

Health Financial Systems
User Meeting 2017

ABOUT THE SPEAKERS

Mike Newell
President

Kristin DeGroat
Healthcare Reimbursement
and Compliance Counsel

Southwest Consulting Associates

www.southwestconsulting.net
<http://blog.southwestconsulting.net/blog>
<https://www.linkedin.com/company/southwest-consulting-associates>

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**Provider Reimbursement Review Board
(PRRB) Update:**

From Cost Report to Appeal

August 17, 2017

Mike Newell and Kristin DeGroat

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OVERVIEW

- Remember When
 - Pre August 21, 2008
 - Self Disallowance
- The Here and Now
 - August 21, 2008
 - Protest
- Shift from Appeal Rules to Payment Rules
 - Proposed in 2015 IPPS Rule
 - Finalized in 2016 OPPI
 - Final Rule
 - Practical Implications
- Jurisdiction
 - Dissatisfaction
 - Decisions
- Jurisdictional Challenges
 - Alert 10
 - Barberton
 - Women and Infants' Hospital of Rhode Island
- Alert 11
 - Implementation Challenges
- Best Practices
- Alert 12
- Litigation Update
- CMS Rulings 1498-R/R2

APPEALS START WITH WHAT IS IN
THE COST REPORT

REMEMBER WHEN

- What you did in the cost report mattered for jurisdictional purposes as long as you met the three criteria for PRRB jurisdiction
 1. Dissatisfied with Medicare reimbursement for cost reporting period
 2. Amount in controversy
 - > \$10K for individual appeals
 - > \$50K for group appeals
 3. Hearing request filed timely

**REMEMBER WHEN**

- Before August 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



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 PRRB 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-D14 (Mar. 19, 2012)



THE HERE AND NOW

- August 21, 2008
 - Protest requirement effective 12/31/2008
 - New regulations regarding content of hearing requests
 - New PRRB instructions



PROTEST

- Self-disallow by following the procedures for filing the cost report under protest
 - 42 CFR § 413.24 and section 115 of the Provider Reimbursement Manual (PRM), Part 2 (CMS Pub. 15-2)
 - 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



PROTEST

- CMS's "Protest" requirement was invalidated by the D.C. District Court for cost reporting periods prior to January 1, 2016
 - 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)



SHIFT FROM APPEAL RULES TO PAYMENT RULES

- 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
 - 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 by following the procedures for filing the cost report under protest
- Let's examine the changes, the cited justification and practical implications



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*



2016 OPPS FINAL RULE

- Elements of the 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**



2016 OPPS FINAL RULE

- 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



2016 OPPS FINAL RULE

- 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.”

**2016 OPPS FINAL RULE**

- “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



FY 2016 OPPS FINAL RULE

- To amend for Medicaid Eligible Days, providers **MUST:**
 1. **Identify the number of additional Medicaid eligible days being sought in the amendment**
 - Can your process provide proof of eligibility and a detail listing of additional days?
 2. **Describe the process used to identify the days claimed in the initial filing**
 - Can your process precisely document all steps taken in the as-filed Medicare DSH process and articulate them to the MAC's or PRRB's satisfaction?
 3. **Explain why the additional Medicaid days could not be verified at the time of the initial filing**
 - Processes and procedures to support WHY the additional Medicaid days could not have been claimed at filing?
 - Processes must incorporate "all available and practical means to identify, accumulate, and verify with the State the actual Medicaid eligible days that are reported"
 - Are you diligent in following those processes?

**PRACTICAL IMPLICATIONS**

- Comprehensive process for claiming "costs" for Medicare DSH that fully addresses
 - Filing of **ALL** allowable costs in the initial cost report
 - Protest items
 - Filing a timely cost report amendment(s)
- Best Practices when preparing As-Filed cost reports
- FY 2017 cost reporting periods in-process
 - Includes **Worksheet S-10 UC** data reporting



APPEALS MAY START WITH THE COST REPORT, BUT THEY END WITH JURISDICTION



JURISDICTION

- 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
 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)



JURISDICTIONAL DECISIONS

- From October 2016 to April 2017
 - The Board issued 35 decisions denying jurisdiction, including:
 - **One** (1) because (1) the Provider failed to show dissatisfaction, issues not claimed in the cost report; filed an amended cost report including the issues, but MAC refused to accept and (2) cannot appeal the MAC's refusal (FY 2004) – One Board Member dissented saying it was improper for the MAC to refuse to accept the amended cost report, as filed to correct material errors
 - **Seventeen** (17) because the Providers' failed to meet the dissatisfaction requirement – (16) protest requirement, (1) failure to claim (FY 2008)
 - **Ten** (10) because the Providers' appeals/add issues were either not filed with all required documents or not filed timely
 - **Five** (5) because the Providers' appealed an issue(s) that was not addressed in the revised NPR
 - **One** (1) because the Provider could not meet the \$10,000 amount in controversy requirement
 - **One** (1) because the Provider did not brief the issue in the Final Position Paper and the Board deemed it abandoned



JURISDICTIONAL DECISIONS

- The PRRB granted three DSH related requests for Expedited Judicial Review (EJR), including:
 - **Two** (2) for multiple groups on the Medicare Advantage (Part C) Days issue
 - **Three** (3) for multiple groups on the Dual Eligible Days issue
- The PRRB issued seven DSH specific favorable decisions, including:
 - **Four** (4) finding jurisdiction to hear Rehab Low Income Patient (LIP) Payment issues since the Providers were not challenging the establishment of the prospective payment rates, but instead challenging the accuracy of the Medicare Contractor's calculation of the provider-specific data elements being used in the LIP adjustment calculation.
 - **One** (1) changing their position on the filing of Part C Days appeals by granting the consolidation of Part C SSI fraction and Medicaid fraction groups
 - **One** (1) changing their position on an SSI "Provider Specific" issue stating that it is the same as an SSI "Systemic Errors" issue since both are based on SSI data
 - **One** (1) granting the bifurcation of a group that appealed both the Dual Eligible and Part C Days as one issue, but denying jurisdiction over an argument that these issues were also appealed as sub issues in a Medicaid Eligible days appeal



JURISDICTIONAL CHALLENGES

- Issue not adjusted or protested for all cost reporting periods ending on or after December 31, 2008
 - The PRRB is denying jurisdiction
 - Need to amend cost reports that have not had an NPR issued for protest
 - Protest – It may be your only avenue to appeal an issue



JURISDICTIONAL CHALLENGES

- Medicaid eligible days when there was no adjustment made by the MAC
- Danbury Hospital v. Blue Cross Blue Shield Ass'n, PRRB Dec. No. 2014-D3 (Feb. 11, 2014), declined review, Administrator (Mar. 26, 2014)
 - 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 as the Provider failed to adequately describe its internal process for gathering Medicaid Days



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



BARBERTON

- The MAC challenged Board jurisdiction again this time arguing that a hospital did not claim the additional Medicaid days at issue in the as-filed cost report relying on Alert 10 and stating that the provider had to establish a "practical impediment" why
- The MAC 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)

**BARBERTON**

- PRRB took jurisdiction, why?
 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
 2. Gaps in the State's eligibility database
 - Eligibility matches were not consistent, one point in time a negative determination and another point a positive determination
 - Unbeknownst to the hospital, changes in eligibility data continued to be updated resulting in different eligibility verification results based on the timing of the matching frequencies
 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."



WOMEN AND INFANTS' HOSPITAL OF RHODE ISLAND

- Relying on Barberton, the PRRB issued a favorable jurisdictional decision for Women and Infants' Hospital of Rhode Island's 2006 Medicaid eligible days appeal
- The MAC filed two jurisdictional challenges arguing that the PRRB did not have jurisdiction over the issue since no adjustment had been made
- The Provider responded by arguing that it was not required to formally claim DSH, that an adjustment was not required, that a revision to the DSH payment was made on Worksheet E, part A and filed an Alert 10 response noting the standards that were set out in Barberton
- The PRRB found that the Provider was able to establish as "practical impediment" as to why it could not claim these days at the time it filed the cost report.

**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."

**IMPLIMENTATION CHALLENGES**

- Only some providers have been able to withdraw their appeals pursuant to Rule 48(3) because only some MACs are issuing "correspondence"
- Other providers either have to withdraw their appeals without "correspondence" or keep appealing the issue
- Practicality
 - MACs are not working the reopenings and settling the issues withdrawn
 - Probably going to have to reinstate hundreds of appeals
- What can you do?



BEST PRACTICES

- Be aware of all the changes in the cost reporting and appeals rules – Many pitfalls and PRRB 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 – use Alert 11 to your advantage, avoid the pitfalls and reopen for issues that the MAC can settle

**BEST PRACTICES**

- Medicaid Eligible Days
 - Evaluate your current process for compiling Medicaid days in the as-filed cost report
 - Are you really putting your best foot forward?
 - Can you meet the standard the PRRB set forth in Barberton?
- Consider employing an independent 3rd party review of Medicaid eligibility subsequent to the filing of the cost report and file an amended report if necessary
 - Retroactive Medicaid eligibility lags significantly in many states
 - Determining a patient's Medicaid eligibility is a very detailed and comprehensive process
 - Lot of time and effort for hospitals to compile the patient demographics, check for updates to patient matching criteria, etc.



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ALERT 12

- "Effective June 19, 2017, the CMS Office of Hearings, which handles . . . appeals for the Provider Reimbursement Review Board (PRRB) . . . will be moving its offices from its current address of 2520 Lord Baltimore Drive, Suite L to:

CMS Office of Hearings
1508 Woodlawn Dr.
Suite 100
Baltimore, MD 21207"

- "Any correspondence sent to the . . . PRRB . . . to be delivered June 19th and later should be sent to the new address."
- "Any hearings scheduled on or after that date will also be held at the new address."
- "If you have any questions, please call our information line at 410-786-2671."



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LITIGATION UPDATE

- Part C Days
 - *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
 - 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
 - May 2017 - Hearing before the D.C. Court of Appeals



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LITIGATION UPDATE

- July 25, 2017 - D.C. Court of Appeals issued its decision
 - Once the 2004 Rule was vacated, the Court told the Agency that the Medicare Act required CMS to provide a "further opportunity for public comment and a publication of the provision again as a final regulation" before they could "reimpose the rule."
 - The Court held that CMS cannot "circumvent this notice and comment requirement by claiming that it was acting by way of adjudication rather than rulemaking."
- *Allina III*
 - January 29, 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
 - CMS filed a motion to dismiss the Medicaid fraction side of the Medicare DSH calculation
 - August 4, 2017 - U.S. District Court ruled for the hospitals, denying the government's motion to dismiss
 - The Court also ordered the parties to confer and proposed a plan for the case by August 25th



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LITIGATION UPDATE

- Massachusetts Section 1115 Waiver Commonwealth Care Health Insurance Program (CCHIP)

See [Southwest Consulting UMass Memorial Health Care and Steward Health 2009 DSH CCHIP Section 1115 Waiver Days Groups](#), PRRB Decision No. 2017-D4 (Jan. 27, 2017)

- **Issue:** Whether days attributable to patients who were eligible for, and received, assistance through CCHIP, should be included in the numerator of the Medicaid fraction for the Medicare DSH calculation."
- **MAC Arguments:**
 1. CCHIP is a subsidized insurance coverage benefit and that the benefit does not make a person eligible for Medicaid
 2. Even if the government matches the State's CCHIP funding, it does not mean CCHIP is eligible for Medicaid or medical assistance
 3. The patients are not Medicaid patients
 4. The waiver does not make CCHIP patients eligible for inpatient hospital services.
 5. The CCHIP patient population is not eligible for matching federal payments but only the pool of funds used to provide premium assistance is matched by XIX funds



LITIGATION UPDATE

- **PRRB Decision:** CCHIP days should be included in the Medicaid numerator, and remanded to the MAC to recalculate the DSH payment
 1. The approved expenditure authority clearly states that 1115 demonstration program expenditures, including CCHIP, are regarded as expenditures under title XIX
 2. The days at issue, as confirmed by testimony at the hearing, are for CCHIP patients federally funded under the waiver
 3. The CCHIP patients under appeal received the same core benefits as other MassHealth recipients, including inpatient hospital benefits
 4. The Board majority is not persuaded by the MAC's arguments
- The CMS Administrator reversed the Board's Decision
 - "[T]here is no equivalency for purposes of the Medicare DSH calculation under 42 CFR 412.106 between a State providing traditional Medicaid benefits through a managed care enrollment and a State providing, through a waiver, a premium subsidy to CCHIP eligible individuals to purchase healthcare from the same managed care plan."



LITIGATION UPDATE

- The Providers filed in D.C. District Court - May 16, 2017
- August 4, 2017 - The D.C. District Court issued a Scheduling Order
 - August 25, 2017 – Administrative Record must be filed with the Court
 - October 2, 2017 and December 15, 2017 – Providers' briefs/responses must be filed with the Court
 - November 3, 2017 and January 9, 2018 – CMS' briefs/responses must be filed with the Court



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CMS RULINGS 1498-R AND 1498-R2

- 1498-R
 - Many Providers appealed to D.C. District Court challenging the Ruling and entered into a settlement agreement with CMS for the periods noted in bold below
- 1498-R2
 - Amendment resulted from the D.C. Circuit Court's decision in *Catholic Health* denying the inclusion of Dual Eligible Days in the Medicaid fraction of the DSH calculation
 - CMS is "allowing providers to elect whether to receive suitably revised Medicare-SSI fractions on the basis of 'covered days' or 'total days' for **Federal fiscal year 2004 and earlier, or** for hospital-specific **cost reporting periods, for those patient discharges occurring before October 1, 2004.**" (emphasis added)
 - This election is available for not yet settled Medicare cost reports and for appeals remanded to the contractor pursuant to CMS Ruling 1498-R that were not covered in the settlement



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CMS RULINGS 1498-R AND 1498-R2

- Challenge to CMS' methodology used in calculating the SSI fraction
 - **Issues:** Whether the DSH calculations were understated due to the failure of CMS and the MACs to include all SSI eligible patient days in the numerator of the Medicare fraction for NPRs issued after CMS Ruling 1498-R
 - **Provider Arguments:** "federal statute at 42 U.S.C. § 1382h(b) continues non-cash benefits (i.e., Medicaid benefits), and that SSA policy allowing the resumption of SSI cash payments without reapplying illustrates a beneficiary's continued entitlement to SSI benefits"; "certain additional SSI codes illustrate continued SSI eligibility even when the individual's SSI payments are suspended or placed in a stop payment status and that these individuals continue to be 'entitled to' SSI benefits." Further, "additional SSI codes should be included in the data matching process used to determine the SSI ratio for the Medicare DSH calculation."
 - **PRRB Decisions:** "Based on 42 C.F.R. § 405.1867, the Board must comply with the CMS Rulings 1498-R and 1498-R2"; and thus "the Board does not have the authority to revise the data matching process described in . . . the 2011 Final Rule, including what SSI codes the Agency will and will not use in calculating the SSI fraction to be applied to all hospitals."

See *Hall Render Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction v. Wisconsin Physicians Services; Palmetto GBA c/o National Government Services; CGS Administrators; National Government Services Inc.; Novitas Solutions, Inc.; Cahaba GBA c/o National Government Services Inc.; Noridian Healthcare Solutions, LLC*, PRRB Dec. No. 2017-D11 (Mar. 27, 2017)

See also *Hall Render Individual, Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction v. Wisconsin Physicians Services; Palmetto GBA c/o National Government Services; CGS Administrators*, PRRB Dec. No. 2017-D12 (Mar. 27, 2017)





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ABOUT THE SPEAKERS

Mike Newell President	Kristin DeGroat Healthcare Reimbursement and Compliance Counsel
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Southwest Consulting Associates
2805 Dallas Parkway, Suite 620
Plano, TX 75093
(972) 732-8100

www.southwestconsulting.net
<http://blog.southwestconsulting.net/blog>
<https://www.linkedin.com/company/southwest-consulting-associates>