SQUIRE PATTON BOGGS

Minding the Self-Disallowance Gap

May 19, 2015

Today's Presenters

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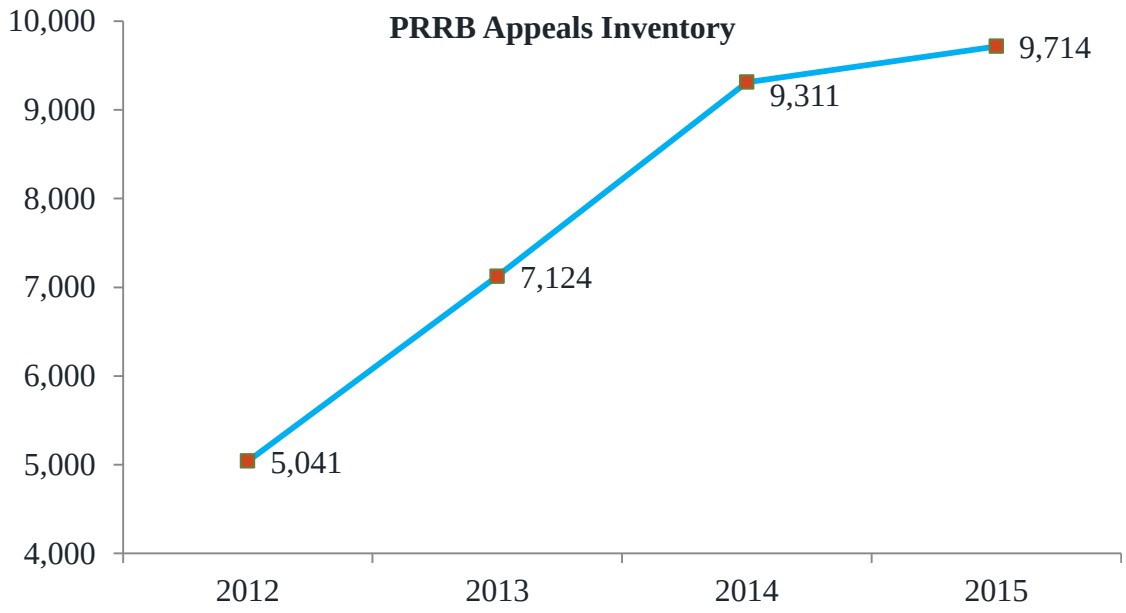
Introduction

- The Provider Reimbursement Review Board (Board) currently has 9,714 pending appeals.



- The Board focuses on jurisdiction as a way to limit the number of appeals -- the self-disallowance regulation is the agency's gatekeeper.

Introduction

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- Various gaps exist between cost report filing and reimbursements appeals.

- **Goal of the presentation**: To notify you of new reimbursement issues and suggest best practice for preserving appeal rights.

Introduction

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- Part I: Introduction to the Self-Disallowance Regulation
- Part II: Current Reimbursement Issues and Best Practices for Satisfying the Self-Disallowance Regulation

The Self-Disallowance Regulation – The Gatekeeper

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- 42 C.F.R. § 405.1835(a)(1)(ii): applicable to FYEs on or after 12/31/2008
- Two types of Board appeals:
  - Late Notice of Program Reimbursement (NPR) appeals – *Charleston Area Med. Ctr. v. Sebelius*, D.D.C., No. 13-766 (Aug. 6, 2014)
    - FYE 2015 Inpatient Prospective Payment System Rates Regulation
  - NPR appeals - *Banner Heart v. Burwell*, 1:14-cv-01195-APM (D.D.C.) and *Denver Health v. Burwell*, 1:15-cv-00413-APM (D.D.C.)

What Makes the Self-Disallowance Regulation Difficult?

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Organizational Gap

- Finance group, working with consultants, files the cost report.
- Outside counsel files appeals with the Provider Reimbursement Review Board.
- Involvement of legal department varies from provider to provider.

What Makes the Self-Disallowance Regulation Difficult?

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Timing Gap

- Cost reports are due 5 months after fiscal year ending
- Late NPR appeals – Medicare administrative contractors have 1 year after the cost report filing to issue the Notice of Program Reimbursement. If the contractor fails to do so, providers have 180 days to file an appeal. 42 U.S.C. §1395oo(a)(1)(B) and (3)
- NPR appeals – NPR moratorium. Usually takes years to receive NPR, then 180 days to file appeal

Why Do We Care?

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Why it's relevant: Example of Rural Floor Budget Neutrality issue

- Best example: *Cape Cod v. Sebelius,* 630 F.3d 203 (D.C. Cir. 2011)
- Impacted FYs 1997-2012: up to 1.1% of annual Inpatient Prospective Payment System payments
- FY 2012 Inpatient Prospective Payment System Rates Regulation. 76 Fed. Reg. 51476, 51788-51790 (August 18, 2011)
- Providers' subsequent appeals

Filing Cost Reports Under Protest

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Provider Reimbursement Manual, Part II, §§ 115.1 and 115.2

- "Include the nonallowable item in the cost report."
- "the disputed item and amount for each item must be specifically identified."
- "The effect of each nonallowable cost report item is estimated by applying reasonable methodology."
- Provide "copies of the working papers used to develop the estimated adjustments."

Filing Cost Reports Under Protest

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Board Rule 7.2

- 7.2.A: the following information must be submitted:
  - A concise issue statement describing the self-disallowed item
  - The reimbursement or payment sought for the item, and
  - The authority that predetermined that the claim would be disallowed.
- 7.2.B: No access to data
- 7.2.C. Protest: must follow the applicable procedures for filing a cost report under protest as contained in CMS Pub. 15-1, Section 115.

See 42 C.F.R. § 405.1835(a)(1)(ii).

Filing Cost Reports Under Protest

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So…

- Identify each protested issue/self-disallowance item on a worksheet.
- State reimbursement impact for each issue with “reasonable methodology which closely approximates the actual effect.”
  - Offer support for calculation of impact.
- Make sure total protested cost equals the sum of each individually protested item.
  - Enter this amount into Line 75 of Worksheet E, Part A.
- Documentation requirement: Date of cost report filing and evidence of delivery. Cost report acceptance by Medicare contractor.

Part II – Current Reimbursement Issues

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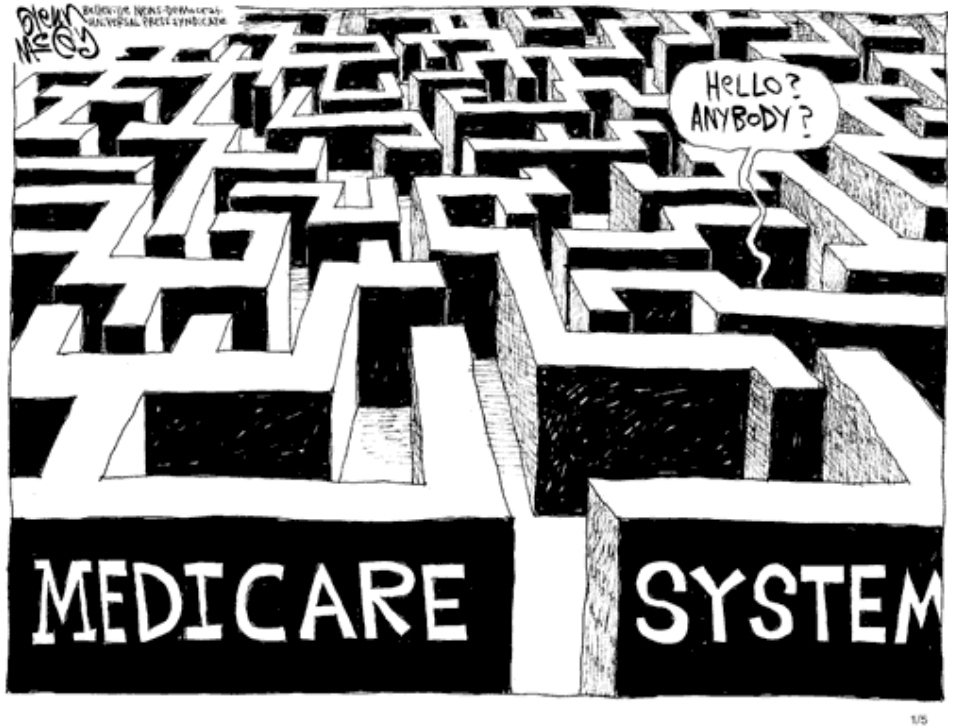
- Two-Midnight Rules and the 2% reduction
- Outliers Issue
- Disproportionate Share Hospital



Current Reimbursement Issues

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The Two-Midnights Rule and the 0.2% Reduction

- Redefining “inpatient” for reimbursement purposes;
- A one-year time limit to request Medicare Part B payment;
- A new requirement for written physician orders as a condition for every inpatient stay.

Two Pending Cases, Both Involving FY 2014:

- *American Hosp. Asso’c. v. Burwell*, 1:14-cv-00609-APM
- *Portercare Adventist Health System v. Burwell*, 1:15-cv-00192-RDM

Current Reimbursement Issues

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The Two-Midnights Rule and the 0.2% Reduction

Redefining “inpatient” for Part A reimbursement purposes

- A patient that remains in the hospital for one night vs. “two midnights”

“An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain **at least overnight** and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.”

Medicare Benefit Policy Manual (ch. 1 § 10.) (emphasis added)

Current Reimbursement Issues

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The Two-Midnights Rule and the 0.2% Reduction

Requiring Physician Certification for Inpatient Stays

- Each patient's record contains a written physician order (vs. recommendation) admitting him/her as an inpatient.
- Medicare Act only requires certification for extended hospital stays (42 U.S.C. § 1395f(a)(3)).
- Congress specifically amended the statute in 1967 to make clear that a physician order is not required for Part A payment for short-term hospital stays.

Current Reimbursement Issues

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The Two-Midnights Rule and the 0.2% Reduction

Legislative History: House and Senate Reports

- "[E]liminate the. . .requirement that there be a physician's certification of medical necessity with respect to each admission to a general hospital, and to require such a certification only in cases of hospital stays of extended duration[.]"
- "[A]dmissions to general hospitals are almost always medically necessary and the requirement for a physician's certification of this fact results in largely unnecessary paperwork."

Current Reimbursement Issues

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The Two-Midnights Rule and the 0.2% Reduction

One-Year Time Limit to Request Medicare Part B Payment

- Review of inpatient/outpatient determinations
- Clawback of Part A amount
- Requests for Part B payment must be submitted as a “new claim” within 1-year from the date of service (78 FR 50,909)

Current Reimbursement Issues

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The Two-Midnights Rule and the 0.2% Reduction

The Secretary's (Mis)Calculation of the 0.2% Reduction

- The Secretary estimated 40,000 net patient encounters would shift from Outpatient Prospective Payment System (OPPS) to Inpatient Prospective Payment System (IPPS)
- 0.2% reduction in IPPS rates to offset the $220 million in IPPS expenditures

Current Reimbursement Issues

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The Two-Midnights Rule and the 0.2% Reduction

The Secretary's (Mis)Calculation of the 0.2% Reduction

- The Secretary estimated 400,000 encounters shift from OPPS to IPPS and 360,000 encounters shift from IPPS to OPPS
- 1,569,693 inpatient stays of one day and → OPPS
- 121,662 outpatient encounters of 48 hours → IPPS
- Net **1.4 million** less IPPS encounters

Current Reimbursement Issues

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The Two-Midnights Rule and the 0.2% Reduction

Preserving Your Appeal Rights

- Medicare Cost Report
  - Protesting the 0.2% Reduction
    - **Multiply 0.2% times Worksheet E, Part A, Line 1.**
  - **Self-Disallow Inpatient → Outpatient**
- Medicare Claims Appeals Process
  - Encounters that are clawed back
  - **Timing: Pre or Post-Cost Report?**

Current Reimbursement Issues

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The Two-Midnights Rule and the 0.2% Reduction

Navigating the Medicare Claims Appeals Process

- No recoveries from October 1, 2013 through March 31, 2015
- Initial Determination
- Request for Redetermination (120 calendar days)
- Request for Reconsideration (180 calendar days)
- Request for Administrative Law Judge

Review (60 calendar days)

- Medicare Appeals Council (60 calendar days)
- Judicial Review (60 calendar days)
- Accrual of Interest at 9.875%

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Medicare Outlier Payments

- 5-6% of IPPS payments to pay for extraordinarily costly inpatient cases
- Self-funded by IPPS hospitals
- In 2003, CMS purportedly overhauled its outlier payment regulations to end massive redistribution to turbo-chargers

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Consistent Underpayment of Medicare Outliers

Federal Fiscal Year	No. of Cost Reports	IPPS Payments Net of IME, DSH, and Outlier Amounts ($)	Outlier Payments ($)	Outlier Payment Level (%)	Target Outlier Payments (5.1%)	Shortfall in Outlier Payments ($)
2003	3,766	$70,104,375,686	$3,431,618,745	4.67%	$3,767,463,815	($335,845,070)
2004	3,677	74,535,535,959	2,846,868,395	3.68%	4,005,597,823	(1,158,729,428)
2005	3,542	79,072,816,316	3,394,863,336	4.12%	4,249,434,807	(854,571,471)
2006	3,349	77,100,363,595	3,631,620,995	4.50%	4,143,433,660	(511,812,665)
2007	3,354	77,284,667,386	3,618,576,770	4.47%	4,153,338,289	(534,761,519)
2008	3,336	78,795,837,031	3,951,944,640	4.78%	4,234,549,725	(282,605,085)
2009	3,209	79,813,559,321	3,915,181,476	4.68%	4,289,242,914	(374,061,438)
2010	3,072	79,733,087,154	3,660,488,700	4.39%	4,284,918,277	(624,429,577)
2011	2,973	77,197,362,245	3,707,407,929	4.58%	4,148,646,443	(441,238,514)
2012	2,716	67,461,311,753	3,137,279,264	4.44%	3,625,423,498	(488,144,234)
Total	**32,994**	**$761,098,916,446**	**$35,295,850,250**	**4.43%**	**$40,902,049,251**	**($5,606,199,001)**

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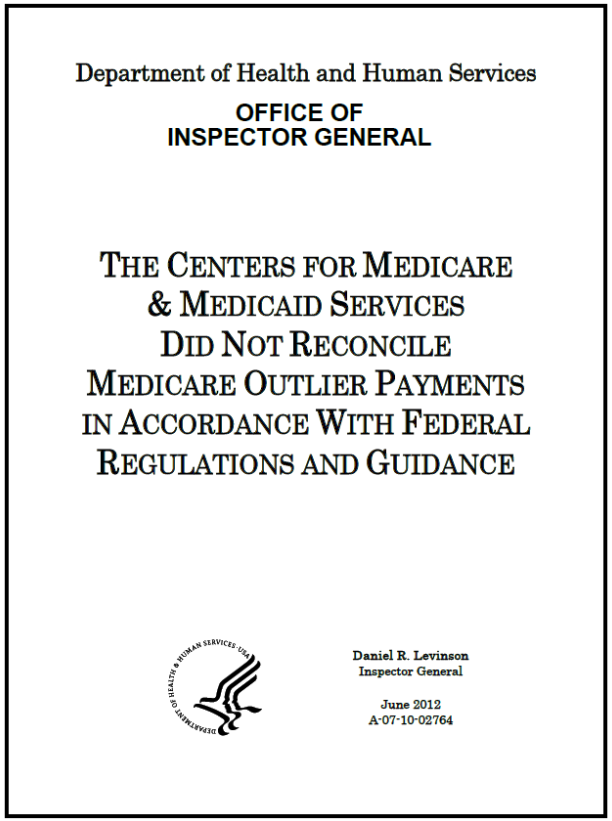
HHS-OIG's Review of Medicare Outlier Payments



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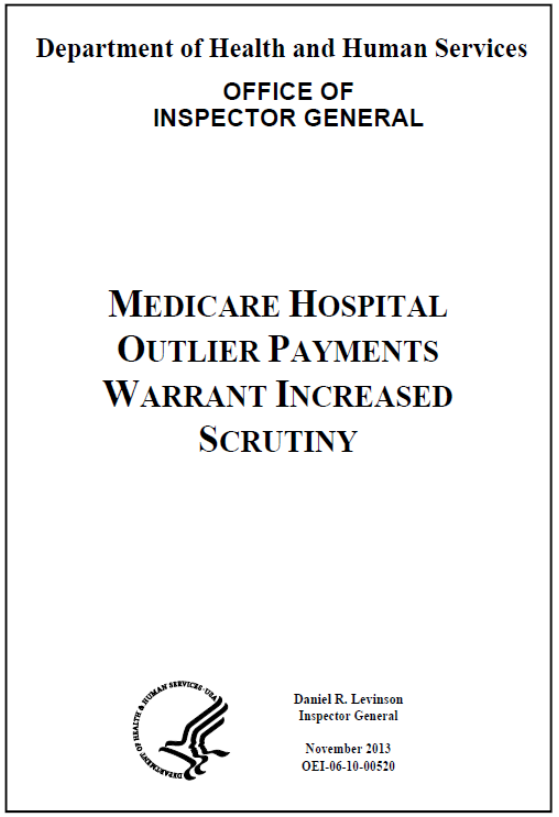
THE CENTERS FOR MEDICARE & MEDICAID SERVICES DID NOT RECONCILE MEDICARE OUTLIER PAYMENTS IN ACCORDANCE WITH FEDERAL REGULATIONS AND GUIDANCE

Daniel R. Levinson
Inspector General

June 2012
A-07-10-02764



Department of Health and Human Services

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MEDICARE HOSPITAL OUTLIER PAYMENTS WARRANT INCREASED SCRUTINY

Daniel R. Levinson
Inspector General

November 2013
OEI-06-10-00520

Current Reimbursement Issues

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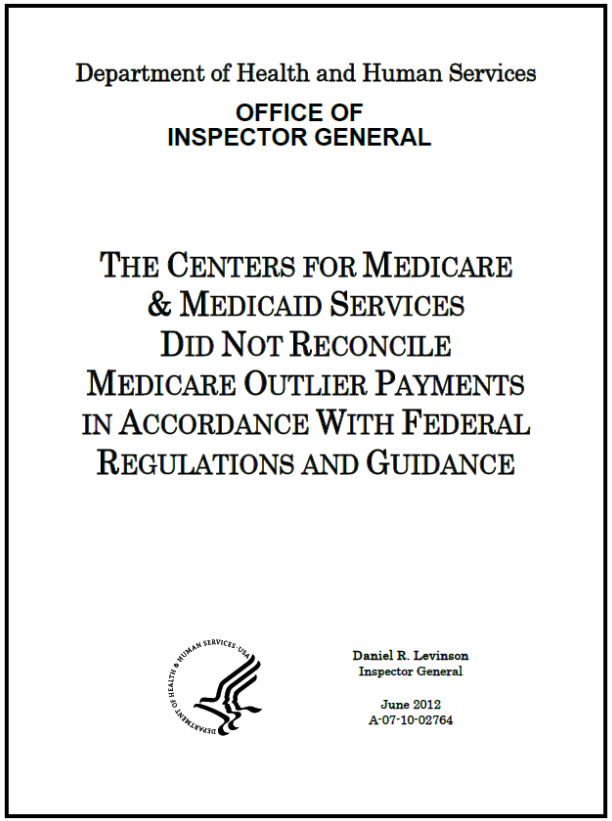
HHS-OIG's Review of Medicare Outlier Payments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June 28, 2012 OIG Report Findings:

- 2003 - 2008, CMS failed to reconcile outlier payments associated with cost reports referred by contractors.
- About $664 million in un-reconciled outlier payments.

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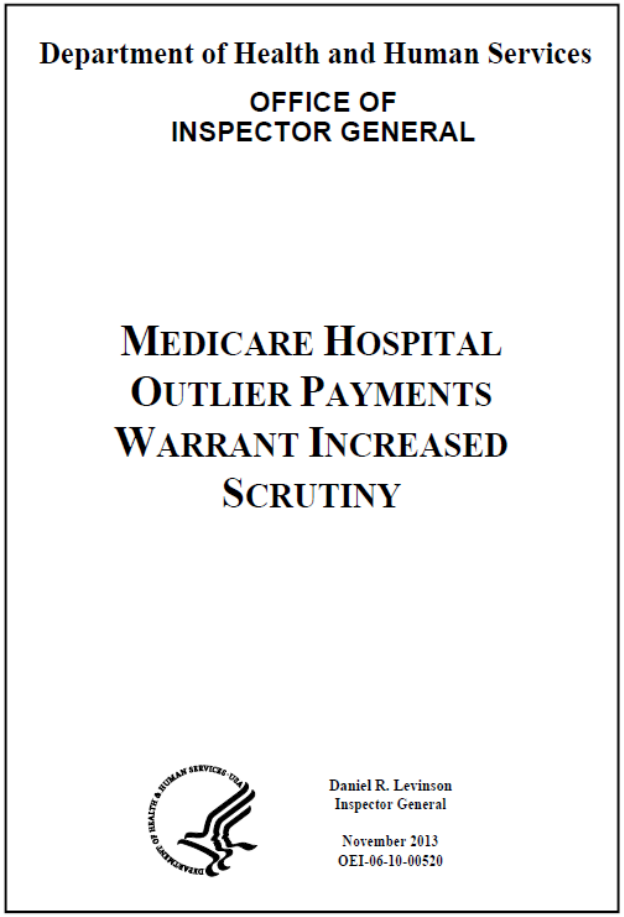
HHS-OIG's Review of Medicare Outlier Payments

November 13, 2013 OIG Report Findings:

- In 2008-2011 –
  - 158 hospitals had outlier payments averaging 12.8% of IPPS payment vs. only 2.2% for other hospitals.
  - 41% of outlier payments for claims in 16 of the 746 MS-DRGs totaling $6.5 billion.
  - High-outlier hospitals charged substantially more for the same MS-DRGs, yet had similar average lengths of stay and CCRs.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Current Reimbursement Issues

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CMS's Response to HHS-OIG's Findings

FEDERAL REGISTER

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Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services
42 CFR Part 412
Office of the Secretary

45 CFR Part 170
Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates; Revisions of Quality Reporting Requirements for Specific Providers, Including Changes Related to the Electronic Health Record Incentive Program; Proposed Rule

FY 2016 IPPS Proposed Rule:

"As we did in establishing the FY 2009 outlier threshold. . .we are proposing not to make any adjustments for the possibility that hospitals' CCRs and outlier payments may be reconciled upon cost report settlement. We continue to believe that CCRs will no longer fluctuate significantly and, therefore, few hospitals will actually have these ratios reconciled upon cost report settlement."

Current Reimbursement Issues

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Medicare Outlier Payments

Preserving Your Appeal Rights

- Medicare Cost Report
  - Identifying alternative fixed loss thresholds
- Calculating the estimated amount in controversy
  - Number of outlier cases x (HHS's outlier threshold – Alternate outlier threshold) x 80%
- Clearly note that you are providing an estimate, as actual amount awaits CMS redetermination

Current Reimbursement Issues

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Disproportionate Share Hospital (DSH) Issues

- Issue specific protest
- State-verified data only available years after hospitals filed cost reports
  - CMS Alert 10: to enable a provider to demonstrate that it properly self-disallowed its Medicaid eligible days claim.

Thank You

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Questions?

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- Reimbursement issues related to the 2016 IPPS rules once they have been finalized – August/September 2015

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