THE EVOLUTION OF THE PRRB PROCESS:

From Cost Report to Appeal and the Almost Forgotten Reopening

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OVERVIEW

- Remember When
  - Pre-2008
  - 2004 Proposed Rule
  - 2008 Final Rule
  - New PRRB Instructions
- Shift from Appeal Rules to Payment Rules
  - Proposed in IPPS NPRM
  - Finalized in OPPS Final Rule in 2015
  - Effective January 2016 Cost Report filings
- Resulting Jurisdiction Landscape Over Time
- Leading to
  - Alert 10
    - Barberton
  - Alert 11
    - Implementation Challenges
- Best Practices
- Litigation Update
- Questions

WHOLE THING BEGINS WITH WHAT IS IN THE COST REPORT

REMEMBER WHEN

- Before 2008 – simple time
  - No Protest required
  - Self-disallowance in effect
    - *Bethesda – 1988*
  - Add issues up to date of hearing
  - Sent in letter specifying what you didn't like

REMEMBER WHEN

- Proposed Rule 2004
  - Finalized in 2008
  - Most provisions effective August 21, 2008
    - Regulatory changes
  - New protest requirement effective 12/31/2008
  - New regulations regarding content of hearing requests
  - New PRRB instructions effective August 21, 2008

REMEMBER WHEN

- What you did in the cost report mattered for PRRB jurisdiction purposes – three criteria for PRRB jurisdiction
  - Dissatisfied with Medicare reimbursement for cost reporting period
  - Amount in controversy > $10K
    - > $50K for group appeals
  - Hearing request filed timely

REMEMBER WHEN

- Dissatisfied with Medicare reimbursement for cost reporting period – two avenues
  - Claim the cost in the cost report
    - Audit Adjustment
    - No Audit Adjustment
  - Self-disallow by following the procedures for filing the cost report under protest
    - Relates to items that the provider thinks may not be in accordance with Medicare policy – where MAC does not have the discretion to award the reimbursement
    - Avoid allegation of fraud or similar fault by claiming without protest items at variance with Medicare policy

REMEMBER WHEN

- Self-disallow by following the procedures for filing the cost report under protest – PRM
  - The disputed amount – for each issue – must be specifically identified
  - The effect of each item is estimated by applying a reasonable methodology that closely approximates the actual effect of the item
    - Through normal cost finding process
  - Must submit copies of work papers with the cost report used to develop the estimates
    - So contractor can evaluate the reasonableness for acceptability purposes

REMEMBER WHEN

- Self-disallow by following the procedures for filing the cost report under protest
  - "If you Deliberately include in cost, without disclosing the fact, in the provider cost report that is nonreimbursable under the regulations you are subject to those provisions concerning suspected fraud or abuse. Where you fail to comply with the requirements for filing cost reports under protest as set forth above, such cases are referred to the CMS regional office."

THE HERE AND NOW

- Shift from appeal rules to payment rules
  - Addition to the Cost Reporting Regulations of the Substantive Reimbursement Requirements of an Appropriate Cost Report Claim

    See 80 Fed. Reg. 70555-70580 (November 13, 2015)
  - New Paragraph (j) To 413.24 – provides that
    - In order to receive or potentially qualify for payment, the provider must include in it's cost report an appropriate claim for the specific item
    - Claim payment of the item
    - Self-disallow the item
- Let's examine the changes, the cited justification and practical implications

THE HERE AND NOW

- Specific language in the 2015 IPPS Proposed Rules:
  - *"we are proposing to revise the cost reporting regulations in Part 413, Subpart B by adding the **substantive reimbursement requirement** that a provider must include an appropriate claim for an item in its cost report. The failure to account appropriately for the item in its cost report will foreclose payment for the item in the NPR issued by the contractor and in any decision, order, or other action by a reviewing entity (as defined in 405.1801(a) of the regulations) in an administrative appeal filed by the provider." - CMS*

THE HERE AND NOW

- Elements of the 2016 OPPS Final Rule:
  - Claim for payment
    - Consistent with Medicare policy
  - Self-disallow
    - No authority to pay
    - File under protest
    - Elements of codified protest requirements
  - Applicable to original filing that is accepted by the MAC – with three exceptions
    - Amended cost report submission that is accepted
    - If the MAC adjusts the cost report
    - MAC reopens and revises its determination
  - Original Cost Report – **Safest Bet**

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THE HERE AND NOW

- Example given – DSH claim
  - Claimed 1,000
  - Want 2,000
  - Amended to 1,500
  - Asked for 250 more during audit
  - Asked for reopening for another 250

- "The back and forth process between the provider and the contractor eliminates, or minimizes and sharpens, potential disagreements, which obviates the need to file some administrative appeals or narrows the issues in many cases."

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THE HERE AND NOW

- "to the extent a provider fails to claim a specific item appropriately in its cost report, the final contractor determination (as defined in 405.1801(a)) may not include payment for the item."
- Questions whether cost report included an appropriate claim for item under appeal
  - Follow procedures set forth in 405.1873 for Board appeals
  - Follow procedures set forth in 405.1832 for MAC appeals
- Left up to the reviewing entity

THE HERE AND NOW

- If to PRRB
  - Board must give parties opportunity to brief
  - Board may decide
    - Met appropriate claim rule
    - Did not meet appropriate claim rule
  - However, this has to do with payment
    - "the NPR issued by a contractor may not include payment for the item and payment also may not be permitted in any decision, order, or other action by a reviewing entity….in an administrative appeal filed by the provider."

THE HERE AND NOW

- Amended Cost Reports
  - Acceptance discretionary by MAC
  - One time sure thing for DSH
    - "we will instruct contractors, in this limited circumstance, that they must accept one amended cost report submitted within a 12-month period after the hospital's cost report due date, solely for the specific purpose of revising a claim for DSH by using updated Medicaid-eligible patient days, after a hospital receives updated Medicaid eligibility information from the State."
  - Not a one time sure thing for any other issue

THE HERE AND NOW

What does this mean from a PRRB jurisdiction and appeal litigation perspective?

Turn over to Kristin DeGroat to discuss all that is jurisdiction and appeals

THE HERE AND NOW:
ALL THAT IS JURISDICTION AND APPEALS

- Why do we appeal?
  - "Dissatisfied" with the MAC's final determination
  - No longer enough
  - No discretion as to jurisdiction

THE HERE AND NOW

- 42 CFR § 405.1873
  - Applies to cost reporting periods beginning on or after January 1, 2016
  - PRRB review is narrowed to whether a provider complied with the requirements of Section 413.24(j)
  - Board can no longer dismiss a provider's claim for failing to comply with the protest or claim requirement
  - PRRB can only issue one of four types of decisions

THE HERE AND NOW

- Four types of decisions:
  1. Hearing Decision
  2. EJR Decision
  3. Decision Denying EJR
  4. Jurisdictional Dismissal Decision

DISSATISFACTION

- CMS has eliminated the dissatisfaction requirement for Board jurisdiction over Provider appeals based on the MAC's failure to timely issue a NPR
  - Providers no longer have to claim an issue on their cost report that they appeal based on the untimely issuance of the NPR

    See 79 Fed. Reg. 49853, 50199-50201,50350-50351 (Aug. 22, 2014)

DISSATISFACTION

- CMS - "dissatisfaction" means that providers were required to claim or challenge all matters in a cost report to be able to appeal those items
- PRRB - "dissatisfaction" means that providers could appeal matters not claimed in a cost report because a regulation or other factor dictated or indicated that the items could not be claimed
- United States Supreme Court had to step in

  See Bethesda Hosp. Ass'n v. Bowen, 485 U.S. 399, 404 (1988)

DISSATISFACTION

- "Despite the providers' failure to claim all the reimbursement they believed should have been made, the plain language of the dissatisfaction requirement in section 1878(a)(1)(A) of the Act supported Board jurisdiction because the contractor had no authority to award reimbursement in excess of a regulation by which it was bound, and thus it would have been futile for the providers to try to persuade the contractor otherwise."
- "However, that the dissatisfaction requirement might not be met if providers were to bypass a clearly prescribed exhaustion requirement or…fail to request from the intermediary reimbursement for all costs to which they are entitled under applicable rules." (dicta)

DISSATISFACTION OR SELF DISALLOWANCE

- "We [CMS] no longer required providers to make a cost report claim for reimbursement of items for which the contractor did not have the discretion to award payment due to a regulation or manual provision but, consistent with the dicta in *Bethesda*, we continued to require providers to include cost report claims for allowable costs. However, our policy, as revised in response to *Bethesda*, was also challenged in the courts, and a circuit split resulted."

SELF DISALLOWANCE

- Cost reporting periods prior to December 31, 2008
  - Providers were "self-disallowing" item(s) on their cost reports
  - Where a regulation, manual, ruling or other legal authority predetermined that the claim would be disallowed
  - By citing the authority, describing the item(s) and showing the reimbursement/payment sought
- By "self-disallowing", the Board held that the providers preserved their right to appeal

See Norwalk Hospital v. Blue Cross Blue Shield Ass'n/Nat'l Gov't Serv., *Inc.*, PRRB Dec. No. 2012-D-14

CLAIM OR PROTEST

- Cost reporting periods ending on or after December 31, 2008
  - Providers will not be granted appeal rights for item(s) unless
    - either expressly claimed on a cost report or
    - self-disallowed as a protested amount on a cost report
- File the cost report consistent with law, but under protest

  See PRRB Rule 7.2

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PROTEST

- "Under longstanding Medicare policy as set forth in § 413.24 of the regulations and section 115 of the Provider Reimbursement Manual (RPM), Part 2 (CMS Pub. 15-2), a provider must make an appropriate cost report claim for a specific item in order to be reimbursed for the item, whether through the NPR by the contractor or as the result of an administrative appeal or judicial review."
- "In addition, as set forth in section 115 of the PRM, Part 2, we also require that providers make a specific claim for an item in its cost report, in order to meet the dissatisfaction requirement for Board jurisdiction."

PROTEST

- CMS's "Protest" requirement was invalidated by the D.C. District Court
  - Granted providers' motion for summary judgment in a challenge of the Board's denial of jurisdiction based on the application of the "self-disallowance" regulation
- Held that the "protest" requirement was foreclosed by the Supreme Court's decision in *Bethesda*

See Banner Heart Hospital, et al. v. Burwell, case no. 14-cv-01195 (APM) (D.D.C. August 19, 2016)

PROTEST

- *Banner* only speaks cost reporting periods prior to January 1, 2016
- After January 1, protesting is no longer just a pre-requisite for jurisdiction, it is now a requirement for payment
  - CMS has comingled cost reporting and appeal rules
    - For appeals to have any significance, you must ensure that you have complied with all cost report requirements
    - Must claim or protest item(s) at the cost reporting stage to protect them at the appeal stage

JURISDICTIONAL CHALLENGES

- The MAC and PRRB are 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

JURISDICTIONAL CHALLENGES

- Danbury Hospital - FYE 09/30/2005
- PRRB Decision - 02/11/2014
- Issue – Whether the PRRB has jurisdiction over a claim for Medicaid eligible days for which there was no adjustment made by the MAC within the NPR
- MAC's Position – The days claimed by the hospital in the cost report were not adjusted, but accepted as reported by the provider
- Provider's Position – The Board has jurisdiction in accordance with *Bethesda*
- The PRRB found it lacked jurisdiction and declined to hear the case

JURISDICTIONAL CHALLENGES

- The PRRB focused on three areas in its decision:

1. The Provider did not adequately describe its internal process for gathering State information, particularly how it identified and verified Medicaid eligible, but unpaid days.
2. The Provider did not adequately identify the nature of the days that it was seeking to include on appeal (474 days). Provider claimed data was "not readily available".
3. Upon the PRRB requesting data in a second request, the Provider suggested that it may have been at fault for not identifying at least some of the days at issue on the as-filed 2005 cost report.

See Danbury Hospital v. Blue Cross Blue Shield Ass'n, PRRB Dec. No. 2014-D3 (Feb. 11, 2014), *declined review*, Administrator (Mar. 26, 2014)

ALERT 10

- May 23, 2014 - issued in response to Danbury
- "parties to an appeal currently pending before the Board that includes the Disproportionate Share Payment ("DSH") paid/unpaid Medicaid eligible days issue (the "Issue") an opportunity to supplement the record based on the *Danbury Hospital* decision."
- Supplemental responses were due July 22, 2014
- Many responses were filed

ALERT 10

- MAC challenged Board jurisdiction on "dissatisfaction"
- Argued that the hospital did not claim the additional Medicaid days at issue in the as-filed cost report - establish a "practical impediment" why
- Relied on prior decisions in Norwalk and Danbury
- Reasoned that it is the hospital's obligation to submit Medicaid eligible days data during the cost reporting process and the hospital's burden of proof to ensure that only days verified with the State as Medicaid eligible are claimed

See Barberton Citizens Hospital v. CGS Admr., LLC/Blue Cross and Blue Shield Ass'n, PRRB Dec. No. 2015-D5 (Mar. 19, 2015)

ALERT 10

- In Barberton, the PRRB ruled:
  1. Provider established an impediment associated with retroactive eligibility determinations
     - Namely, that in-process eligibility determinations could take up to a year after the date of service
     - Made it impossible for the provider to claim the days in the as-filed cost report

ALERT 10

2. There may be issues with the State's database
   - Namely, there were gaps in the Medicaid eligibility database
   - At one point in time an eligibility match may result in a negative determination while at a future point in time, it may result in a positive determination
   - Unbeknownst to the hospital, changes to eligibility determinations and/or demographic data continue to be updated in the eligibility database, which yielded different eligibility verification results based on the timing of the matching frequencies

ALERT 10

3. There were limitations regarding accessing the State's database
   - Necessary data elements are continually being updated
   - The State's database is dynamic, not static and more times than not, matches performed significantly after the cost report is filed will yield more complete and comprehensive results
4. Provider's process of identifying Medicaid eligible days for the as-filed cost report was a comprehensive process
   - "**All available and practical means to identify, accumulate, and verify with the State the actual Medicaid eligible days that were reported on its Medicare cost reports, and was diligent in following that process.**"

ALERT 11

- Issued - June 30, 2015
- Effective July 1, 2015
- Amended PRRB Rules 46 and 48
- Rule 46
  - 46.1 – "Provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case or, if no dismissal was issued, within three years of the Board's receipt of the Provider's withdrawal of the issue(s)".
  - 46.2 – "As a Result of Administrative Resolution or Agreement to Reopen."
  - 46.3 – "Dismissals for Failure to Comply with Board Procedures."
    - Only granted in rare circumstances
    - Must give "good cause" as to why outside of Provider's control.

ALERT 11

- Rule 48
  - "Provider's request to withdraw an issue(s) or case must be in writing." It also provides that "[i]t is the Provider's responsibility to withdraw:"
    1. "an issue(s) or case that the Provider no longer intends to pursue;"
    2. "an issue(s) or case in which an administrative resolution has been executed and attach a copy of such administrative resolution;"
    3. "an issue(s) for which the Intermediary has agreed to reopen the final determination for that issue(s) and attach a copy of the correspondence from the Intermediary where the Intermediary agreed to that reopening; and"
    4. "a case in which all issues have been handled, whether by resolution, transfer, dismissal, or withdrawal."

ALERT 11

- Rule 48
  - Allows a provider the right to request a withdrawal for an issue(s) for which MAC agreed to reopen
  - Requires that the provider attach "correspondence" from the MAC showing the agreeance
- Example
  - Provider withdrew their appeal pursuant to Rule 48(3) and attached "correspondence"
  - MAC did not process the reopening
  - Provider requests reinstatement of the appeal pursuant to Rule 46.2 within 3 years of the withdrawal
  - PRRB reinstates that appeal

ALERT 11

- Reopenings have been given new life
  - Providers are requesting reopenings
  - MACs are issuing Notices of Intent to Reopen
  - Providers are withdrawing appeals for Medicaid eligible days with the assurance that they may later reinstate those appeals
  - MACs are settling providers Medicaid eligible days and issuing NPRs

BEST PRACTICES

- Be aware of all the changes in the cost reporting and appeals rules – Many pitfalls and Board rulings against providers on jurisdiction
- Take no chances – Don't just assume you can automatically appeal an item after filing your cost report that you later discover or document
- Keep protesting – be prepared to include an estimate of the item, a calculation and a description
- File reopenings – avoid the pitfalls and reopen for issues that the MAC can settle

BEST PRACTICES

- Alert 10 – Evaluate your current process for compiling Medicaid days in the as-filed cost report
  - Are you putting your best foot forward
  - Can you meet the standard the PRRB set forth in *Barberton*
  - Employ an independent third-party review of Medicaid eligibility subsequent to the filing of the cost report
    - Revise the work that you performed internally at a subsequent date, but before MAC audit
  - Ask yourself - Does this represent best practices or give the hospital the best opportunity to ensure that it is capturing all the Medicaid patient days that the hospital is legally entitled to claim

LITIGATION UPDATE

- *Allina I*
  - December 2, 2015 - CMS issued its decision on remand
    - CMS stated that "days associated with Medicare patients who are enrolled in a Part C plan are to be included in the numerator and the denominator of the Medicare fraction."
- *Allina II*
  - August 17, 2016 - D.C. District Court issued its decision
    - The hospitals argued that including Part C days in the FY 2012 SSI fractions was arbitrary and capricious since CMS did not articulate any rationale for doing so

LITIGATION UPDATE

- *The Court found that it was "not difficult to understand the agency's reasoning", pointing to the now vacated 2004 Final Rule, the 2013 Final Rule, and CMS' decision on remand of Allina I.*

- *Allina III*
  - January 2016 - filed in response to CMS' decision on remand.
    - Hospitals argued that days associated with Medicare patients who are enrolled in a Part C plan should be included in the numerator and the denominator of the Medicaid fraction
    - Still pending in the D.C. District Court

LITIGATION UPDATE

- CMS Ruling 1498-R Litigation
  - All the Providers who filed a case in Court have been or are in the process of being paid
  - If your appeal was remanded and you did not file a case in Court, you need to review your numbers and if your SSI percentage appears to do down, you should now think about filing a case in Court

QUESTIONS/COMMENTS?

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