

# **Recent Trends In Medicare Appeals**

## **Michigan Chapters Of HFMA Spring Conference**

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**Kenneth R. Marcus, Esq.**

**Honigman Miller Schwartz and Cohn LLP  
660 Woodward Avenue  
Detroit, MI 48226  
313 465 7470  
313 465 7471  
kmarcus@hongiman.com**

## I. Graduate Medical Education

### A. Background:

1. *Indirect Medical Education (IME) adjustment*, 42 C.F.R. § 412.105.
  - a. Recognizes the additional indirect costs associated with a graduate medical education program.
  - b. Computation involves number of full-time equivalent (FTE) interns and residents in numerator and number of “available beds” in the denominator.
  - c. Number of FTE interns and residents capped.
2. *Direct Graduate Medical Education (GME) payment*, 42 C.F.R. § 413.75 – 413.83.
  - a. Payment for the direct cost associated with training interns and residents.
  - b. Payment based on a per resident amount, established in the mid 1980’s, multiplied by weighted number of FTE residents.
  - c. Number of FTE interns and residents capped.

### B. Developments:

1. *Training In Nonpatient Care Activities*
  - a. Issue: Should FTE residents not engaged in patient care be included for purposes of the IME adjustment?
  - b. *Rhode Island Hosp. v. Leavitt*, 548 F.3d 29 (1<sup>st</sup> Cir. 2008), held that residents assigned to an educational research rotation should not be included for purposes of the IME adjustment.
  - c. The *Rhode Island Hospital* decision is the first U.S. Court of Appeals decision on this issue, and it does not follow prior district court decisions. 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 Mar. 21, 2007) (unpublished); *Riverside Methodist Hosp. v. Thompson*, No. C2-02-94, 2003 WL 22658129, at \*6 (S.D. Ohio July 31, 2003) (unpublished).

See also, *Henry Ford Hosp. (Detroit, MI) v. Blue Cross Blue Shield Association/National Government Services*, PRRB Dec. No. 2008-D34 (Sept.12, 2008) (Medicare and Medicaid Guide (CCH) ¶ 82,109) (holding that, in light of regulations in effect during 1991, 1996, 1998 and 1999, research time may be included in FTE count), rev'd CMS Administrator Decision, Nov. 13, 2008 (Medicare and Medicaid Guide (CCH) ¶ 82,212), appeal pending in United States District Court for the Eastern District of Michigan, Case No. 09-10195 (AJT).

2. *Training in Nonprovider Setting*

a. Issues:

- (1) Is a written agreement between the provider and the nonprovider setting required if the hospital otherwise satisfies the requirements of the Medicare Act, *i.e.*, the residents are involved in patient care activities and the hospital incurs all or substantially all of the costs related to the training?
- (2) Does the requirement that the hospital must incur “all or substantially all” of the costs relating to the training at the nonprovider setting require that a single hospital must incur the costs?

b. Although the regulations have been amended and “clarified” on multiple occasions, no significant regulatory changes occurred in 2008.

c. PRRB Decision: “All Or Substantial All Costs” Issue

*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.)

d. No judicial decisions were issued in 2008. At least two cases involving the written agreement requirement are pending in federal district court, with decisions likely in 2009:

- (1) *Cottage Health System d/b/a Santa Barbara Cottage Hosp. v. Leavitt*, No. 08-0098(JDB) (D.D.C.)
- (2) *Covenant Med. Cnt., Inc. v Leavitt*, No. 07-15108 (ADT) (E.D. Mich.)

3. *Counting Managed Care Days*

- a. Issue: Whether hospital is required to file UB-92 in order to count Medicare HMO enrollees for purposes of the IME and GME?
- b. The PRRB has held in at least five cases (all of which are now in court, see below) that the UB-92 filing was not required.
- c. At least five cases presenting this issue are pending in the United States District Court for the District of Columbia:
  - (1) *Cottage Health System d/b/a Santa Barbara Cottage Hosp. v. Leavitt*, No. 08-0098(JDB) (D.D.C.).
  - (2) *Bayfront Med. Cnt. v. Leavitt*, No. 08-249 (PLF) (D.D.C.)
  - (3) *Loma Linda University Med. Cnt. v. Leavitt*, No. 08-1520(HKK) (D.D.C.)
  - (4) *Hosp. of Univ. of Pennsylvania v. Leavitt*, No. 08-1665(JRB) (D.D.C.)
  - (5) *Sparrow v Johnson*, 08-1021 (RMC) (D.D.C.)

## II. Disproportionate Share Hospital Payments

A. Background:

- 1. *The Medicaid Low Income Proxy.* Under the Medicare Prospective Payment System (PPS), Medicare’s payments to hospitals for inpatient operating costs are based on predetermined, nationally applicable rates, subject to certain payment adjustments. 42 U.S.C. §1395ww(d); 42 C.F.R. Part 412. Under 42 U.S.C. §1395ww(d)(5)(F)(vi), the Secretary of the Department of Health and Human Services (DHHS) is required to make an add-on payment for operating costs for PPS hospitals serving a “significantly disproportionate number of low-income patients,” which is computed for a given cost-reporting period based on the sum of two fractions. For one of these fractions, known as the “Medicaid Low Income Proxy,” it is assistance [i.e. Medicaid] received services at the hospital. 42 U.S.C. §1395ww(d)(5)(F)(vi)(II). In general, the more Medicaid inpatient days that a hospital has, the larger its Medicare DSH adjustment.

2. *The Medicare Proxy.* In addition to the Medicaid Low Income Proxy, the DSH Adjustment is based on the supplemental security income percentage (SSI%) as set forth in the “Medicare Proxy,” 42 U.S.C. § 1395ww(d)(5)(D)(vi)(I). The “Medicare proxy” is the percentage of a hospital’s inpatients who received Medicare Part A benefits who were also eligible for SSI benefits when they were receiving inpatient services at the hospital. This percentage is called the “SSI percentage.”

B. Developments:

1. *Medicaid Low Income Proxy: General Assistance Days.*

- a. Issue: Whether State paid only general assistance days should be included in the Medicaid Low Income Proxy?
- b. General Assistance Days. Some state Title XIX Plan’s include programs of medical assistance for persons not eligible for Medicaid.
- c. *Adena Reg. Med. Cnt. v. Leavitt*, 527 F.3d 176 (D.C.Cir. 2008).
  - (1) 25 hospitals contended that persons eligible for Ohio Health Care Assurance Plan (HCAP) should be included in the Medicaid Low Income Proxy.
  - (2) The district court held in favor of the hospitals. *Adena Reg. Med. Cnt. v. Leavitt*, 524 F.Supp.2d 1 (D.D.C. 2007).
  - (3) The Court of Appeals reversed the district court. The Court found that 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.”

2. *Medicaid Low Income Proxy: Section 1115 Waiver Days.*

- a. Issue: Should Section 1115 Waiver days be included in the Medicaid Low Income Proxy?
- b. Section 1115 Waiver Days
  - (1) Section 1115 of the SSA, as codified at 42 U.S.C. § 1315, allows the Secretary to approve State research and demonstration projects that promote the objectives of the Title XIX Medicaid program. For purposes of the Disproportionate Share Hospital (DSH) Adjustment, persons enrolled in such programs are referred to as “Section 1115 Waiver Days.”

- (2) Until early 2000, the Medicare regulations did not specifically address the treatment of Section 1115 waiver days under DSH, and CMS policy on this issue was not clear. Thus, there was an inconsistency in whether hospitals were allowed to include Section 1115 Waiver Days in the DSH calculation.
  - (3) Hospitals may include Section 1115 Waiver Days for discharges occurring on or after January 20, 2000. 42 C.F.R. § 412.106(b)(4)(ii).
- c. *Cookeville Reg. Med. Cnt. v. Leavitt*, 531 F.3d. 844 (D.C. Cir. 2008).
- (1) The United States District Court for the District of Columbia ruled in favor of the plaintiffs. The Secretary of DHHS appealed to the U.S. Court of Appeals for the District of Columbia.
  - (2) Shortly thereafter, 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.
  - (3) On appeal, the Court held in favor of the Secretary, based on the reasoning that the DRA clarified an ambiguity in the existing legislation.

3. *The Medicare Proxy.*

a. Issues:

- (1) Was the hospital-specific SSI% accurately computed?
- (2) Was the “global” SSI% accurately computed?

b. The SSI%

- (1) CMS computes the SSI percentage, but does not release the underlying data to the hospital. It is the stated position of CMS that certain of these data cannot be released to hospitals. See 70 Fed. Reg. 47,440 (Aug. 12, 2005).
- (2) The SSI% calculation uses FFY data. CMS computes these percentages by matching its Medicare Provider Analysis Review (MEDPAR) files of all Medicare claims paid to a

hospital during the period with the file maintained by the SSA of all individuals eligible for SSI benefits during the same period.

- (3) The Medicare Claims Processing Manual (MCPM) Section 3-20.3 instructs the Intermediary to use the SSI% CMS computes in the Intermediary's determination of the DSH payment.

c. Hospital Specific SSI%

- (1) 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.
- (2) 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).

d. "Global" SSI% Challenge

- (1) In *Baystate Med. Cnt. v. Leavitt*, 547 F.Supp.2d 20 (D.D.C. 2008), the Court held in favor of the Hospitals that the Secretary was required but failed to use the "best available data" for fiscal years 1993-1996. The Court issued a complex decision, summarized as follows:
  - (a) The Administrator acted in accordance with law in holding that CMS properly excluded from the SSI fraction patients who had lost their entitlement to SSI payments notwithstanding their special status under Section 1619(b) of the SSA for other purposes.
  - (b) The Administrator's finding that CMS relied on the best available data in determining the patients entitled to SSI benefits was arbitrary and capricious because CMS failed to use superior data readily available to it, including:
    - i) an updated SSA tape available before the end of the DSH cost report settlement period that would have reflected retroactive SSI eligibility determinations;
    - ii) forced pay SSI records; and

- iii) inactive SSI records - the “stale records” - omitted from the SSI fractions for 1993 and 1994.
- (c) The Court ordered a remand is necessary to determine whether individuals without Title II numbers were excluded from the match process and to allow the Administrator to provide any further explanation of why social security numbers and other patient identifiers (such as the patient’s name) were not considered the “best available data” for use in the match process. The Court found that the Administrator abused his discretion in concluding that retrospective relief should not be granted in these respects.
- (d) The issue raised by *Baystate* regarding the standard for counting days attributable to patients “entitled to benefits under part A” of the Medicare program was dismissed based on the limitations on judicial review set by Section 1395oo.
- (2) On March 31, 2008, the Court issued its opinion that granted in part and denied in part the parties’ cross motions for summary judgment.
- (3) On November 7, 2008 the Court granted in part and denied in part the parties motions to amend the March 31, 2008 opinion. The Court remanded for the purpose of enabling CMS to submit refined SSI data. The Hospitals sought but did not receive an order that the Court would retain jurisdiction. Instead, under the remand order the Hospitals would be required to exhaust administrative remedies, i.e., to proceed through the PRRB appeals process, in the event they remained dissatisfied with the computation of the SSI%.
- (4) Final judgment, subject to appeal, was entered on December 8, 2008.
- (5) On February 6, 2009, the Secretary filed a Notice of Appeal. On March 10, 2009, the Secretary withdrew its appeal. Thus, the decision is final

### **III. Bad Debt**

#### **A. Background:**

1. A provider is authorized to claim Medicare bad debt if it has satisfied the requirements set forth in 42 C.F.R. § 413.89.
  - a. The debt must be related to covered services and derived from deductible and coinsurance amounts.
  - b. The provider must be able to establish that reasonable collection efforts were made.
  - c. The debt was actually uncollectible when claimed as worthless.
  - d. Sound business judgment established that there was no likelihood of recovery at any time in the future. For End Stage Renal Disease, *See* 42 C.F.R. § 413.178(b).
2. Bad Debt Payment is not made for reasonable charge-based methodology or fee schedule § 413.89(i).

B. Developments:

1. *Use of Collection Agency.*
  - a. Provider Reimbursement Manual Provisions
    - (1) Provider Reimbursement Manual (PRM) § 310A permits a provider to use a collection agency.
    - (2) PRM § 310.2 Presumption That Debt Uncollectible. If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible.
    - (3) PRM § 314 - A previously reimbursed bad debt paid in a subsequent period must offset the bad debt claim in such subsequent period.
  - b. *Battle Creek Health Sys. v. Leavitt*, 498 F.3d 401 (6<sup>th</sup> 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.
  - c. *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.

- d. CMS Joint Signature Memorandum Dated May 2, 2008. Reiterates the 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.
2. *Reduction Applicable To Dual Eligibles and Qualified Medicare Beneficiaries in States Imposing a Medicaid Cap.*
    - a. 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?
    - b. Background. Certain individuals are eligible for Medicare and Medicaid, and are referred to as "dual eligibles" and QMBs. 42 U.S.C. § 1396a(a)(10)(E)(i); 42 U.S.C. § 1396d(p)(1). Certain states impose a cap on Medicaid liability for dual eligibles and QMBs, as authorized by 42 U.S.C. § 1396a(n)(2). Prior to 1998, Medicare paid 100% of allowable bad debt. The BBA of 1997 imposed reduction in payment, transitioning to the present level of 70%. 42 U.S.C. § 1395x(v)(1)(T). In states with a cap on Medicaid liability, a hospital cannot collect the Medicare bad debt from either the patient or the Medicaid program. Thus, in these states a hospital is limited to the reduced Medicare bad debt with no opportunity to collect the balance.
    - c. *Detroit Receiving Hosp. and University Health Cnt. v. Leavitt*, 561 F.Supp.2d 795 (E.D. Mich. 2008) held that the bad debt reduction imposed by 42 U.S.C. § 1395x(v)(1)(T) applied to dual eligibles and QMBs where a Medicaid cap had been imposed. This case is on appeal to the United States Court of Appeals for the Sixth Circuit, Case No. 08-1920.
  3. *Bad Debt Related To Medicare Part B Fee Schedule Services.*
    - a. Issue: Whether Medicare bad debt payment is allowed for Part B services for which Medicare payment is made under a fee schedule?
    - b. Background. The governing regulation in effect during the years on appeal, 42 C.F.R. § 413.80, was silent as to whether Medicare bad debt payment is available to a provider relating to the unpaid copay and deductible regarding the provision of Part B services for which the provider is paid under a fee schedule.
    - c. *Abington Crest Rehabilitation and Nursing and Rehabilitation Cnt. v. Leavitt*, 541 F.Supp.2d 99 (D.D.C. 2008), held that the Secretary's interpretation of the regulation so as to deny the

Medicare bad debt claim was reasonable. The Court agreed with the Secretary's argument that the statutory basis for payment of Medicare bad debt, *i.e.*, the ban on cross subsidization, did not apply to Part B services for which payment was made under a fee schedule. This case is on appeal before the United States Court of Appeals for the District of Columbia, Case No. 08-5120.

4. *Bad Debt Applicable to Dual Eligibles and QMBs not first submitted to Medicaid Program that imposes a Medicaid cap.*
  - a. 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?
  - b. The lead case is *Community Hosp. of Monterey Peninsula v. Thompson*, 323 F.3d 782 (9<sup>th</sup> Cir. 2003). 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.)