Medicare Litigation Update

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Topics

- PRRB Jurisdictional Requirements and Challenges
- Case Law Developments – Substantive Areas Addressed:
  - DSH
  - Bad Debt
  - Wage Index & Rural/Urban Classifications
  - Outliers
  - Medical Education
  - Two Midnights
JURISDICTIONAL WARS:
THE PRRB (AND MACs) STRIKE BACK
Fundamental Jurisdictional Requirements

Statutory Jurisdictional/Procedural Requirements

(42 U.S.C. §139500(9))

• Dissatisfaction with final payment determination (What does “dissatisfaction” mean?)
• Timely appeal --180 days from final determination
• Requisite amount in controversy – $10K for individual; $50K for group
Additional Jurisdictional Requirements

- **Regulatory Jurisdictional/Procedural Requirements**
  - Regulations effective for cost reporting periods ending on or after 12/31/2008 (42 C.F.R. §405.1835(a))
  - Original NPR
    - claimed item and audit adjustment in NPR; or
    - protested item (becoming increasingly important)
  - Revised NPRs
    - only matters specifically revised are within the scope of an appeal (not within scope if "reopened but not revised")
Cost Report Protest Items and Ensuing Appeals

- Program manual instructions for cost report protest items (Board Rule 7.2.C; Provider Reimbursement Manual, Part II, § 115, 3630.1)
- Identify each protested issue/self-disallowed item
- State reimbursement impact for each issue
  - PRM: "reasonable methodology which closely approximates the actual effect“ (Board getting more strict about this)
- Provide work papers showing calculation of impact
  - PRM: contractor may "evaluate the reasonableness of the methodology for purposes of establishing whether the cost report is acceptable"
Cost Report Protest Items and Ensuing Appeals (cont’d)

- Other requirements for protested item appeals (Board Rule 7.1)
  - Concise issue statement
  - Reimbursement impact
  - Authority "that predetermined that the claim would be disallowed"
- Cost report protested item page and workpapers (Board Rule 21.D.2 requirement for group Schedule of Providers)
Increased Scrutiny of Jurisdictional Requirements

Emerging Trends in Jurisdictional Objections/Decisions

• What does it mean to be “dissatisfied”? (42 U.S.C. §139500(a))
  • Rules are not new, but MACs becoming more aggressive with challenges
  • Questioning jurisdiction over issues preserved due to expectation of better data, e.g., DSH days, SSI realignment
  • “Adverse” findings as to all specific issues?
Increased Scrutiny of Jurisdictional Requirements

Emerging Trends in Jurisdictional Objections/Decisions (cont’d)

- PRRB’s Discretionary Jurisdiction – 42 U.S.C. §1395(d)
  - As long as there is a timely appeal as to some issues, Board can hear all issues in an appeal. *Loma Linda University Medical Center v. Leavitt*, 492 F.3d 1065 (9th Cir. 2007)
  - Board has become very conservative in exercising discretionary jurisdiction

Increased Scrutiny of Jurisdictional Requirements

Emerging Trends in Jurisdictional Objections/ Decisions (cont’d)

- Revised NPRs
  - New Board rules for documentation in 2013
  - Make sure all documents required to establish jurisdiction are in record (whether on the Board’s list or not)
  - Board will use documents in record to make jurisdictional determination
- Board’s “own motion” review
- Timing of jurisdictional objections and responses (Board Rule 44.4)
Increased Scrutiny of Jurisdictional Requirements

Emerging Trends in Jurisdictional Objections/Decisions (cont’d)

- Self-disallowed vs. unclaimed item
  - Pre-2008 regulation change
    - *St. Vincent’s*, PRRB 2013-D39 – Unclaimed ASC and Organ Costs
    - *Danbury*, PRRB 2014-D3 – Medicaid Eligible Days
  - Post 2008 regulation change protest requirement
  - Appeals from Revised NPRs (including those yielded by administrative resolutions)
  - Identifying the specific issues (*e.g.*, dual eligible, charity care, Medicare + Choice/MA)
Group Appeals: Special Considerations

❖ One "Common" Issue

• Single question of fact or interpretation of law, regulations, or CMS Ruling that is common to each provider (42 C.F.R. § 405.1837(b)(2))

• Not common issue if Board could make different findings for different providers based on factual differences (Board Rule 13)

• Board may allow a group appeal to encompass multiple years if no change in relevant law, but not multiple issues
Mandatory vs. Optional Groups

- Commonly-owned/controlled providers
  - CIRP - mandatory Common Issue Related Party group
  - Related party—standard Medicare definition
    (42 C.F.R. § 413.17; PRM Part I Ch. 10)
  - No commingling of related and unrelated providers
Group Appeals: Special Considerations

- Schedules of Providers
  - Documentation showing jurisdictional/procedural requirements met (Board reviewing much more closely)
  - Organized by lettered columns on cover schedule with corresponding tabs for supporting documentation
    - Date of final determination
    - Date of hearing request filing
Schedules of Providers (cont’d)

- Number of days between final determination and appeal filing (receipt by Board if filed on or after 8/21/08)
  - For issues added to individual appeal then transferred to group, number of days from determination to add (21.C.)
- Audit adjustment number or protest item information
  - Additional documentation for revised NPRs (21.D.; see earlier slide)
- Amount in controversy (Asking for calculations)
- Prior case numbers (Board Rule 21E)
Group Appeals: Special Considerations

**Schedules of Providers (cont’d)**

- Dates of Direct Add/Transfer
  - Paper trail showing how provider cost year added to group (new Board Rules 16.1, 21.G)
  - Direct adds to group (Board Rule 16.1.B)
- Provider representative letter including year and issue (Board Rule 21.H)
- Full copies to Board and lead MAC; cover schedule only to BCBSA (Board Rule 20.1)
MEDICARE REIMBURSEMENT
CASE LAW DEVELOPMENTS

Significant Cases 2014-2015
Allina v. Sebelius, 746 F.3d 1102 (D.C. Cir. 2014)

- Issue: Do Part C Days belong in the SSI fraction of the DSH calculation?
- District Court: Secretary's promulgation of the 2004 final rule violated the APA and did not meet the legal standard of being "a logical outgrowth of the proposed rule."
- Appeals Court: District Court went too far in ordering the Secretary to recalculate DSH payments to include Part C days in the Medicaid fraction, holding that the agency was free to decide "how to resolve the problem." Also found that "the statute unambiguously requires that Part C days be counted in one fraction or the other."

Note: Many hospitals have received reopening notices with recent NPRs, saying the MAC will reopen this issue upon a final unappealable decision in Allina. Recent communications from MACs state that CMS will be issuing an interpretive adjudication on this issue “shortly.”
Nazareth Hospital v. Secretary, 747 F.3d 172 (3rd Cir 2014)

Issue: Should state General Assistance (GA) days be counted in the Medicaid Fraction?

Secretary allowed Section 1115 waiver project days to be included in Medicaid Fraction, but not GA days.

District Court: Found no rational distinction between GA days and Section 1115 waiver project days.

Appellate Court: Found that Section 1115 waiver projects further the purpose of Medicaid and are under various federal controls. Therefore, it was rational for Secretary to exclude GA days in the Medicaid Fraction, but allow Section 1115 waiver days.
DSH: Non-Medicaid State Medical Assistance Days

  - Issue: Should state-run health care program patients be counted in the Medicaid Fraction?
  - Kentucky Hospital Care Program (KHCP) patient days included in State Plan as part of calculation of Medicaid DSH.
  - District Court: Just because the program is mentioned in the State Plan as part of the definition of the Medicaid DSH adjustment does not mean the Secretary approved the plan itself under Subchapter XIX. Also, Medicaid DSH adjustment not “medical assistance.”
  - Decided in August 2015, will have to wait and see if it gets appealed, would go to 6th Cir.
DSH: Revised NPR Jurisdictional Issues


- **Issue:** Does the Board have jurisdiction over an SSI Fraction appeal if a cost report was re-opened, and revised NPR issued to adjust the Medicaid Fraction and resulting DSH adjustment?
- **District Court:** Just because the overall DSH adjustment was adjusted does not mean every component of the calculation was revised or reconsidered. If a portion was not revised or reconsidered, cannot be appealed.
- **Left open issue of whether an item reconsidered but not modified can be appealed.**
Hooper, Lundy & Bookman, PC

DSH: The Revised DSH Adjustment

  - As of FY 2014, DSH is a combination of traditional DSH and a prospective element of a hospital’s share of a DSH pool.
    - To calculate hospital’s share of the DSH pool, Secretary must estimate uncompensated care using “appropriate data.”
    - For FY 2014, Secretary used Medicare and Medicaid SSI days from 2010/2011 cost report data, updated as of March 2013.
  - Statute limits review on estimates to determine factors and the period selected by the Secretary.
  - Provider challenged that Secretary did not use updated data.
  - District Court: No review allowed, challenge relates to estimate and period.
Bad Debts: Crossover Claims and Must-Bill Policy

- **Maine Medical Center v. Burwell, 775 F.3d 470 (1st Cir. 2015)**
  - **Issue:** Must a provider have RA’s before claiming crossover bad debt?
    - Technical glitch in Maine Medicaid’s system caused claims to not be processed, and no RAs issued for two years.
    - Provider developed alternative documentation for compiling crossover bad debts for that period, which were rejected.
  - CMS Administrator held that a provider must first bill the state and receive an RA as evidence. District court affirmed.
  - Appeals Court: Must-bill and RA policies entitled deference, but could be exceptions for RAs. However, Secretary’s rejection of alternate data in this case upheld.
    - Provider’s alleged delay and lack of effort to correct the problem seems to have been a factor in court’s decision.
Bad Debts: Crossover Claims and Must-Bill Policy

- **Grossmont Hospital Corp. v. Burwell, __ F.3d __ (D.C. Cir. 2015)**

  - Issue: Must hospital bill Medicaid and received determination prior to claiming crossover bad debt?
  - Hospital’s FI’s system to transmit claims to Medi-Cal did not always work. Even after a mass re-processing, some claims were missing.
  - Appeals Court: Upheld must-bill and state determination policies; given substantial deference.
Bad Debts: Pending at Outside Collection Agency

  - Issue: Can accounts pending at an outside collection agency be written off as bad debt?
  - CMS policy that accounts pending at OCA cannot be written off as bad debt.
  - District Court: CMS policy pre-dates moratorium, and providers could not provide evidence of their policies pre-moratorium. Also, CMS policy is a reasonable interpretation, and does not violate APA.
  - Note: conflicting cases on this issue.
Attrium Med. Cntr. v. DHHS, 766 F.3d 560 (6th Cir. 2014)

Issue 1: Is short term disability paid through payroll rather than insurance a “wage” or “wage-related cost”?  
Appeals Court: Within Secretary’s discretion to treat general fund disability payment as a “wage” for which hours must be reported.

Issue 2: Should unworked “Baylor” hours be treated as “paid hours”?  
Hospital offers full-time salary and benefits to employees working two 12-hour weekend shifts. Recorded as 40 hours.

Appeals Court: Deference given to Secretary’s policy to include all recorded hours as paid hours, regardless if actually worked.
Wage Index: Multi-Campus Apportionment

- **Anna Jacques Hosp. v. Burwell, __ F.3d __ (D.C. Cir. 2015)**
  - Problem caused by shift from MSAs to CBSAs as geographic area.
  - Three hospital system spanning multiple CBSAs, but all counted in main campus’ area’s wage index.
  - Other providers in that CBSA challenged because statute requires wage index to reflect wage costs in the hospital’s geographic area.
    - CMS changed to desired treatment (to apportion wage data between campuses) two years later.
  - Appeals Court: Secretary’s decision not to apportion wage data for first two year was permitted and reasonable.

Issue: Can a provider who redesignated from urban to rural under Section 401 apply for MGCRB geographic reclassification based on the acquired rural status?

District Court: Found statute to be ambiguous, and granted Secretary deference in establishing regulations that prohibit Section 401 provider from seeking MGCRB reclassification based on acquired rural status.
**Wage Index: Rural/Urban Reclassification**

- **Geisinger Comm. Med. Cts. V. Sec’y DHHS, __ F.3d __ (3rd Cir. 2015)**
  - Issue: Can a provider who redesignated from urban to rural under Section 401 apply for MGCRB geographic reclassification based on the acquired rural status?
  - Appeals Court: Found statute to be unambiguous, and required Section 401 hospitals to be treated as rural for all purposes under subsection (d), including MGCRB reclassification.
  - Dissent: Disagrees, finds statute ambiguous and Secretary should be given deference, cites *Lawrence*. 
Outliers

- **District Hospital Partners, L.P. v. Burwell**, 786 F.3d 46 (D.C. Cir. 2015)
  - Issue: Whether the Secretary properly calculated the outlier thresholds for 2004, 2005, and 2006. District Court ruled in favor of the Secretary.
  - Court of Appeal Decision:
    - 2005 and 2006 thresholds affirmed
    - 2004 threshold overturned with directions to Secretary to furnish better explanation
    - What happens with 2004 could potentially still impact 2005 and 2006
  - Case to watch: **Banner Health v. Burwell**, 1:10-cv-01638, pending in D.C. District Court

Issue: Is regulation requiring written affiliation agreement to aggregate FTE caps permissible?

One hospital had an FTE cap of zero, affiliated with another hospital with a higher FTE cap, and became primary site for a residency program. Hospitals let their affiliation agreement expire and lapse without renewal, and PRRB denied aggregated cap for those years.

District Court: The requirement for a written affiliation agreement is permissible and reasonable.
Rush University Medical Center v. Burwell, 763 F.3d 754 (7th Cir. 2014).

- Issue: Whether residents’ time spent in pure research activities counted as part of IME costs for FYs 1983-2001.
- After passage of ACA, but before applicable regulations, 7th Circuit found that pure research activities could be counted. See, Univ. of Chicago Med. Ctr. v. Sebelius, 618 F.3d 739 (7th Cir. 2010).
- Appeals Court: Upheld regulation excluding pure research from IME costs.
Two Midnights

- **American Hospital Association v. Burwell, No. 14-609 (D.C. District Court)**
  - Challenges the Two Midnights policy
  - Motion to Dismiss filed by government; Motions for Summary Judgement exchanged, stayed until MTD is ruled on.

- **Shands Jacksonville Medical Center v. Burwell, No. 14-263 (D.C. District Court)**
  - Multiple cases consolidated under *Shands*, challenging the related 0.2% Reduction
  - Motions for Summary Judgment exchanged; oral argument on the MSJs occurred August 3, 2015; decision expected in 2-3 months.
Questions?

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