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PRRB Year-in-Review Highlights Include Fallout from DSH Alert and Bad Debt Collection Policy

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Disproportionate share hospital (DSH) adjustments, bad debts, rural hospitals, medical education costs, volume decrease adjustments, and wage index were among the reimbursement issues addressed in 30 decisions by the Provider Reimbursement Review Board (PRRB) in fiscal year 2014. As of the beginning of December, the CMS Administrator had issued reviews of seven of those decisions. In addition, both district and appellate courts further reviewed the determinations of CMS and the PRRB. The PRRB also continues to work on winnowing the backlog of cases that are being filed, in ways that concern some providers. This Strategic Perspective provides a topical review of some of the major decisions of the year.

Alert in wake of *Danbury* decision

Providers with pending appeals have been informed that they had 60 days to supplement the record to support the PRRB's jurisdiction to consider contentions that self-disallowed bed days attributable to Medicaid-eligible patients (Medicaid days) should be added to the number claimed on a cost report to calculate their eligibility for disproportionate share hospital (DSH) payments, according to Alert 10 issued by the PRRB on May 23, 2014. The Alert states that the PRRB will require detailed explanations of the reasons that the specific provider could not obtain verification from the state Medicaid agency of the days it wishes to add.

The PRRB issued the Alert to implement its ruling in *Danbury Hospital v Blue Cross Blue Shield Ass'n* (2014-D3, February 11, 2014) that self-disallowed Medicaid days could be the subject of an appeal under Soc. Sec. Act Sec. 1878(a) and 42 C.F.R. Sec. 405.1835. The hospital's self-disallowance, however, must have been the result of an inability to obtain verification of the Medicaid days from the state agency as required by 42 C.F.R. Sec. 412.106 for reasons beyond the provider's control.

Dan Hettich, an attorney in King & Spalding's Washington D.C.'s Healthcare Practice Group and vice-chair of the American Health Lawyers Association's Regulations, Accreditation and Payment practice group, noted that "this decision has wide implications because, historically, Medicare administrative contractors (MACs) generally had accepted the addition of Medicaid-eligible days after the cost report was filed under the understanding that the exact number of Medicaid-eligible days simply could not be known at the time of filing." Hettich noted that while the Danbury decision has been appealed to a federal district court in Connecticut, a settlement is likely because the dollar amounts at issue are relatively small.

Of more significance is the Alert, according to Hettich. The PRRB has received "hundreds, if not thousands, of responses to Alert 10 from providers

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throughout the country--some challenging the very premise of the Alert 10 requirement, others submitting as much responsive information as they could muster, and still others doing both." In November, the PRRB held a hearing at which expert witnesses were called to explain why many of the PRRB's requests related to Alert 10 could not be answered. Hettich said that the PRRB was "thoroughly engaged and seemed to find the testimony extremely informative [but] it is not clear what the Board's current plans are regarding the hundreds of responses it received in response to Alert 10.

Disproportionate Share Hospital Calculation

The U.S. Court of Appeals for the Third Circuit determined that the HHS Secretary's Final rule disallowing General Assistance (GA) patient days from being included in Medicare DSH adjustments, but allowing Soc. Sec. Act Sec. 1115 waiver patient days to be included, was reasonable. In reversing the lower court's decision that found the Secretary's regulation to be arbitrary and capricious, the Third Circuit concluded that the Secretary provided numerous rational bases to justify the exclusion of days covered under Pennsylvania's GA plan. *Nazareth Hospital v. Secretary United States Dept. of Health and Human Services*, U.S. Court of Appeals, Third Circuit, 13-2627, April 2, 2014.

The CMS Administrator affirmed a PRRB decision that upheld the Medicare Administrative Contractor's (MAC's) exclusion of bed days attributable to patients whose care was covered under GA or other programs funded solely by state or local governments from the DSH payment calculation. The PRRB's interpretation of Soc. Sec. Act Sec. 1886(d)(5)(F)(vi)(II) was correct. The phrase "entitled to assistance under a state plan approved under Title XIX" describing patient days countable toward the Medicare DSH adjustment includes only patients who were eligible for Medicaid, not the additional patients whose uncompensated care was counted toward the separate Medicaid DSH adjustment under Soc. Sec. Act Sec. 1923. Owensboro Medical Health System, *CMS Administrator Review* of Dec. No. 2014-D1, January 15, 2014.

Medicare Bad Debt

Disallowance of claims for bad debt was proper in a case in which the provider had turned the claims over to collection agencies after 120 days of effort and the collection agency was continuing collection activity, the PRRB ruled. Multiple group claims were combined into one decision, which clarified that a debt is not considered worthless until the collection agency has ceased its activity and returned the claim to the hospital. CHS Medicare Bad Debt Passive Collection CIRP Groups v. Intermediary (Various), *PRRB Hearing* Dec. No. 2014-D13, Case Nos. 08-0611GC, 08-0619GC, 08-0621GC, July 1, 2014.

Hettich noted that while the PRRB issued multiple decision regarding Medicare bad debt in 2014, "this decision stands out because there the Board reversed course from its prior decisions and held that the MAC's policy of categorically disallowing Medicare bad debts that continue to be held by a collection agency was not a change in the agency's policy as it existed in 1987 and, therefore, did not violate the bad debt moratorium." The decision is currently under appeal in the district court for the District of Columbia. Hettich said, because " CMS also has a policy that Medicare and non-Medicare accounts must be treated similarly, CMS's current position that Medicare accounts cannot be claimed until they have been returned from a collection agency means that virtually *all* accounts must be returned from the collection agency before Medicare bad debts can be claimed."

The CMS Administrator modified a decision of the PRRB after BlueCross BlueShield Association (BCBSA) and the Center for Medicare requested a reversal of the PRRB's decision regarding whether an adjustment to disallow Medicare bad debt on a cost report was appropriate. The Administrator agreed with the PRRB's decision to disallow the bad debt because Ashton Hall Nursing & Rehabilitation Center did not demonstrate that the bad debts it claimed were actually uncollectible and worthless. Ashton Hall Nursing & Rehabilitation Center v. Blue Cross Blue Shield Association/Novitas Solutions, Inc., *CMS Administrator Decision*, Review of PRRB Dec. No. 2014-D5, May 30, 2014.

Reclassification

The confirmation of the reclassification of a New Jersey hospital as a "rural hospital" by the PRRB was reversed by the CMS Administrator because the state of New Jersey does not have a rural area. Previously, the PRRB held that an actual rural area was not necessary and that this hospital qualified for reclassification based on its location in a rural census tract of a metropolitan statistical area (MSA). Deborah Heart and Lung Cancer v. Blue Cross Blue Shield Association, *CMS Administrator Decision*, Review of PRRB Dec. No. 2014-D7, June 18, 2014.

Rural Health Clinic

The CMS Administrator reversed a decision of the PRRB and held that services provided by contracted physicians at a rural health clinic (RHC) were "physician services" under 42 C.F.R. Sec. 405.2412 and "direct services" under 42 C.F.R. Sec. 491.9(c) because they were provided on a regular ongoing basis at a RHC. The Administrator concluded that the distinction the provider attempted to rely on to escape the RHC productivity screening guidelines was reserved for physician services purchased on a limited and intermittent basis and could not be relied upon by the provider simply because its physicians were under contract. Welch Community Hospital v. BlueCross BlueShield Association/ Palmetto GBA, *CMS Administrator Decision*, Review of PRRB Dec. No. 2014-D-9, July 31, 2014.

Graduate and Indirect Medical Education Costs

The disallowance of a Florida provider's resident full-time equivalent (FTE) count by a Medicare fiscal intermediary (FI) was overturned by the PRRB. The FI's finding that the provider's graduate medical education(GME) and indirect medical education (IME) programs should not be considered "new programs" was improper according to the PRRB, because it relied upon an incorrect retroactive application of the interpretation of the term "new program." Cleveland Clinic Florida Hospital v. Wisconsin Physicians, *PRRB Hearing* Dec. No. 2014-D22, Case Nos. 06-1304, 07-0199, 08-0025, 08-0231 and 08-1852, September 9, 2014.

Hettich said that the PRRB, for the second time, "held that CMS's 2009 "clarification" regarding its definition of a new residency program was not a clarification at all but a substantive change in policy." The CMS Administrator did not review this decision so it is now final.

The CMS Administrator has reversed a decision by the PRRB ordering an FI to re-audit disallowed resident rotations for fiscal years (FY) 2003 and 2004 based on Section 5504 of the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148). Section 5504 changed certain requirements for counting resident time in nonprovider settings for purposes of determining GME and (IME) reimbursement. The PRRB found that the FI erroneously applied pre-ACA provisions even though the appeals were jurisdictionally proper and pending as of the date of ACA enactment. The Administrator reversed the PRRB because the ACA provisions regarding GME payments were not to be applied retroactively, but prospectively. Eastern Maine Medical Center v. BlueCross BlueShield Association, *CMS Administrator Decision*, Review of PRRB decision 2014-D10, July 23, 2014.

The U.S. Court of Appeals for the Seventh Circuit concluded that medical residents' research activities for the years 1983 to 2001 were not reimbursable as IME costs. The court reached its decision by overruling its own prior holding allowing the adjustments, in favor of an HHS regulation updated in 2010 (42 C.F.R. §412.105(f)(1)(iii)(C)).expressly disallowing the inclusion of resident research activities in IME calculations. The court held that the ambiguity inherent in the section of the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148), which gave rise to the earlier Seventh Circuit decision, was grounds to give deference to HHS. *Rush University Medical Center v. Burwell*, U.S. Court of Appeals, Seventh Circuit, 13-3285, August 18, 2014.

PRRB Jurisdiction

The PRRB, the rest of the Department of Health and Human Services, and all current and future Medicare contractors are enjoined from applying 42 C.F.R. Sec. 405.1835(a)(1)'s "dissatisfaction" requirement for PRRB jurisdiction to any pending or future PRRB appeal that is based on the Medicare contractor's failure to issue a timely Notice of Program Reimbursement (NPR) within 12 months of the provider's filing of its cost report. The court concluded that the provider met the requirements of Social Security Act Sec. 1878(a)(1)(B) regarding PRRB jurisdiction over appeals where the Medicare contractor did not issue a timely NPR. *Charleston Area Medical Center v Sebelius*, U.S. District Court, District of Columbia, Civil Action No. 13-643 (RMC), August 6, 2014.

Volume Decrease Adjustment

The CMS Administrator modified a decision of the PRRB concluding that while the MAC correctly excluded a hospital's variable costs, the PRRB's calculation of the provider's volume decrease adjustment (VDA) was improper. The PRRB's calculation resulted in an overpayment to the hospital. Unity Healthcare v. Blue Cross Blue Shield Association/Wisconsin Physicians Service, *CMS Administrator Decision* Review of PRRB Decision No. 2014-D15, July 10, 2014; see also Lakes Regional Healthcare (Spirit Lake, Iowa) v. Blue Cross Blue Shield Association/Wisconsin Physicians Service, *CMS Administrator Decision*, Review of Dec. 2014-D16, September 4, 2014.

Hettich said while sole community hospitals (SCHs) will probably disagree with some of the reasoning in the original PRRB decision, the holding was largely favorable to SCHs. "Unfortunately, the Administrator overturned those decisions and we understand that at least one of the Administrator's decisions will be challenged in federal court," Hettich said. He added that this is likely "the first time the Board and the Administrator have directly addressed the new and unfavorable way in which many MACs are now interpreting the volume decrease adjustment calculation." Also, as the 2006 SCH base-year hospital specific rate gets older, Hettich said, "the amount of money at issue in these adjustments is going to increase."

Wage Index

The United States Court of Appeals for the Sixth Circuit affirmed the decision of a district court, which agreed with an HHS determination to treat short-term disability payments and part-time weekend work payments as "wage" costs rather than "wage-related" costs. The court determined that the HHS Secretary's wage-index determinations did not exceed the Secretary's authority and represented reasonable and consistent interpretations of the CMS *Provider Reimbursement Manual* (PRM). *Atrium Medical Center v. HHS*, U.S. Court of Appeals, Sixth Circuit, 13-3288, September 8, 2014.

Merger

The surviving entity of a hospital merger failed to establish that a bona fide hospital sale existed and, therefore, was unable to recover a claim for $8.1 million in depreciable assets. In reaching its decision to affirm the district court's order of summary judgment in favor of the Secretary of HHS, the U.S. Court of Appeals for the District of Columbia Circuit found that the Secretary did not err in considering one appraisal approach as all appraisal methods demonstrated a large discrepancy between the actual value of the hospital sold and the consideration received. *Catholic Healthcare West v. Sebelius*, U.S. Court of Appeals, District of Columbia Circuit, 13-5090, April 11, 2014.

Crossover Claims

Medical Center (MMC) was denied nearly $3 million in crossover claims due to a MaineCare system processing malfunction. In granting HHS Secretary Sebelius' cross-motion for judgment on the administrative record, the court determined that the Secretary's final administrative decision that MMC failed to provide the required documentation to receive Medicare reimbursement was not arbitrary, capricious, an abuse of discretion, not in accordance with law, or otherwise unsupported by substantial evidence. *Maine Medical Center v. Sebelius*, U.S. District Court, D. Maine, 2:13-cv-00118-JAW, March 25, 2014.

Capital Costs

Federal regulations entitling "new hospitals" to 85 percent of their reasonable capital-related costs for their first two years of existence and exempting them from the inpatient prospective payment system's (IPPS) capital costs formulae during that time are ambiguous, according to the D.C. Circuit. When, as here, "ambiguity begets ambiguity," courts "have little choice but to declare" that CMS's interpretation of the ambiguous regulations is "arbitrary and capricious" and, therefore, not warranted any deference. *Select Specialty Hospital v. Burwell*, U.S. Court of Appeals, District of Columbia Circuit, 12-5355, July 8, 2014.

Conclusion

Hettich noted that "if history is any teacher I would expect that the CMS Administrator has overturned the vast majority of cases decided in favor of providers by the PRRB." Regarding Alert 10, Hettich said, "The upshot of all this is that the PRRB's issuance of Alert 10 may have been premature and the PRRB may have gotten more than it bargained for in issuing it." The PRRB docket has a backlog of hundreds of cases; a look at the cost report years in decisions issued by the PRRB shows many arose more than 10 years' ago. Hettich noted that the PRRB is more proactively managing appeals by, for example," sending letters to ask whether all providers have been added to a mandatory group appeal so that it can proceed toward hearing."

The PRRB is also more strictly construing the requirements for its own jurisdiction. The *Danbury* decision, according to Hettich, may be part of that overall project. "Reducing the appeal backlog by reducing the number of jurisdictionally eligible appeals is particularly troubling for providers," Hettich said.