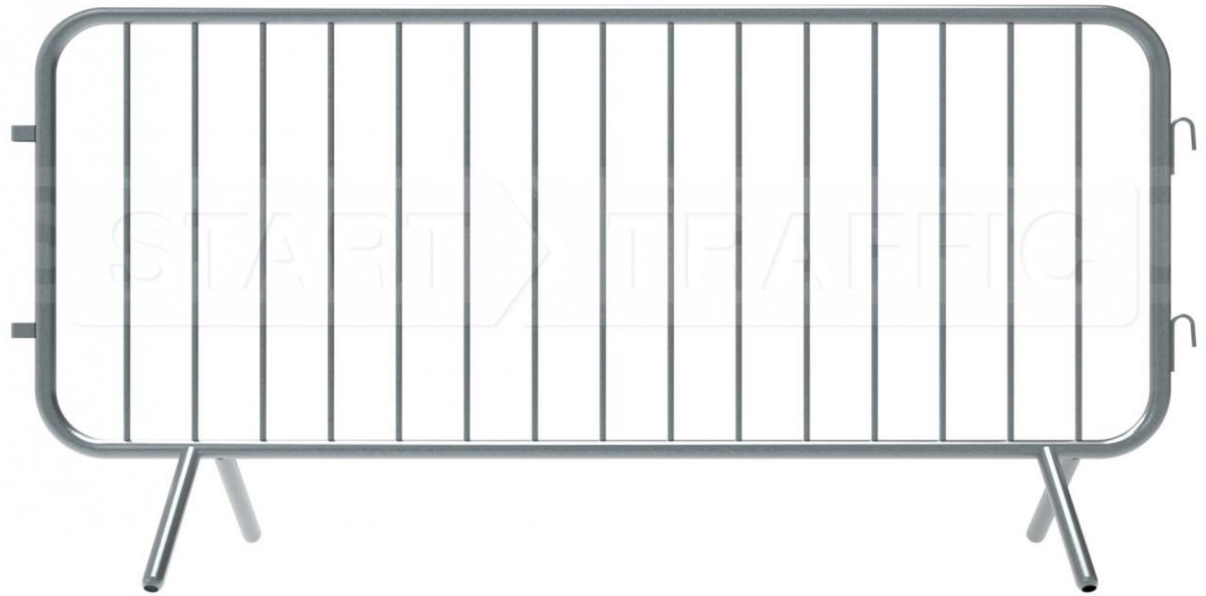
- Review Charity Care Policy
- Hospital's Charity Care Policy dictates what services are included on Line 20 of the S-10 worksheet – hospitals with more generous policies may have more charity care to report
- Compare policy to data collected on S-10 to ensure that all services that qualify are reported
- Make clear that the Charity Policy applies to both insured and uninsured patients and can include discounts
- Identify a clear uninsured discount policy in the FAP
- Include non-covered Medicaid services and Medicaid services exceeding length of stay requirements in the Charity Policy and FAP
- If a state requires that uninsured patients be given a discount, recite in the Charity Policy and FAP

Hospital Medicare Reimbursement – S-10

- **2019 Proposed Rule Highlights**
- Updated estimates for Factors 1 and 2
- Worksheet S-10 data used for **two-thirds** of Factor 3 to calculate and distribute UC payments
- A scaling factor for all hospitals, annualized cost reports and CCR trim where applicable
- Worksheet S-10, Line 30 will still be used as the data metric for uncompensated care costs (Line 23 + Line 29)
- Increased scrutiny by MACs for aberrant data
- **Patient detail is now required with cost report submissions to substantiate charity care and uninsured discounts for cost reporting periods beginning on or after 10/1/2018**

Barriers to Success

Avoid Costly Errors



Medicare Hospital Reimbursement

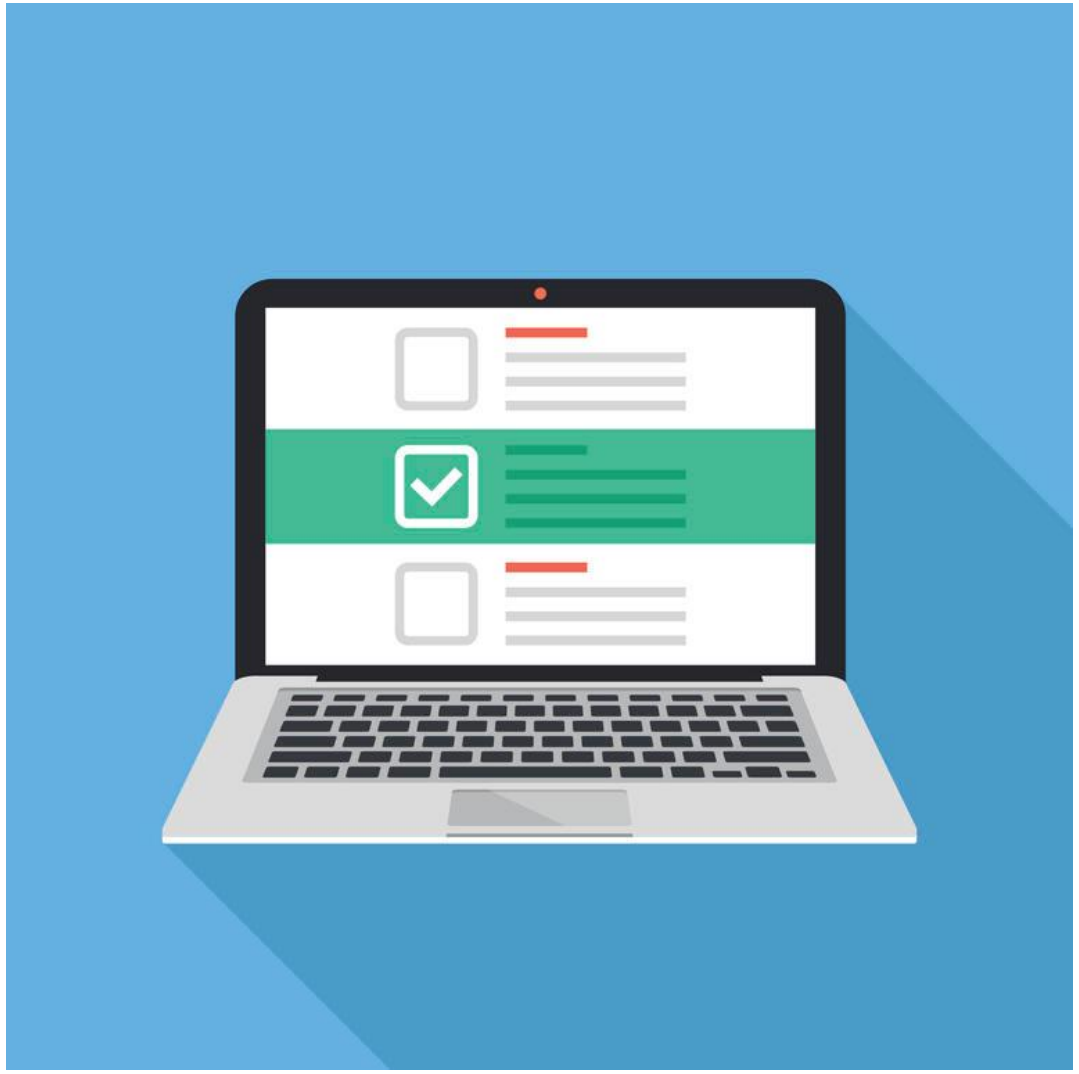
- Review data collection procedures to ensure all relevant data is collected and maintained
- Insure accuracy of all data

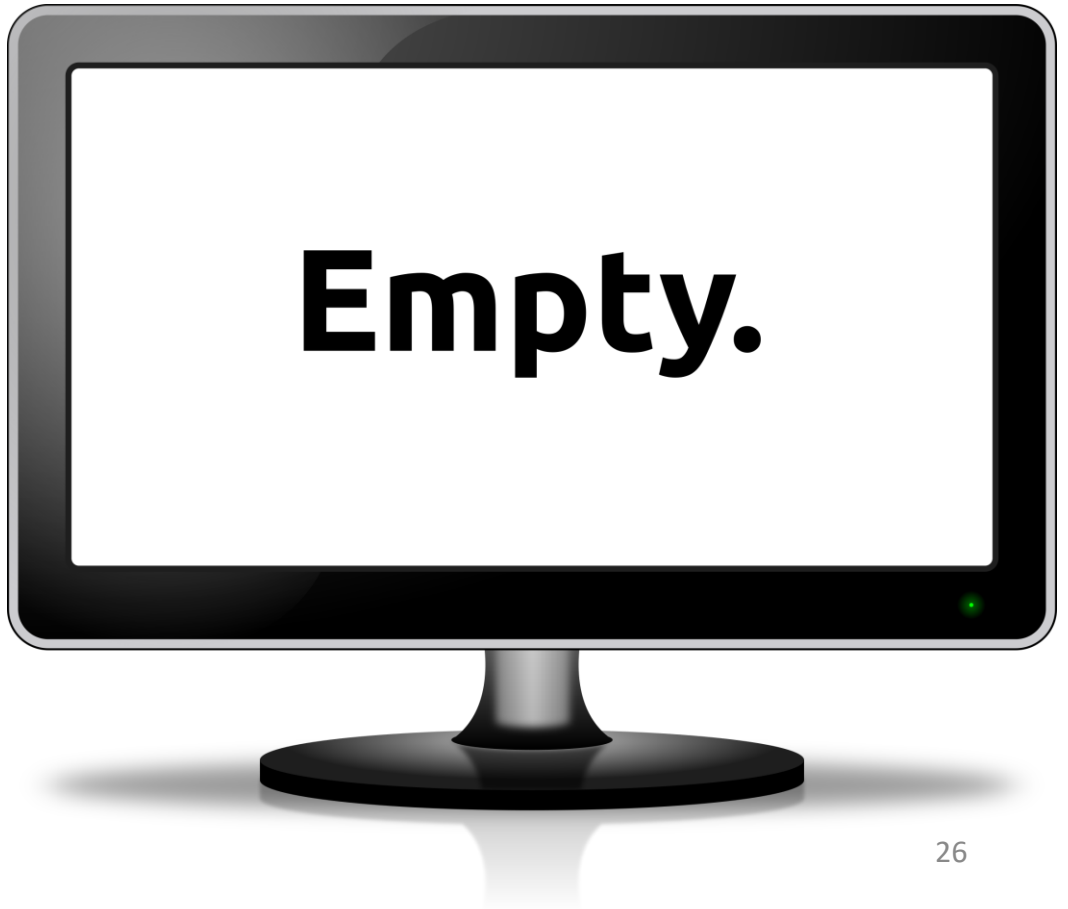
DOCUMENT,
DOCUMENT,
and
DOCUMENT

Keep and Maintain Documentation

- Review data retention schedules to ensure data is maintained and can be located
- Audits will review individual patients – prepare to justify

Documentation is Lost

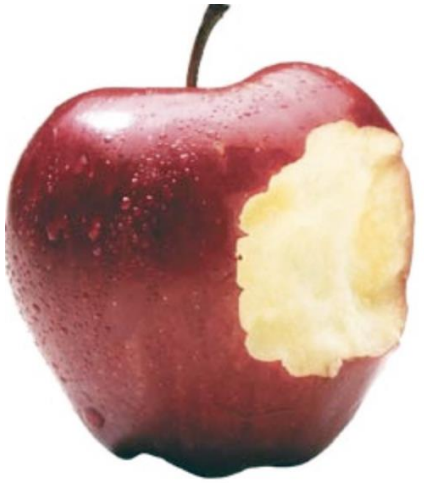




St. Vincent Randolph Hospital v. Price
2017 WL 3599779 (August 22, 2017)

- Hospital challenged denial of reimbursement of costs associated with a properly refinanced loan by a successor corporation replacing a faulty, poor documented loan, to build a new hospital to replace old facility
- District court found original loan poorly documented and no documentation to show proceeds of refinanced loan used to pay off old loan
- 7th Circuit reversed: no reason given by agency as to why properly refinanced loan, written consistent with requirements, was not eligible for reimbursement; no reason given as to why documentation of refinancing was inadequate – file apparently did not reflect the loan payoff, but adequate evidence existed outside required documentation
- Adequate documentation is critical to maximizing reimbursement

Hospital Medicare Reimbursement – Medicaid Eligible Days



Danbury, Barberton and Alert 10

How many bites at the apple?

- Jurisdictional challenges to appeals **adding Medicaid eligible days** in the Medicare DSH calculation
- *Barberton Citizens Hospital v. CGS Administrators/BCBSA*
  - A detailed description of the process the provider used to identify and accumulate actual paid and unpaid eligible days that were reported on the cost report
  - The number of additional Medicaid paid and unpaid days the provider seeks to add
  - A detailed explanation why the additional Medicaid paid and unpaid days could not have been verified by the state at the time of filing of the cost report; if there is more than one reason, state the reason and how many paid and unpaid days it applies to

Hospital Medicare Reimbursement

- Review process for not only claiming Medicaid eligible days but how data is compiled to be included in the as-filed cost reports in general
- Hospitals need a consistent and detailed process for claiming costs
  - All allowable costs in the initial cost report
  - Filing timely cost report amendments
- CMS will instruct contractors to accept an amended cost report submitted within a 12-month period after the hospital's cost report due date to allow submission of this revised eligible-days data. 80 FR 70298, 70560 (Nov. 13, 2015).
- Absence of a cohesive, consistent process will result in unnecessary, costly hurdles that may result in the dismissal of an appeal – and the loss of reimbursement

Hospital Medicare Reimbursement

University Medical Center v. Wisconsin Physician Services, 2018 – D41

June 27, 2018

- 374 Medicaid eligible days at issue
- Jurisdictional challenge – *Barberton* standard
  - Met for any days paid after the filing of the cost report
  - Not met for any days paid before the date of the filing of the cost report because the "the Provider should have known these days were Medicaid eligible and claimed these days on its cost report."

Hospital Medicare Reimbursement Common Cost Report Errors

- Incomplete or incorrect answers on Worksheets S-2and 3 (statistics and patient days)
- Incomplete number of Medicaid eligible days
- Incorrect resident FTEs or nor correctly reporting prior year resident-to-bed ratios
- Failure to review for CBSA reclassification and qualification for special status, e.g., sole community hospital, Medicare dependent hospital
- Nursing and Allied Health program pass-through payments

Hospital Medicare Reimbursement

- Jurisdiction – Basic Tenet of Demonstrating "Dissatisfaction"

  42 U.S.C. §§ 1395oo(a)(1)(A), (a)(2), and (a)(3), and 42 C.F.R. §§ 405.1835(a)(1), (a)(2),

- Current PRRB Rules 7.3 and 7.4
- Before 12/31/2008 jurisdiction could be based on a "self disallowed item"
- After 12/31/2008 protested item must be on the cost report
- After 12/31/2016 -- requiring costs to be listed

with protested items for reimbursement -- claim

Hospital Medicare Reimbursement

Banner Hospital v. Burwell,
201 F. Supp. 3d 131 (D.C. Cir. 2016)

- CMS Order 1727-R
- 42 C.F.R. § 413.24
- The appeal is pending on or after April 23, 2018, or was initiated on or after that date; *and*
- The cost reporting period under appeal ended on or after December 31, 2008, and began before January 1, 2016; *and*
- The provider had a good faith belief that the item was not allowable under Medicare regulations or payment policy
- WARNING: Place a claim or protest in nature of claim on cost report

Hospital Medicare Reimbursement

Substantive reimbursement requirement for cost report claim

42 C.F.R. 413.24(j)

- Applies to cost report periods beginning on/after 1/1/2016, therefore for the first time to cost reports filed for FYE 12/31/2016
- General requirement for a “specific claim” for items in accordance with CMS policy or estimated reimbursement amount for any “self disallowed item”
- For a self disallowed item, provide an “estimated” reimbursement amount for each item, attach a worksheet, an explanation of why provider is entitled to the reimbursement together with a description of how the provider estimated the amount claimed
- 42 C.F.R. 413.24(J)(5) Procedures required for review to determine whether the cost report included an appropriate claim. 405.1801(a). If any question, PRRB must review (can it review on its own motion?) PRRB Rule 7.4 (any party)

Hospital Medicare Reimbursement

What do these requirements mean?

- CMS amended the regulation by deleting the jurisdictional requirement that a provider must included a protested item in order to self-disallow a reimbursement item
- CMS promulgated an entirely new section of the regulation to set forth in detail the PRRB's review of compliance with the regulation requiring the setting forth on the cost report of an appropriate claim
- CMS amended the regulation to set forth the Administrator's review of the PRRB decision's findings regarding an appropriate claim
- Somewhat different rules for amended cost reports, adjusted reports, and re-openings

Hospital Medicare Reimbursement

What do these requirements mean?

- Compliance with the regulations regarding a proper claim will be reviewed as a condition on payment – not as a basis for determining jurisdiction
- Significant shift – potential for the PRRB to devote more resources to substantive matters
- Regulation requires the PRRB to issue one of four decisions
  - Findings of compliance with 413.24(J) (Claim requirements) for PRRB Hearing Decisions and PRRB Decisions granting EJR
  - No Findings when entering a jurisdictional dismissal or denying EJR
  - Regulation limits ability of PRRB to dismiss appeals

Hospital Medicare Reimbursement

Dismissals for lack of jurisdiction 2015

177 decisions – 53 Decisions pro-provider; 124 NEGATIVE

Appeals from Revised NPR with No Adjustment	39
No letter of Representation or Inadequate Jurisdictional Documents	27
Appealed SSI fraction of DSH without prerequisite request for recalculation	16
Failure to file Timely Appeal within 180 days	11
Appeal Closed Before Request to Transfer	5
EJR Denied – No Jurisdiction over Underlying Issue	4
Issues not Briefed in Position Paper deemed Abandoned	3
Medicare DSH – No Impediment	3
Miscellaneous	16
Total	124

Recent Jurisdictional Decisions = Avoidable Mistakes by Hospitals

Issue	May 2018	June 2018	July 2018
EJR	9	15	11
Appeal from RNPR without adjustment	5	1	1
Duplication of issues	3	3	3
Untimely Appeals	4	0	0
Failure to follow filing requirements, *e.g.*, file letter of representation	3	5	1
Failure to Request Use of Cost Report Period instead of FFY	13	5	1
Other	6	4	5
Total decisions	43	33	22

Hospital Medicare Reimbursement

PRRB Rules 7.2 and 8 - Issue Statement and Adjustments with Multiple Components

- Give a concise issue statement – include
  - The adjustment and the number of the adjustment
  - Controlling authority
  - Why the adjustment is incorrect
  - How the payment should be calculated
  - Reimbursement impact
  - Basis for Jurisdiction
  - Attach:
  - Copy of adjustment report or statement why unavailable
  - Calculation for reimbursement impact
  - Claim with documentation (Rules 7.3 and 7..4)
- Frame issue with multiple components – each component must be appealed as a separate issue, e.g., DSH, dual eligible, charity, HMO days, etc.
- Jurisdictional amount, $10,000, individual; $50,000 group

Hospital Medicare Reimbursement

Group appeals – PRRB Rules 12, 13 and 20

- A group case must consist of one legal or factual issue (Rule 13)
- Optional – two or more providers with a common issue
- Mandatory – Common Issue Related Party Group (CIRP)

  Providers that are commonly owned or controlled
- Optional and CIRP groups cannot be mixed
- PRRB Rule 18 – Restructuring Groups
- PRB Rule 20 – Schedule of Providers

Hospital Medicare Reimbursement

To appeal or to re-open? That is the question!

PRRB Rule 47 – Reinstatement

PRRB will grant reinstatement of an issue(s)/case if an issue(s)/case was withdrawn–

- As a result of an administrative resolution in which the Intermediary agreed to reopen a final determination under appeal with the Board but failed to issue a new final determination (e.g., Revised NPR) for that issue(s) as agreed
- Because the Intermediary agreed to reopen/revise the cost report for that issue(s) but failed to reopen the cost report and issue a new final determination (e.g., Revised NPR) for that issue(s) as agreed

ALWAYS APPEAL TO PROTECT RIGHTS

Hospital Medicare Reimbursement

PRRB Substantive Case Decisions

Fiscal Year 10/1 to 9/30	Decisions
2018	52
2017	31
2016	27
2015	30
2014	30
2013	42

Hospital Medicare Reimbursement

Settlement is More Efficient and Less Costly than Protracted Litigation

Hospital Medicare Reimbursement

How to Settle -- Administrative Resolutions (Ars)

- Focus on factual disputes; policy and regulatory challenges will not settle
- Approach MAC with a well documented settlement “package”
- Demonstrate full documentation for requests
- Full documentation required – no “horse trading”
- Are ARs enforceable?

Hospital Medicare Reimbursement

A List of “Do’s and Don’t” --

- Organize all documents; make an index; “pretty” notebooks with tabs
- Do not send duplicate documents
- Coordinate with consultant companies --
- Provide documents requested
- Answer and respond to all questions and issues raised -- promptly
- Be persistent

Medicare Hospital Reimbursement

- Eliminate “Silos”
- To Improve the “System” Everyone Must Be involved

Medicare Hospital Reimbursement QUESTIONS?

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