

Recent Trends In Medicare
Appeals
Michigan Chapters Of HFMA
Spring Conference
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Topics

- Medicare Appeals
 - Medical Education
 - DSH Adjustment
 - Bad Debt

Legal Principles Regarding Medicare Payment for Medical Education

- Medicare Makes Two Education Payments:
- Indirect Medical Education (IME)
Compensates for higher indirect patient care costs in teaching hospital
- Direct Graduate Medical Education (GME)
Compensates for residency education costs

Legal Principles Regarding Medicare Payment for Medical Education

- Indirect Medical Education (“IME”)

The IME is designed to pay PPS teaching hospitals for the *indirect* costs relating to the participation of interns and residents in patient care. The IME payment formula computes a percentage increase in the DRG payment based on teaching intensity, as measured by a hospital's intern and resident-to-bed ratio.

Legal Principles Regarding Medicare Payment for Medical Education

- Direct Graduate Medical Education (“GME”)
- Prospectively determined per-resident amount (PRA), determined in a 1984 base year. The PRA is multiplied by the number of full-time equivalent residents working in all areas of the hospital complex (and nonprovider sites, where applicable), and the product is then multiplied by the hospital's Medicare share of total inpatient days to determine Medicare's direct GME payment (“Medicare Patient Load”). Beginning in Federal Fiscal Year 2001, floors and ceilings on PRA established.

Legal Principles Regarding Medicare Payment for Medical Education

- Beginning in Federal Fiscal Year 2001, floors and ceilings on PRA were established.
- Compare to locality adjusted national average
- If less than 70%, increased to 70% for FY 2001 and 85% for FY 2002.
- If greater than 140%, frozen FY 2001 and 2002, in 2003 updated CPI minus 2%, for 2004-2013, rate frozen

Medical Education: Background

GME

42 C.F.R. Sec. 413.75 through 413.83.

A Separate Payment

Payment = (Weighted FTE's) x (Per Resident Amount) x (Medicare Patient Load)

IME

42 C.F.R. Sec. 412.105

An Add On To PPS DRG Payment

Adjustment: Based On Ratio No. FTE's/Available Beds

Medical Education: Non-Patient Care Activities

- Issue: Should FTE Residents Not Engaged In Patient Care Be Included For Purposes Of Inpatient IME
 - *Rhode Island Hospital v. Leavitt*, 548 F.3d 29 (1st Cir. 2008)
 - Holding: Residents assigned to research may not be included.

Medical Education: Non-patient Care Activities

- *Rhode Island Hospital Is The First Court Of Appeals Decision On This Issue*
- District Courts Held For Providers:
 - *See Univ. Med. Ctr. Corp. v. Leavitt*, No. 05-495, 2007 WL 891195, at *2 (D. Ariz. Mar. 21, 2007) (unpublished); *Riverside Methodist Hosp. v. Thompson*, No. C2-02-94, 2003 WL 22658129, at *6 (S.D. Ohio July 31, 2003) (unpublished).

Medical Education: The Nonprovider Setting

- Is a written agreement between the provider and the nonprovider setting required?
- Must a single hospital “incur all or substantially all of the costs?”

Rotation To Nonprovider Setting

Two Statutory Requirements:

- Activities Related To Patient Care
- Hospital Must Incur All, Or Substantially All, Training Costs Of The Training Setting

IME: SSA Sec. 1886(d)(5)(B)(iv)

GME: SSA Sec.1886(h)(4)(e)

Rotation To Nonprovider Setting

Medicare Regulation Adds Complexities Resulting In Disallowances Of FTE's:

Activities Related To Patient Care

- Direct Training Costs
- Costs of Supervising/Teaching Physician
- “Written Agreement” Requirement; Optional As Of 10/1/2004

Medical Education: The Nonprovider Setting

- No significant regulatory changes in 2008
- *North Dakota GME/IME Group (Bismarck, N.D.) v. Blue Cross Blue Shield*, Dec. No. 2008-D19 (Feb. 26, 2008) (Medicare and Medicaid Guide (CCH) ¶ 81,884) (PRRB held that, for the fiscal years on appeal, 1999, 2000, 2001, costs could be shared by two hospitals), rev'd, CMS Administrator Decision, April 25, 2008 (Medicare and Medicaid Guide (CCH) ¶ 81,937.)

Rotation To Nonprovider Setting: “All Or Substantially All”

- A Single Hospital Must Be Responsible “Full Complement” Of Costs Of “Program”

“A hospital cannot count any FTE residents if it incurs ‘all or substantially all of the costs’ for only a portion of the FTE residents in that program setting.”

68 Fed. Reg. 45439.(August 2004)

- Note this principle is implicated if two or more hospitals fund a “third party entity” that employs residents

Rotation To Nonprovider Setting: “All Or Substantially All”

- Some hospitals do not directly employ residents.
- What CMS refers to as a “third party” may employ and compensate the residents, and hold the accreditations
- Two or more hospitals may fund the “third party.”
- The “single hospital” issue may arise in this setting.
- It is necessary for the hospital to demonstrate that it funds the third party entity, and thus that it compensates the residents through such funding.
- *Covenant Healthcare v BCBSA/NGS*; PRRB Dec.No. 2007-D55 (8/2/2007; CCH ¶ 81,762), rev'd CMS Administrator (10/3/2007; CCH ¶ 81,790)

Rotation To Nonprovider Setting: Written Agreement

Note: Required By Regulation, not Statute

- Requirement Became Effective 1/1/1999
- Optional 10/1/2004
- Issues Regarding Written Agreement:
Does It Exist? Is It Signed? Is It Dated?
Can It Be Retroactive? What Should It
Say? Suppose There Already Is An
Employment Contract?

Rotation To Nonprovider Setting: Written Agreement

“Written Agreement”

For Portions Of Cost Reporting Periods
On/After

10/1/2004, Hospital Has Option:

- (1) Written Agreement **OR**
- (2) Pay Costs Associated With Training No
Later Than End Of Third Month
Following A Month In Which Rotation
Occurred

(See 42 C.R.R. Sec. 413.78(e))

Medical Education: The Nonprovider Setting

- At Least Two Pending cases challenging “written agreement” requirement
 - *Cottage Health System d/b/a Santa Barbara Cottage Hosp. v. Leavitt*, No. 08-0098(JDB) (D.D.C.)
 - *Covenant Med. Cnt., Inc. v Leavitt*, No. 07-15108 (ADT) (E.D. Mich.)

Medical Education: Counting Managed Care Days

- Issue: Must hospital file UB-92 to count Medicare HMO enrollees for IME/GME?
- At least five cases presenting this issue are pending in the United States District Court for the District of Columbia:
- *Cottage Health System d/b/a Santa Barbara Cottage Hosp. v. Leavitt*, No. 08-0098(JDB) (D.D.C.).
- *Bayfront Med. Cnt. v. Leavitt*, No. 08-249 (PLF) (D.D.C.)
- *Loma Linda University Med. Cnt. v. Leavitt*, No. 08-1520(HKK) (D.D.C.)
- *Hosp. of Univ. of Pennsylvania v. Leavitt*, No. 08-1665(JRB) (D.D.C.)
- *Sparrow v Johnson*, 08-1021 (RMC) (D.D.C.)

Disproportionate Share Hospital Adjustment: Background

- The Medicaid Low Income Proxy
 - Patients receiving medical assistance

- The Medicare Proxy
 - The supplemental security income percentage (SSI%)

Disproportionate Share Hospital Adjustment: General Assistance Days

- Issue: Whether State paid only general assistance days should be included in the Medicaid Low Income Proxy?
- *Adena Reg. Med. Cnt. v. Leavitt*, 527 F.3d 176 (D.C.Cir. 2008) Ohio Health Care Assurance Plan (“HCAP”)
- Holding: HCAP was not a part of the Ohio Title XIX State Plan. The Court further found that HCAP patients were not “eligible for medical assistance.”

Disproportionate Share Hospital Adjustment: Section 1115 Waiver Days.

Issue: Should Section 1115 Waiver days be included in the Medicaid Low Income Proxy?

Cookeville Reg. Med. Cnt. v. Leavitt, 531 F.3d. 844 (D.C. Cir. 2008).

- The DC District ruled in favor of the plaintiffs.
- On appeal to the DC Circuit, the DRA was signed into law, Section 5002 of which adopted 42 C.F.R. § 412.106(b)(4)(ii). The Secretary of DHHS moved to alter judgment based on Fed. R. Civ. P. 59(e). The Court granted the motion. The Hospitals then appealed to the U.S. Court of Appeals for the District of Columbia Circuit.
- On appeal, the Court held in favor of the Secretary, based on the reasoning that the DRA clarified an ambiguity in the existing legislation.

Disproportionate Share Hospital Adjustment: The Medicare Proxy

- Issues: Was the hospital-specific SSI% accurately computed?
- Was the “global” SSI% accurately computed?

Disproportionate Share Hospital Adjustment: Hospital Specific SSI% Challenge

- The PRRB has decided a number of cases in favor of providers who contended that the Intermediary did not include all patients and patient days eligible for SSI.
- In 2008, the PRRB issued the decision in *Beverly Hosp. (Beverly, Massachusetts) v. Blue Cross/Blue Shield Assoc./National Government Services LLC-WI*, Dec. No. 2008-D37 (Sept. 23, 2008)

Disproportionate Share Hospital Adjustment: The Global SSI% Challenge

- *Baystate Med. Cnt. v. Leavitt*, 547 F.Supp.2d 20 (D.D.C. 2008)
- Final judgment in favor of providers regarding principal issue of accuracy of SSI% data on December 8, 2008.
- Secretary appealed; withdrew appeal on May 10, 2009.

Bad Debt: Background

- A provider is authorized to claim Medicare bad debt if it has satisfied the requirements set forth in 42 C.F.R. § 413.89.
 - The debt must be related to covered services and derived from deductible and coinsurance amounts.
 - The provider must be able to establish that reasonable collection efforts were made.
 - The debt was actually uncollectible when claimed as worthless.
 - Sound business judgment established that there was no likelihood of recovery at any time in the future.

Bad Debt: Use Of Collection Agency

Issue: If bad debt is at an outside collection agency may it be deemed uncollectable?

CMS Joint Signature Memorandum Dated May 2, 2008.

States Secretary's position that bad debt referred to a collection agency is required to be returned to the provider before it could be claimed as Medicare bad debt.

Bad Debt: Use Of Collection Agency

- *Battle Creek Health Sys. v. Leavitt*, 498 F.3d 401 (6th Cir. 2007) held that bad debt referred to a collection agency was required to be returned to the provider before it could be claimed as Medicare bad debt.
- *Foothill Hosp. v. Leavitt*, 558 F. Supp 2d 1 (DDC 2008) held that the Medicare Bad Debt Moratorium prohibited the intermediary from disallowing bad debt on the basis that it had been referred to but not yet returned from a collection agency. This Court did not follow *Battle Creek*. The decision is final and subject to no further appeal.

Bad Debt: Reduction Applicable To QMB's

- Issue: Does the reduction in Medicare bad debt payment imposed by the Balanced Budget Act of 1997 (BBA of 1997) apply to dual eligibles and Qualified Medicare Beneficiaries (QMBs) in states that impose a cap on Medicaid liability?
- *Detroit Receiving Hosp. and University Health Cnt. v. Leavitt*, 561 F.Supp.2d 795 (E.D. Mich. 2008).
 - Holding: In favor of Secretary. On appeal.

Bad Debt: Medicare Part B Fee Schedule

- Issue: Whether Medicare bad debt payment is allowed for Part B services for which Medicare payment is made under a fee schedule?
- 42 C.F.R. § 413.80 was silent on the issue.
- *Abington Crest Rehabilitation and Nursing and Rehabilitation Cnt. v. Leavitt*, 541 F.Supp.2d 99 (D.D.C. 2008)
 - Holding: In favor of Secretary. On appeal.

Bad Debt: Must Bill Policy

Issue: Must bad debt applicable to dual eligibles and QMBs in a state that imposes a Medicaid cap be submitted to the Medicaid program as a requirement for receipt of Medicare payment for bad debt?

Bad Debt: Must Bill Policy

- *Community Hosp. of Monterey Peninsula v. Thompson*, 323 F.3d 782 (9th Cir. 2003). Holding: In favor of Secretary
- Cases challenging this policy continue to be brought before the PRRB.
 - See, e.g., *Port Huron Hosp. (Port Huron, MI) v. BlueCross Blue Shield Assoc./National Government Servs., LLC-WI*, PRRB Dec. No. 2008-D32 (Medicare and Medicaid Guide (CCH) ¶ 82,104), rev'd CMS Administrator Dec. Oct. 14, 2008, (Medicare and Medicaid Guide (CCH) ¶ 82,215), appealed to United States District Court for the District of Columbia, *Port Huron Hospital v. Leavitt*, Case No. 08-02085 (RMU); *Summer Hill Nursing Home, LLC v. Leavitt*, Case No. 08-00268 (RMC) (D.D.C.)

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