View From the Board and Beyond

Medicare Cost Reporting Issues and Updates

TAHFA and HFMA South Texas Fall Symposium

Juliet M. McBride
Senior Associate, King & Spalding
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Overview

- New CMS Requirement for "Appropriate Cost Report Claims"
- Banner Heart Hospital Decision
- PRRB Board Alert 10 and Barberton Decision
- Cost Reports and CMS's 60-Day Overpayment Rule
- *Allina* update
- MACRA Proposed Rule
- Other Notable Issues

NEW CMS REQUIREMENT FOR "APPROPRIATE COST REPORT CLAIMS"

Cost Report Appeals – Statutory Basis

- Medicare statute allows providers to appeal cost report determinations to PRRB if:
  - Provider is "dissatisfied" with the MAC's final determination of Medicare reimbursement;
  - The amount in controversy is > $10,000; and
  - Hearing request is filed within 180 days of NPR

    OR
  - Provider does not receive NPR on a timely basis (12 months of cost report filing);
  - Amount in controversy is > $10,000; and
  - Hearing request is filed within 180 days of when NPR should have been received

CMS's Prior Policy -- "Dissatisfaction"

- In 2008, CMS adopted the following rule:
  - Provider has right to PRRB hearing only if it has preserved its right to claim dissatisfaction by:
    - Including a claim for specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or
    - If Medicare rules do not allow for payment, by self-disallowing the requested item on the cost report
    - 42 C.F.R. § 405.1835(a)

CMS's Prior Policy -- "Dissatisfaction"

- CMS's Goal with 2008 PRRB rule:
  - To overturn decision in *Bethesda Hospital Ass'n* v. *Bowen* which stated self-disallowance was not required
  - To deny hospitals ability to "appeal" items that were not filed on the cost report but which could have been
    - i.e., no "dissatisfaction" if not claimed
    - 2008 rule tried to resolve circuit split on this issue
- Practical consequence of 2008 rule:
  - MACs will challenge jurisdiction over items that are appealed and for which "no adjustment" was made

CMS's New Policy – "An Appropriate Cost Report Claim"

- Adopted in FY 2016 OPPS Rule
- Effective for cost reporting periods beginning on or after January 1, 2016
- Eliminates 2008 "dissatisfaction" policy
- Adopts new 42 C.F.R. § 413.24(j) as part of cost report requirements (not a jurisdictional issue)
  - (j)(1): in order to receive reimbursement for a specific item, the provider must claim specific item on cost report or self-disallow the item
  - (j)(2): if a provider self-disallows, provider must include a reimbursement amount in the protested line of the cost report for each specific item and include separate worksheet explaining why item was self-disallowed and how reimbursement was calculated for each specific item

CMS's New Policy

- New 42 C.F.R. § 413.24(j) cont'd
  - (j)(3): Whether the provider's cost report includes an appropriate claim for a specific item is determined by reference to the cost report that the provider submits and is accepted by MAC, including amended and adjusted cost reports
  - (j)(4): if MAC concludes there is an appropriate claim, MAC must either pay or deny and make adjustment; if MAC concludes there is not an appropriate claim, MAC cannot pay even if substantive reimbursement requirements are met

CMS's New Policy

- Impact of new policy:
  - CMS avoids *Bethesda*-type litigation on question as to whether PRRB has "jurisdiction" to hear appeal for unclaimed items
  - Statute grants CMS great discretion to require "documentation" to prove claims for reimbursement
  - Places ultimate discretion on MACs to accept "amendments" to filed cost reports on issues like bad debts that were unknowingly returned

Implications of New Policy

- Rule fails to recognize that many essential pieces of information necessary to claim accurate reimbursement are unavailable at time cost report is due
  - DSH, DGME, IME, and bad debt are best examples
  - MAC has discretion to reject late information
- Rule eliminates MAC discretion to remove or correct obvious errors or mistakes in cost report
  - "final contractor determination must not include any reimbursement for the specific item, regardless of whether the other substantive requirements for the specific item are or are not satisfied."

Exception for Medicaid Eligible Days

- CMS has "identified only one circumstance" in which hospitals might have difficulty obtaining information to complete cost report – Medicaid eligible days
- CMS will instruct contractors to accept one amended cost report within 12 months of due date of original cost report "solely for purposes" of revising Medicaid eligible patient days
- Hospital must include in amendment (similar to Board Alert 10):
  - Number of Medicaid-eligible days to be included in DSH;
  - "Description" of the process used to "identify and accumulate" Medicaid eligible days reported in the cost report; and
  - An explanation as to why the additional days could not be verified by the State by time cost report was submitted.

Some Practical Tips

- Run reports as contemporaneous with the filing of the cost report as practical
- Document all efforts to assemble and verify Medicaid eligible days with the State
- Don’t assume you can appeal additional Medicaid days after filing either original or amended cost report
- Because 12 months is not enough, continue to protest Medicaid eligible days pursuant to new policy

Banner Heart Hospital v. Burwell

- Plaintiff hospitals filed appeal with PRRB on outlier issue and requested EJR.

- PRRB denied EJR; determined it had no jurisdiction because plaintiffs did not self-disallow amounts associated with outlier regulations.

- Plaintiffs challenged the PRRB's ruling in D.C. district court.

Banner Heart Hospital v. Burwell

- District court decision:
  - The Supreme Court already decided this issue in *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988).
  - The plain language of the Medicare statute does not require a provider to first raise with the MAC legal challenges to the Medicare regulations in order to preserve its right to appeal.
  - Rejected Secretary's argument which tried to distinguish *Bethesda* due to the 2008 regulation requiring exhaustion.

The PRRB's Alert 10 and the Barberton Decision

PRRB Alert 10

- Involves cost report appeals for "Medicaid eligible days"
- Followed Board decision in *Danbury* appeal
  - *Danbury Hospital v. BlueCross BlueShield Association*, PRRB Dec. No. 2014-D3, Feb. 11, 2014
  - Holding: A provider is "dissatisfied" with its final DSH payment determination if it can "establish that a practical impediment did exist preventing it from obtaining required verification [of Medicaid eligible days] from the State" at the time it filed its cost report. *Danbury* at 22.
- Board ordered providers to supplement record by July 22, 2014 with three items of information

Alert 10

- Information required by Alert 10:
  - A detailed description of the process that the provider used to identify and accumulate the actual Medicaid paid and unpaid eligible days that were reported and filed on the Medicare cost report at issue.
  - The number of additional Medicaid paid and unpaid eligible days that the provider is requesting to be included in the DSH calculation.
  - A detailed explanation as to why the additional Medicaid paid and unpaid eligible days at issue could not be verified by the state at the time the cost report was filed. **If there is more than one explanation/reason, identify how many of these days are associated with each explanation/reason**.

Barberton Citizens Hospital v. Blue Cross Blue Shield Association

- Provider seeks to add Medicaid eligible days to FY 2004 and 2005 cost report
- MAC challenged jurisdiction, citing no "dissatisfaction" and failure to follow Alert 10
- Live hearing on jurisdiction held at PRRB on November 20, 2014

Barberton Citizens Hospital v. Blue Cross Blue Shield Association

- Provider's Arguments:
  - *Bethesda* and progeny establish that providers can claim "dissatisfaction" with amount of Medicare reimbursement even where cost or items are not included in cost report
  - Alert 10 and "practical impediment" standard are an impermissibly retroactive change in agency practice and interpretation of the dissatisfaction requirement
    - CMS and MAC policy has been to allow a provider to verify eligibility of Medicaid days a substantial amount of time after cost report filing
      - Provider marshalled evidence from consultants that showed hundreds of cases where Medicaid eligible days appeals were settled by MACs
      - Provider established that MAC settled similar appeals for Provider in 2000-2003 and dozens of such appeals for CHS in same period

Barberton Citizens Hospital v. Blue Cross Blue Shield Association

- Provider's Arguments, continued:
  - Provider met the "practical impossibility" standard
    - Provider's process for "identifying and verifying" eligible days for 2004 and 2005 cost report used all available and practical means to verify eligibility:
      - How provider used Ohio Medicaid verification systems
      - Only 7 percent difference between as-filed and additional days
    - Provider could not possibly verify 100 percent of days on as-filed:
      - Retroactive eligibility determinations
      - During 2004-2007, Ohio Medicaid verification system experienced "data gap"
      - Emdeon declaration confirming millions of missing eligibility records between 2004 and 2007 historical database update
  - Provider should be entitled to presumption of "impossibility" and should not have to identify a "day by day" reason as to why eligibility could not be verified

Barberton Citizens Hospital v. Blue Cross Blue Shield Association

- Board Decision (March 19, 2015)
  - "Barberton has established that a practical impediment, through no fault of its own, prevented it from identifying and/or verifying with the relevant State the Medicaid eligible days at issue prior to the filing of the cost reports at issue."
  - Board relied upon:
    - Barberton had in place a process that used all "available and practical means to identify, accumulate and verify with the State" the actual Medicaid eligible days reported on its cost reports
      - 7 percent difference between 2004 and 2005 cost reports gave "comfort" that Barberton was did "all that it could have reasonably done"
    - Barberton does not need to assign a specific impediment to each additional Medicaid day
    - State of Ohio does not provide public access to type of information necessary to attribute specific impediments to specific days
      - Percentage of net eligible days was low – 6 percent for '04 and 9.8 for '05

PRRB Alert 11

- Revises Board rules effective July 1, 2015
- Revisions include:
  - Provider's may submit written motions for reinstatement of dismissed issues or cases within three years of date of dismissal (46.1)
    - Motion must set forth reason for reinstatement
    - Board will not reinstate if provider is at fault
  - Withdrawals as a result of Administrative Resolution (46.2)
    - Upon written motion, Board will grant reinstatement of an issue/case withdrawn as a result of an AR in which intermediary agreed to reopen a final determination under appeal, but failed to issue a new final determination
    - Upon written motion, Board will grant reinstatement of issue/case if provider requested withdrawal because intermediary agreed to reopen, but failed to do so. Must present intermediary's written agreement to reopen

COST REPORTS AND CMS'S 60-DAY OVERPAYMENT RULE

Cost Reporting and the 60-Day Overpayment Refund Rule

- CMS issued a Final Rule on February 11, 2016 (effective March 14, 2016) implementing ACA Section 6402(a) requiring that overpayments be reported and returned by the later of:
  - the date which is 60 days after the date on which the overpayment was ***identified***; or
  - *the date any corresponding cost report is due*, if applicable.
- Any overpayment improperly retained by a person after the deadline for reporting and returning an overpayment is an obligation for purposes of False Claims Act liability.

60-Day Overpayment Refund Rule and Cost Reports

- Per final rule, overpayments that would typically be settled on a provider's cost report need not be returned within 60 days of identification but instead *must be returned when the cost report is filed*.
- CMS reasoned that:
  - "When a provider files its cost report, it is attesting to the accuracy of the provider's reconciliation of the interim payments and costs";
  - Therefore, "the 'applicable reconciliation' is the provider's year-end reconciliation of payments and costs to create the cost report";
  - Conclusion: "overpayment should be returned at the time the cost report is filed."
- Upshot: Providers should include payment-in-full with any cost report that indicates they have been overpaid or risk liability under the overpayment law.

60-Day Overpayment Refund Rule and Cost Reports

- CMS established two exceptions to this rule:
  1. overpayments associated with changes in the Supplemental Security Income (SSI) ratio used in calculating a hospital's disproportionate share payment (DSH) and
  2. overpayments attributable to outlier payment reconciliation.
- In those limited cases, there is no "refund obligation until such time as the final settlement of the hospital's cost report occurs."

60-Day Overpayment Refund Rule and Cost Reports

- What if an overpayment is identified ***after*** the cost report is filed but ***before*** an NPR has been issued?
- CMS:
  - "If the provider self-identifies an overpayment after ***the submission and applicable reconciliation*** of the Medicare cost report, it is their responsibility to follow the procedures in [the Final Rule], and report and return the overpayment within 60 days of identification."
  - Providers should "submit an amended cost report[] along with the overpayment refund."

60-Day Overpayment Refund Rule and Cost Reports

- Must a provider file an amended cost report every time it becomes aware of the potential need for a negative audit adjustment (which are relatively common)?
- This would "force providers to send in numerous overpayments for minor errors while the cost report is open . . . ." (No *de minimis* exceptions.)

60-Day Overpayment Refund Rule and Cost Reports

- CMS also stated:
  - "If the MAC notifies a provider of an improper cost report payment, the provider has received credible information of a potential overpayment and ***must conduct reasonable diligence on other cost reports within the lookback period*** to determine if it has received an overpayment."
- Does this mean that whenever a MAC makes an adjustment for an alleged overpayment in a current year, providers must seek reopening for all prior years?
- What if adjustments are minor and routine such as minor FTE adjustments for overlapping resident rotations?

60-Day Overpayment Refund Rule and Cost Reports

- Only cost report errors that result in actual overpayments need be disclosed:
  - "If a provider identifies an error or omission that does *not* result in an overpayment, then the requirements of [the Overpayment Law] . . . do not apply."
- But, the interplay between cost report items and reimbursement can be complex so be careful before determining that a cost report error is "harmless."
- Also note continuing refund obligations where the overpayment is the result of a third party's error and not the provider's.

Recent Application of 60-Day Overpayment Refund Rule

- NY health system settlement on 8/23 for nearly $3 million
  - Settled allegations that it violated the 60-day overpayment rule by improperly retaining Medicaid overpayments that stemmed from Medicaid managed care software glitch
  - Took nearly 2 years to reimburse $ identified by Comptroller and system was on "notice"
  - $3 million represents more than three times the amount of alleged Medicaid overpayments
  - Although no proposed or final rule for Medicaid overpayments, providers are still subject to the ACA's 60-day overpayment rule for Medicaid payments even in the absence of rulemaking from CMS
  - Highlights vulnerabilities related to payments from state Medicaid programs
- Other examples, issues stemming from potential wage index data errors and unique considerations in calculating potential damages where budget neutrality is applied

ALLINA UPDATE

Status of *Allina* Litigation: Are Part C Days Part A Days?

- Recap of D.C. Circuit Court's opinion
  - Agreed with district court that 2004 regulation was invalid but held that the district court went too far in ordering CMS to recalculate the SSI fraction w/o MA days, etc.
  - CMS has to treat Part C days somehow (they either <u>are</u> days entitled to benefits under Part A or they are not) so question becomes whether, in the absence of the regulation, CMS could still treat MA days as days entitled to benefits under Part A
  - Court remanded to CMS Admin'r to address that question

Status of *Allina*

- On December 2, 2015, Admin'r concluded she could adopt the same policy even without the 2004 regulation

CENTERS FOR MEDICARE & MEDICAID SERVICES

Decision of the Administrator

In the case of:

ALLINA HEALTH SERVICES, *et.al.*,

Plaintiff

vs.

SYLVIA M. BURWELL, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Defendant

Civil Nos. 1:10-cv-01463
1:12-cv-00328

This case is before the Administrator, Centers for Medicare & Medicaid Service (CMS), by order dated April 1, 2014, from the United States Court of Appeals for the District of Columbia Circuit.

Background

Pursuant to a court ordered remand, the case is now before the Administrator for a determination, in the absence of the vacated "2004 rule", of the appropriate statutory interpretation to be used to calculate the Providers' disproportionate share hospital (DSH) adjustment payment with respect to the treatment of the inpatient hospital Medicare Part C days for Federal fiscal year (FFY) 2007. The specific issue is whether enrollees in Medicare Part C[1] are "entitled to benefits" under Part A, as that phrase is used at section 1886(d)(5)(F)(vi)(I) of the Social Security Act, and, therefore, whether these days should be counted in the numerator and denominator of the "Medicare fraction"[2] of the DSH

- This decision was challenged in DDC on 1/29/16 and assigned to Judge Rudolph Contreras.

Allina FY2012 Case

- Plaintiffs challenged CMS's treatment of MA days as days entitled to benefits under Part A to FY 2012 in the absence of the rule vacated in the original *Allina* case.
- Decision issued 8/17/16.
  - Even in the absence of the rule, CMS can still treat MA days as days entitled to benefits under Part A.
  - The statute itself provides an "adequate legislative basis" for including Part C days in the Medicare fraction.

Implications of *Allina*

- Implications for providers today
  - Continue to appeal issue!
  - Treatment of Part C days on cost reports (before and after 10-1-13)
  - 340B implications
  - Calculation of the size of the 2017 DSH "pie"

Insurance on Allina?: The Unpaid SSI Day Issue

- It is well known that CMS includes *unpaid* Part A days (e.g., days paid under Part C) in the DSH Medicare fraction.
- It is less known that CMS includes only *paid* SSI days in the numerator of the DSH Medicare fraction.
- These policies are inconsistent:
  - The statute uses the same term "entitled" when referring to both Part A days and SSI days.
  - If Medicare beneficiaries are "entitled" to Part A benefits on days where they are not paid under Part A, then SSI beneficiaries are "entitled" to SSI benefits on days they are not paid SSI benefits.
- Hospitals should consider protesting this issue in their cost reports and pursuing through appeal.
- Serves as an "insurance" policy on *Allina*

MACRA PROPOSED RULE

NEW PAYMENT SYSTEM FOR PHYSICIANS

The Statute

- Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"), Pub. L. 114-10 (signed Apr. 16, 2015)
  - Repealed SGR cuts
  - Performance-based adjustments to fee-for-service physician payment rates
    - Leverages/collapses many existing physician reporting programs – PQRS, Value-Based Purchasing, Meaningful Use. These programs individually sunset at close of 2018 with reporting periods ending in 2016.
  - Incentive payments to eligible participants in Alternate Payment Models (APMs)

The Proposed Rule: Two Paths

- Merit-Based Incentive Payment System (MIPS)
  - FFS payment adjustments based on composite scores in four performance categories
    - First performance period to run from Jan. 1 to Dec. 31 2017.
    - First payment adjustments to occur in 2019 (based on 2017 performance period).
  - Annual payment updates of .25 percent beginning 2026
- Advanced Alternate Payment Models (APMs)
  - Participation in APMs with certain performance requirements
  - Exempt from MIPS performance adjustments
  - 5% bonus payments 2019 - 2024
  - Annual payment updates of .75 percent beginning 2026

MIPS: Eligibility

- Eligible: Physicians, PAs, NPs, clinical nurse specialists, CRNAs
- Exempt:
  - New clinicians
  - Advanced APM participants
  - Low-volume practitioners (less than $10,000 in allowable claims *and* fewer than 100 Medicare patients)

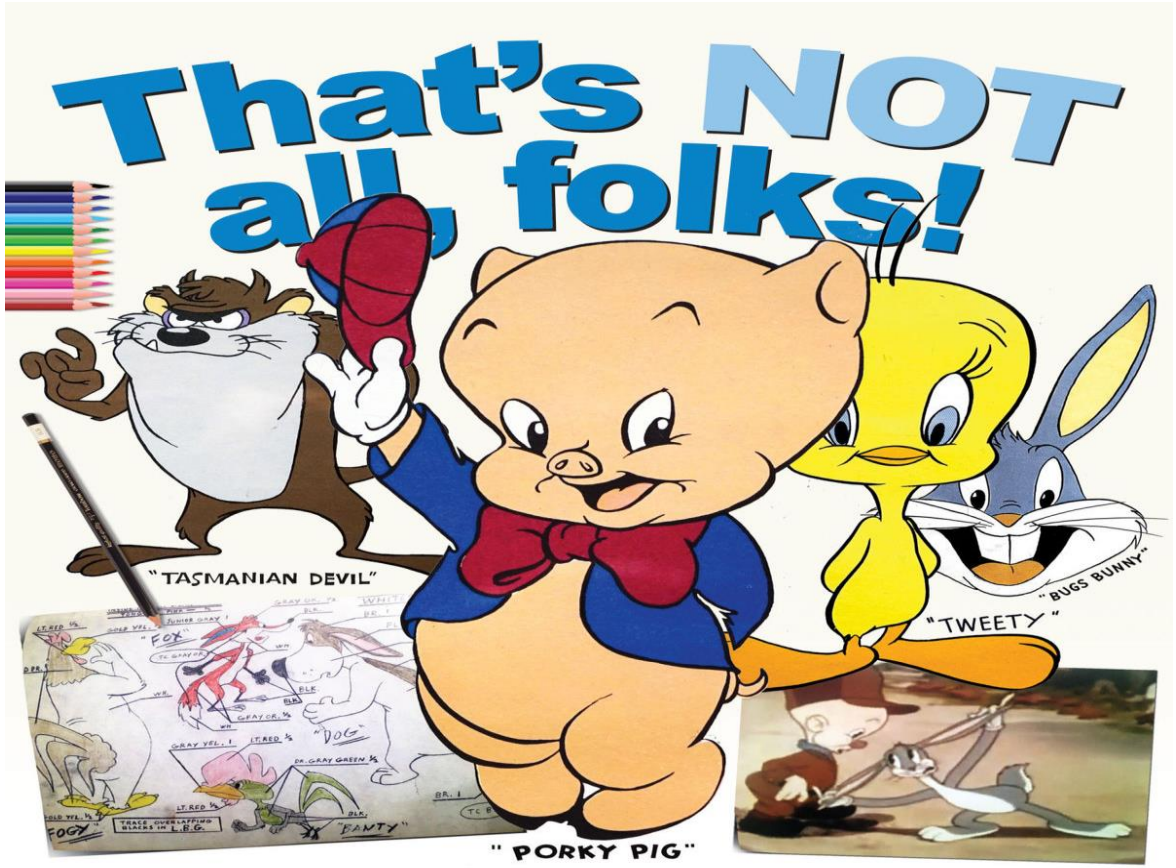
MIPS

- Composite performance score based on four performance categories
  - Quality (50%)
  - Cost/Resource Use (10%)
  - Clinical Practice Improvement Activities (15%)
  - Advancing Care Information (25%)
- CMS may adjust these allocations after year 1
- Payment adjustments as years go by
  - CY 2019: +/- 4 percent
  - CY 2020: +/- 5 percent
  - CY 2021: +/- 7 percent
  - CY 2022: +/- 9 percent
- CMS can increase positive adjustment by factor of 3 to maintain budget neutrality
- Additional non-budget-neutral $500 million for top performers (no higher than an additional 10 percent increase)

Advanced APMs: Eligibility

- APM
  - Innovation Center models, Shared Savings Programs (track 2 & 3), NextGen ACOs, CPC+
- *Advanced* APM
  - Requires use of certified EHR technology
  - Employs quality measures comparable to MIPS
  - Clinicians must bear some financial risk (i.e. APM withholds payment or reduces rates if actual expenditures exceed target)
    - Total risk must be at least 4%
- Qualifying Participants
  - Must meet certain APM patient/payment makeup
- Eligibility determined each calendar year

And That's NOT All Folks



Other Notable Issues – Recoupment/Offset

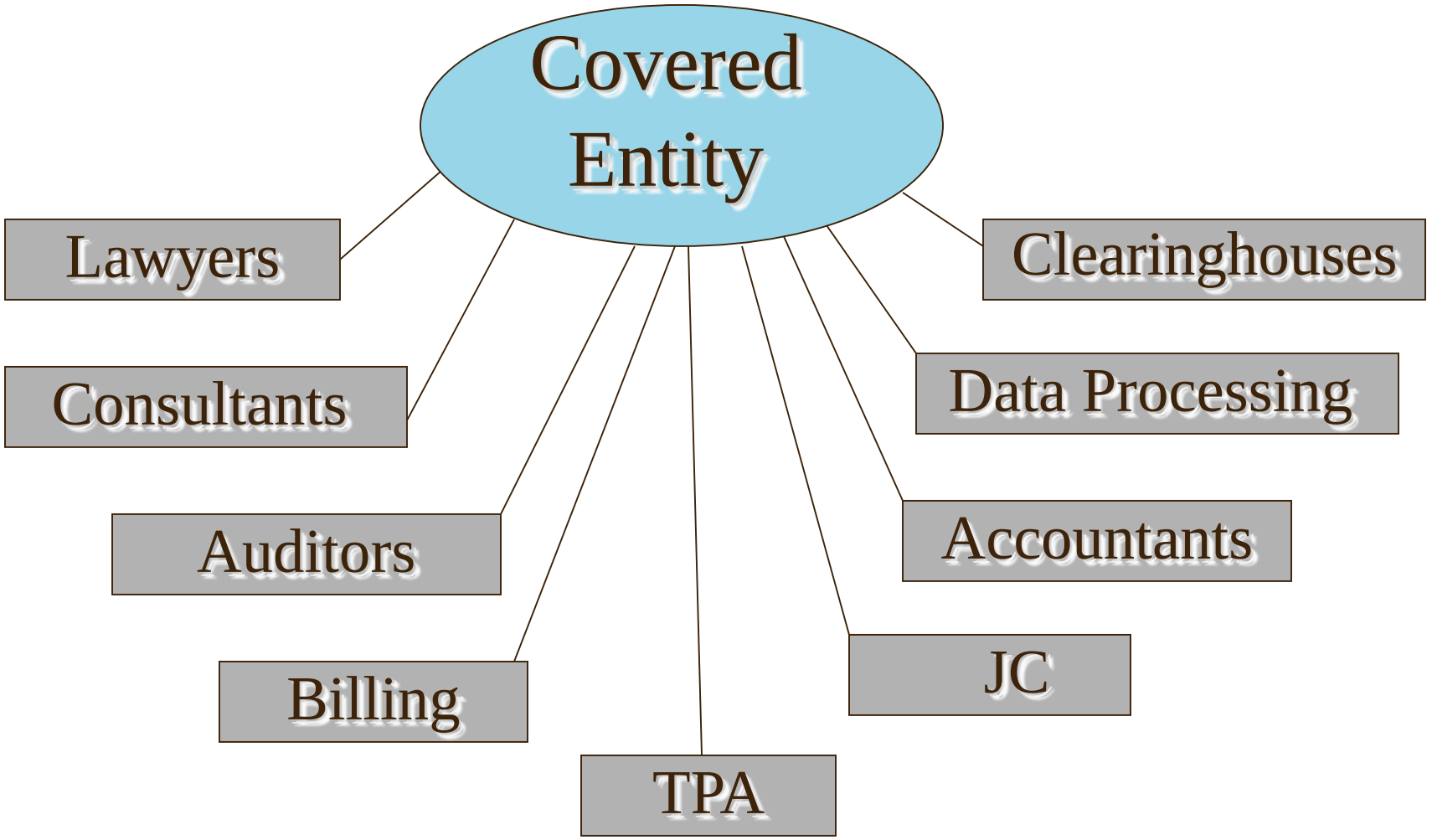
- Recoupment/Offsets at TIN-Level
  - ACA allows CMS to recoup or offset payment by TIN, not just NPI.
  - June MLN Matters SE1612 – CMS announced it made changes to financial account system to allow this functionality.
  - Proposes in PFS Rule that CMS/MAC need only notify obligated provider of intention to recoup/offset and not send separate notice to other applicable (shared TIN) providers.
  - Before effective date of rule, CMS will notify all potentially affected providers. *Question remains whether this has already happened based on the MLN.*
  - Assumption is that related provider will implement overpayment tracking system at corporate level.

Other Notable Issues - HIPAA

- Ramp-up in HIPAA enforcement and rollout of OCR Phase 2 audits
  - On July 11, 2016, OCR notified 167 covered entities of selection for desk audits.
  - Audit will include both covered entities and business associates, selected based on size, affiliations, location, public/private.
  - Through August 4, 2016, HHS has settled 10 cases through Resolution Agreements totaling more than **$20 million**.
  - Understand company policies on privacy, security, breach reporting.
  - Caution in fax, email, storage of information in paper and electronically.

Other Notable Issues - HIPAA

Business Associates



Other Notable Issues – GME/IME; Bad Debts

- GME/IME rotations at non-hospital settings
- Bad debt issues
  - MAC inconsistencies in auditing charity debts
  - Potential implications of charity/indigent policies on other reimbursement issues
- CMS announced, since 2012, Medicare ACOs have garnered more than $1.29 billion in total Medicare savings

Questions?

Thank You!

Juliet M. McBride
Senior Associate
(713) 276-7448
jmcbride@kslaw.com