Medicare Cost Reporting Procedures & The Appeals Process

2013 TAHFA Seminar Series:
*Keep Informed, The Hospital you Save May be Your Own*

El Paso Children’s Hospital
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Proposed DSH Rule for FFY 2014

Issuance of Notices of Program Reimbursement (NPRs)

Amending Cost Reports

Appeals

- Provider Reimbursement Review Board (PRRB), Medicare Administrative Contractors (MACs), Providers
- Board Alert 9
- Appeal of Revised NPRs

PRRB Discretionary Jurisdiction

- Failure to claim
- Self-disallowance

Jurisdictional Challenges

CMS Ruling 1498-R

- Covered issues
- Remands
- Medicare Advantage/Medicare + Choice/Managed Care Part C Days

Considerations regarding appealing PRRB jurisdictional decisions
Effective Federal Fiscal Year 2014

- New DSH formula
  - 25% based on current formula
    - 25 percent of what hospital would have been be paid under existing DSH payment formula
  - 75% based on uncompensated care
    - New payment based in part on uncompensated care
Factor 1 - 75% of amount which would have been paid under old DSH formula

- CMS estimates this to be $9.25 billion

DSH Payment under old rule = $12.34B, 75% = $9.25B

Factor 2 - 1 minus percent change in uninsured population

- CMS estimate this to be 88.8%

Uninsured percentages based on CBO estimates

- Uninsured in 2013 (based on 2010 report) = 18%,
- estimate for 2014 published in Feb 2013 = 16%.

\[1 - \frac{(.16 - .18)}{.18} = 1 - .111 = .889 \text{ less statutory reduction .001} = .888\]

\[\$9.2535B \times .888 = \$8.217B\]
PROPOSED DSH RULE FOR FFY 2014

Factor 3 - Percent of individual hospital uncompensated care costs to total uncompensated care costs

- This represents each hospital’s “piece of the pie”
- CMS discusses the use of S-10 data
- CMS indicates S-10 data is not yet appropriate to use
- CMS proposes a proxy for uncompensated care is to count low income patients
- CMS proposes to use Medicaid eligible days and SSI days as a proxy for uncompensated care
- Hospitals in States which have accepted Medicaid expansion will benefit compared to hospitals States without Medicaid expansion
Being Issued or have been issued for fiscal years 2007 and 2008 and even some fiscal year 2009 Cost Reports

Various issues that may need to be appealed or reopened:

- Disproportionate Share Hospital (DSH) Calculation
  - SSI percentage Ratios (SSI%) – Medicare Proxy (Systemic Errors and Recalculations)
  - Medicare Part C Days
  - Dual Eligible Days – Exhausted/Medicare Secondary Payor (MSP)/No Pay Days
  - 340-B qualification
  - DSH Eligible Days – Medicaid Proxy
- Bad Debts
  - Crossover – Medicare/Medicaid
- IME / GME
- Rural Floor Budget Neutrality Adjustment (RFBNA)
- Outliers
Schedule deadlines for Reopenings
• Three (3) years from the date of the NPR

Schedule deadlines for Appeals
• 180 days from the NPR date for Appeals
• Board must receive Provider’s request no later than 180 days after the Provider received the determination being appealed
• Provider is presumed to have received the determination 5 days after issuance, unless established to the contrary by a preponderance of the evidence. (42 C.F.R. § 405.1801(a)(1))
• Date of receipt by the Board is date of delivery if delivered by a nationally-recognized courier, or the date stamped “received” if delivered otherwise, unless established to the contrary by a preponderance of the evidence
• Determination of date of receipt is not subject to appeal
Order MEDPAR Data through the Centers for Medicare and Medicaid Services (CMS)

- Data Usage Agreement (DUA) process

Appeal your NPRs for self-disallowed items or items adjusted during audit

- Whether through an individual appeal or Group Appeal

Join Group Appeals

- Strength in numbers
- May not have a choice
Amend 2009 – 2012 filed cost reports (may or may not be accepted)...

- Protested Items - for any self-disallowance items such as
  - RFBNA (through FY 2011)
  - SSI%
  - Medicare Part C
  - Dual Eligible Days – Exhausted Days / Medicare Secondary – No Pay Days
  - Additional Medicaid Eligible Days
  - Bad Debts – Crossovers (Medicare / Medicaid)
  - Outliers
A provider may file or the MAC may require an amended cost report to:

1. Correct material errors detected subsequent to the filing of the original cost report.
2. Comply with the health insurance policies or regulations, or
3. Reflect the settlement of a contested liability.

See HIM 15-1, § 2931.2
AMENDING THE COST REPORT

What to send:

- Cover letter to MAC
- Relevant Worksheet(s)
- New or revised list of protested items
- Signed certification page
- Electronic cost report (ECR) data file (resubmit)

See HIM 15-1, § 2931.2
There are three (3) players in the Medicare cost report appeals arena.

- **The Provider**
  - Appeals adjustments

- **The Intermediary**
  - Defends adjustments

- **The PRRB**
  - Strong interest in docket management
  - If a case can be dismissed, it will be dismissed
Updated Model Forms

Rule Changes:

• All correspondence must be served on the MAC and BCBSA (appeals support contractor)
• It is the Provider’s and the Representative’s responsibility to keep all contact information up to date with the Board, including the current email address, as correspondence is frequently issued by the Board electronically
• Additional documentation requirements when Filing a Form D to transfer an issue from an individual appeal to a group appeal as well as when filing a Form E to file directly from a Final Determination into a group appeal
• Schedules of providers with supporting documentation must be sent simultaneously to the Lead MAC and the Board
• Rule 21 has been significantly revised to include additional informational requirements on the Schedule of Providers (Model Form G) and additional supporting documentation requirements
• 5 copies of final position papers must be submitted to the Board 7-10 business days prior to a Board hearing
• When appealing a Revised NPR, additional documentation is now required to support that the issue under appeal was revised in the Revised NPR pursuant to 42 C.F.R § 405.1889
Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision is reopened as provided by § 405.1885, such revision shall be considered a separate and distinct determination or decision to which the provisions of [Medicare regulations governing appeals] are applicable.

See 42 C.F.R. § 405.1889.
(a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in § 405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of § 405.1811, § 405.1834, § 405.1835, § 405.1837, § 405.1875, § 405.1877 and § 405.1885 of this subpart are applicable.

(b)

(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.

(2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

See 42 C.F.R. § 405.1889
Applies when a provider fails to claim a cost to which it is entitled and which, if claimed, it would have received payment, e.g. Bad debt

Generally, the PRRB exercises its discretion to not assert jurisdiction

- See, e.g., Maine General Medical Center v. Shalala, 205 F.3d 493 (1st Cir. 2000)

Several courts have held that the PRRB has discretion whether to assert jurisdiction

- Several PRRB Decisions follow this holding

The Ninth Circuit Court Of Appeals agreed

- Holding that the PRRB has jurisdiction over costs not claimed in cost report and not included in a request for hearing

- See Loma Linda Univ. Med Center v. Leavitt, 492 F.3d 1065 (9th Cir. 2007)
In contrast to the failure of the provider to claim an item that is allowable, a provider may “self-disallow” to preserve an issue for appeal:

- *Norwalk Hospital v. Blue Cross Blue Shield Ass’n/Nat’l Gov’t Serv., Inc.*, PRRB Dec. No. 2012-D-14
- 42 C.F.R. § 405.1803(d), 42 C.F.R. § 405.1811 and 42 C.F.R. § 405.1835

“Self Disallowance” via “Protesting”

- Thus, The Provider Files The Cost Report Consistent With Law, But Under Protest
- PRRB Rule 7.2
The PRRB is currently questioning jurisdiction when a provider appeals an issue not adjusted or protested for all cost reporting periods ending on or after December 31, 2008.

The PRRB is generally denying jurisdiction.

Need to amend cost reports that have not had an NPR issued.

Protest – It may be your only avenue to appeal an issue.
The appeal of a PRRB jurisdictional decision is not ripe until the PRRB issues a decision disposing of the case in its entirety.

Thus, in a multi issue case, appeal of the denial of jurisdiction over one issue only becomes ripe when the PRRB decides all the issues on their merits and thus disposes of the entire case.
Pursuant to CMS Ruling 1498-R, the PRRB Must Remand the Following DSH Issues:

- Supplemental Security Income (SSI),
- Non-covered inpatient days for patients entitled to Medicare Part A and days where the patient’s Part A benefits were Exhausted for discharges before October 1, 2004 (Exhausted Dual Eligible days) and
- Labor/Delivery Room inpatient days (Labor Room days) for cost reports beginning prior to October 1, 2009.
Two (2) Types of Remands

- Alternative
  - Best for Individual appeals
- Standard
  - Best for Group appeals

If you have jurisdictional problems, always ask for a standard remand
Trinity Health, d/b/a St. Joseph Mercy Oakland v. Sebelius (Case 1:10-cv-02070 (PLF))

- In November 2008, QRS had a Hearing before the PRRB, but the PRRB did not render a decision until August 2010.
- PRRB remanded the case, but also decided that the additional SSI Days had to be incorporated into the Medicare fraction of the Provider’s DSH calculation upon remand.
- Administrator reviewed and reversed the PRRB’s Decision to include the SSI Days.
- QRS appealed the Administrator’s reversal to the District Court in the District of Columbia.
- The Case settled in June 2012.
The Queen’s Medical Center v. Sebelius (Case 1:10-cv-00434 (SOM-LEK))

- The Provider appealed the Administrator’s reversal of the PRRB’s Decision to include Exhausted Dual Eligible days in the Medicaid fraction of the Provider’s DSH calculation.
- The Provider requested, among other things, an injunction prohibiting CMS from implementing Ruling 1498-R.
- This case settled confidentially.

- The PRRB also granted an EJR request challenging 42 C.F.R. § 412.106(b)(2)(i), effective October 1, 2004, which eliminated the word “covered” from the Medicare fraction definition.

- This change in the regulation, which applies to fiscal years prior to October 1, 2004 in CMS Ruling 1498-R, requires inclusion of all Medicare Part A exhausted days in the Medicare fraction.

- The Federal District Court in the Western District of Michigan held that the regulation is inconsistent with the Medicare DSH statute and the meaning of entitled to benefits under Medicare Part A.

- On March 27, 2013, the 6th Circuit Court of Appeals reversed the ruling of the district court and remanded the case with instruction to enter judgment in favor of CMS.

- PRRB granted EJR as to the validity of Ruling 1498-R
- Administrator reversed, vacated and remanded back to the MAC - PRRB lacked the authority to grant EJR
- The Providers appealed to the D.C. District Court
- *Alegent Health v. Sebelius* (Case No. 1:10-cv-01354 (ESH))
  - Consolidated with other cases, now over 200 Providers
  - STAYED pending the outcome of the appeal in *Catholic Health Initiatives - Iowa Corp. d/b/a/ Mercy Medical Center - Des Moines v. Sebelius* (Case No. 1:10-cv-00411 (RCL))
  - See *Allina Health Services, et al. v. Sebelius* (Case No. 1:09-cv-01889 (RBW))
Picture a law written by James Joyce and edited by E.E. Cummings. Such is the Medicare statute, which has been described as “among the most completely impenetrable texts within human experience.”

Rehab. Ass’n of Va. v. Kozlowski, 42 F.3d 1444, 1450 (4th Cir. 1994). Certain provisions of this labyrinthine statutory scheme are at issue in this case, which concerns a hospital seeking review of a final decision of the Secretary of the Department of Health and Human Services, who denied it certain payments it believes it is owed for providing care to low-income patients.

See Memorandum Opinion, pg. 1.
CHALLENGE TO THE RULING: APPEALS PROCESS

Catholic Health Initiatives - Iowa Corp. d/b/a/ Mercy Medical Center - Des Moines v. Sebelius (Case No. 1:10-cv-00411 (RCL))

- The Provider appealed the Administrator’s decision reversing the PRRB stating that CMS has a “long-standing policy” of “excluding exhausted days from the Medicaid fraction . . . .”
- The District Court held that this was not a long-standing policy, but retroactive rulemaking
- This case was appealed to the D.C. Court of Appeals and heard on April 15, 2013
- The D.C. Court of Appeals issued its’ decision on June 11, 2013 reversing the district court’s holding and stated the policy on which the agency relied in this case was first announced in an adjudication in 2000, not in the 2004 rulemaking
- The D.C. Court of Appeals further held that the agency’s interpretation of the statute is permissible, and the denial of reimbursement was not arbitrary and capricious
- The Court also held that the Provider did not show that it relied to its detriment on the position the agency allegedly held before 2000
Settled or Pending Appeals in Federal Court Over the Inclusion of Medicare Part C Days in Medicaid Fraction of DSH Calculation

- Northeast Hospital Corporation v. Sebelius, 657 F.3d 1 (D.C. Cir. 2011)
  - Pre 10/1/2004

- Baptist Medical Center v. Sebelius, 855 F. Supp. 2d 1 (D.D.C. 2012)
  - Pre 10/1/2004

- Alegent Health-Immanuel Medical Center, et al. v. Sebelius (Case No. 1:11-cv-00139 (EGS))
  - Pre 10/1/2004

- Allina Health Services, et al. v. Sebelius (Case No. 1:10-cv-01463 (RMC))
  - 2007 - 2008

- Baptist Medical Center, et al. v. Sebelius (Case No. 1:11-cv-01273 (CKK))
  - 1995 - 1998
The Best Offense is a Good Defense

- In light of the time, cost and speculative outcome associated with jurisdictional appeals, a provider is well advised to attend to and if possible to resolve jurisdiction issues at the level of the PRRB
- Request PRRB reconsideration
- Request CMS Administrator review
- Appeal to Federal court

Cost/Benefit Analysis

- The probability weighted cost of a jurisdictional appeal should be compared to the underlying amount of payment to be recovered if the jurisdictional appeal is successful
- A successful jurisdictional appeal returns the case to the PRRB, which does not necessarily mean that a provider will prevail
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