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ATTORNEYS AND COUNSELORS

MHA Michigan Health & Hospital Association

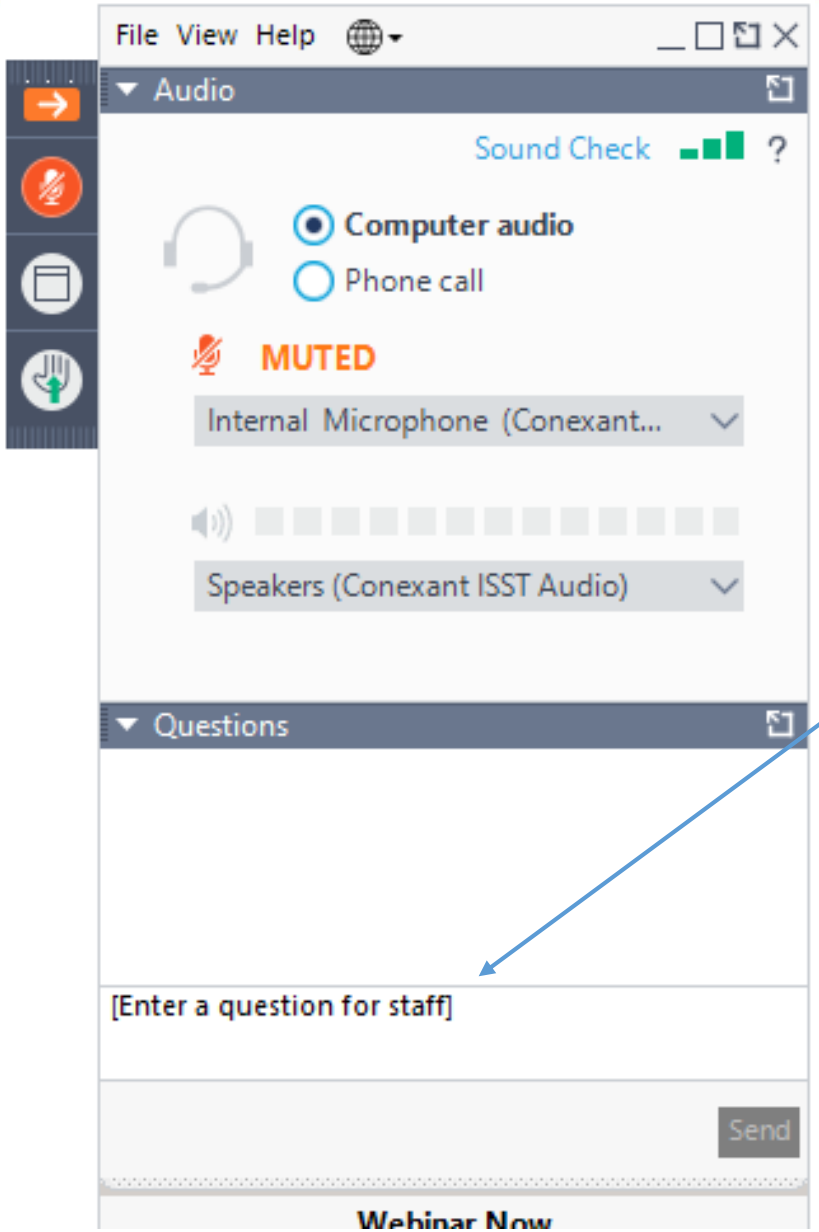
Leading Healthcare

Michigan Hospital Group Appeal Of The Medicare Standardized Amount

September 6, 2018 10:00 AM

All webinar attendees are in listen-only mode. Sound checks will be provided at [15 minutes prior], [10 minutes prior], and at [5 minutes prior].

Asking Questions



Submit questions using the GoToWebinar panel, or email us at vkunz@mha.org

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Speaker And MHA Staff Contact

Speaker
Ken Marcus
Partner
Honigman

MHA Staff Contact
Vickie Kunz
Senior Director, Health Finance
MHA

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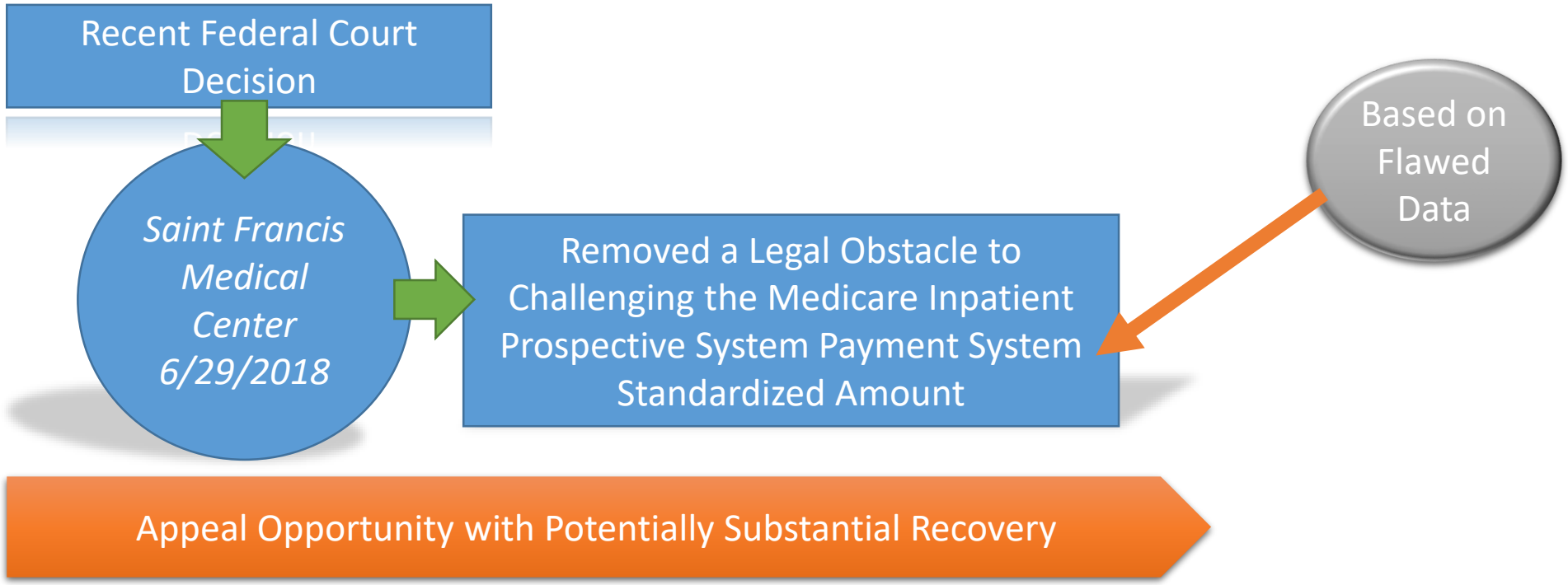
INTRODUCTION

Welcome To Fall (almost)!

Thank you for taking the time to participate.



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AGENDA

- The Standardized Amount Issue
- Explanation of Appeal Opportunity
- Presentation of a group appeal opportunity for MHA member hospitals
- Q & A

THE IPPS STANDARDIZED AMOUNT

Hospital Providers are Paid a Flat Rate for Each Type of Discharge

The Development Required:

1. Establishing Categories of Numerous Types of Discharges, and
2. The Payment Rate Applicable to Each Category of Discharge

The DRG Payment Rate for a Discharge is Based on:

The Standardized Amount

X

The DRG Weight

Our Concern Today is the Standardized Amount

THE IPPS STANDARDIZED AMOUNT

Computation of the Standardized Amount

CMS used 1981 as the "base year"

Obtained 1981 Medicare Cost Reports from "nearly all hospitals participating in Medicare, manually extracted necessary information, and prepared the information in computer-readable form."

Base Year Cost Data Included All Allowable Hospital Costs Incurred in Treating Medicare Patients, Excluding:

- Psychiatric, Rehabilitation, Children's, and Long-Term Hospital's Costs
- Capital-Related Costs
- Direct Medical and Education Cost
- Nursing Differential Costs

THE IPPS STANDARDIZED AMOUNT

- The resulting Medicare cost was then divided by the number of Medicare discharges during the year, resulting in total Medicare allowable costs per discharge, for each hospital included in the data base.
- With periodic updates, the Standardized Amount based on 1981 data has been used for IPPS payment from inception of the IPPS to the present day.

In short, the Standardized Amount is a fraction:
Costs / Discharges

THE IPPS STANDARDIZED AMOUNT

CMS relied on two sources of data for the computation of the Standardized Amount:

1. Hospitals' 1981 Medicare Cost Reports
2. 1981 Medicare Discharge File

Neither of these sources of data distinguished between patients discharged from patients transferred to another hospital or facility

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THE IPPS STANDARDIZED AMOUNT

CMS has acknowledged that "discharge" and "transfer" are distinct terms:

- The terms "discharge" and "transfer" are defined, for purposes of prospective payment, at § 405.470(c) of these regulations. These definitions are essentially the same as they were under the hospital cost limits established as a result of TEFRA *except that in cases where a patient is transferred to another hospital paid under the prospective payment system, the transfer will not be considered a discharge . . ..*

THE IPPS STANDARDIZED AMOUNT

Thus, when CMS determined the Standardized Amount by dividing the total allowable hospital cost in treating Medicare patients in the base year by the number of base year Medicare "discharges," the number of "discharges" included transfers.

Accordingly, the Standardized Amount was understated because CMS erroneously included transfers in the denominator of the average cost per discharge fraction.

THE IPPS STANDARDIZED AMOUNT

- CMS Has Acknowledged But Rationalized The Error:
  - **We agree with the commenters that the treatment of transfers in the discharge count is problematic.** To the extent a transfer is paid on a per diem basis, including the transfer in the discharge count will understate the hospital-specific rate.
  - We do not believe that it is administratively feasible to remove the costs associated with transfer cases.
- But Note: *CMS did remove transfers* when it established the Capital PPS.

THE *SAINT FRANCIS* CASE

277 hospitals contended that IPPS payment was based on errors in the 1981 cost-reporting data that were used to calculate the standardized amounts in 1983.

They argued that this data erroneously characterized transfers of patients from one hospital to another as patient discharges, thus overstating the number of discharges and understating the allowable operating costs per discharge.

Because that determination was embedded in the standardized amount in 1983, it has affected payment decisions ever since.

Saint Francis Medical Center et al. v. Azar, United States Court of Appeals for the District of Columbia, No. 17-5098 (June 29, 2018).

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THE *SAINT FRANCIS* CASE

- The Obstacle: Mini Bootcamp Regarding The "Predicate Facts" Regulation
  - In *Regions Hospital v. Shalala*, 522 U.S. 448 (1998), the Supreme Court held that the reopening regulation did not deprive the right of CMS to correct errors in the average per resident amount for purposes of establishment of the direct Graduate Medical Education ("GME") payment.
  - CMS lost a prior case, *Kaiser Foundation Hospitals v. Sebelius*, 708 F.3d 226 (D.C. Cir. 2013), in which the Court held that the reopening regulation did not preclude correction of erroneous data for purposes of GME payment.
  - To prevent recurrence, CMS adopted the predicate facts regulation. 42 C.F.R. § 405.1885(a)(1)(iii),
  - Under this rule, a decision may be reopened "with respect to specific findings on matters at issue"—a term defined to include a predicate fact that was "first determined for a cost reporting period that predates the period at issue.
  - The regulation imposed a three-year limitation period for seeking a reopening.
  - CMS contended, therefore, that for a reopening *or an appeal*, a predicate fact must be challenged within three years of when it is first de
  - The Standardized Amount is well beyond three years.

THE *SAINT FRANCIS* CASE

The PRRB and the US District Court for the District of Columbia Held that the Predicate Facts Regulation Barred The Hospitals' Challenge To The Standardized Amount.

The DC Circuit, However, Held That The Predicate Facts Regulation Applied To A Reopening With The MAC And Not To An Appeal To The PRRB.

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THE *SAINT FRANCIS* CASE

The DC Circuit Court Summarized As Follows:

- "The provisions we have surveyed establish these basic points: A fiscal intermediary *reopening* its own decision is one thing, and the PRRB reviewing that decision on *appeal* is quite another. Reopenings and administrative appeals are conceptually different, are governed by different statutory and regulatory provisions, and, most importantly here, are governed by different limitations rules. **Accordingly, there is no basis for extending to PRRB appeals the limitations rules that govern reopenings." (Emphasis added.)**

THE *SAINT FRANCIS* CASE

- ✓ The inaccuracy of the Standardized Amount
- ✓ The remedy if the Standardized Amount is inaccurate

The DC Circuit remanded to the DC District Court

On remand to the PRRB the MAC could assert other jurisdictional challenges

If, however, *Saint Francis* becomes final in its current form, presumably the hospitals in that case will be remanded to the PRRB for proceedings on the merits

Note that CMS has the right: To Request US Supreme Court review within 90 days of judgment.

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The Implications Of *Saint Francis*

If *Saint Francis* prevails, CMS may be required to compute a revised Standardized Amount that excludes the transfer data.

- Note as well that in light of the *Saint Francis* decision providers may have the right to appeal the impact in their current year of other statistics established in prior years, *e.g.*, the Medicare direct graduate medical education average per resident amount
  - Note: Appeal of these other issues may present other procedural obstacles, depending on prior appeal opportunities that a hospital may or may not have pursued

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The Appeal Opportunity

In the event of a successful outcome in *Saint Francis,* CMS may be ordered to compute a revised Standardized Amount.

Historically, however, CMS does not dispense relief except to providers that have specifically appealed the issue.

I.e., perhaps somewhat analogous to the Rural Floor Budget Neutrality appeals, in which 1000's of providers received substantial settlement *based on a single judicial decision*, the Standardized Amount is a national statistic. It may not be necessary for every hospital to prevail on the merits a case-by-case basis.

If the Standardized Amount is revised, however, it could be applicable to any inpatient hospital provider that has a jurisdictionally proper appeal challenging the Standardized Amount.

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Fiscal Years Subject To Appeal

An Appeal May be Filed:

- Within 180 days of The Federal Fiscal Year 2019 Final IPPS Rule (which was issued in display form 8/2/2018 and in the *Federal Register* on 8/17/2018.)
- Succeeding years' Final IPPS Rules.
- Notice of Program Reimbursement (NPR) that is within the 180-day appeal period (or, if an appeal has been filed, within 60 days after expiration of the 180-day appeal period).
- "Delayed NPR": The 180-day period beginning one year after the filing of the cost report.

Fiscal Years Subject To Appeal

Basis for Aggressive Appeals

- ❑ The Standardized Amount issue might be construed as being included in pending disproportionate share (DSH) adjustment appeals, since the DSH is an adjustment to the DRG, which in turn is linked with the Standardized Amount.
- ❑ Perhaps other bases.

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GROUP APPEAL PROCEDURE

- Group Appeal Procedure
  - Nonrelated hospitals will be included in a single Michigan Hospital Standardized Amount Group Appeal.
  - The Common Issue Related Party (CIRP) Rule requires related hospitals to establish their own CIRP Group.
    - Thus, CIRP Sub-Groups will be established for related hospitals.

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Appeal Proposal

Appeal Services of MHA and Honigman

MHA Will Provide Communication Services

- Coordinate Communications and Strategy Decisions

Honigman Will Provide Legal Services

- Preparation and filing of appeal documents with PRRB.
- Communications with the MAC.
- Representation of Hospitals before PRRB and, if necessary, federal court.

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Appeal Strategy: Two Tiers

The outcome in the *Saint Francis* case may strongly influence, if not dictate, the outcome of all other appeals.

Accordingly, the initial strategy is to assert and preserve appeal of the Federal fiscal year 2019 Standardized Amount before the PRRB and monitor progress in the *Saint Francis* case.

If there is a legal advantage in doing so, a request will be filed with the PRRB for expedited judicial review and the appeal will proceed to federal court.

Value Pricing: Two Tiers

Value Pricing: Michigan Hospitals will incur costs only for necessary appeal activity and will share recovery, if any, commensurate with efforts.

Tier 1 Fee: PRRB proceedings.

Tier 2 Fee: Federal Court proceedings, if necessary.

PARTICPATION FEE*

*Assumes minimum of 20 Participating Hospitals; Discount consideration for Systems.

MHA Communications Service Fee

- $750 / Participating Hospital
- Payment made directly to MHA

Tier 1 (PRRB) Honigman Legal Fee

- Flat Fee: $4,500 / Participating Hospital
- 3% contingent fee

Tier 2 (Federal Court) Honigman Legal Fee

- Flat Fee: $7,500 / Participating Hospital
- 7% contingent fee

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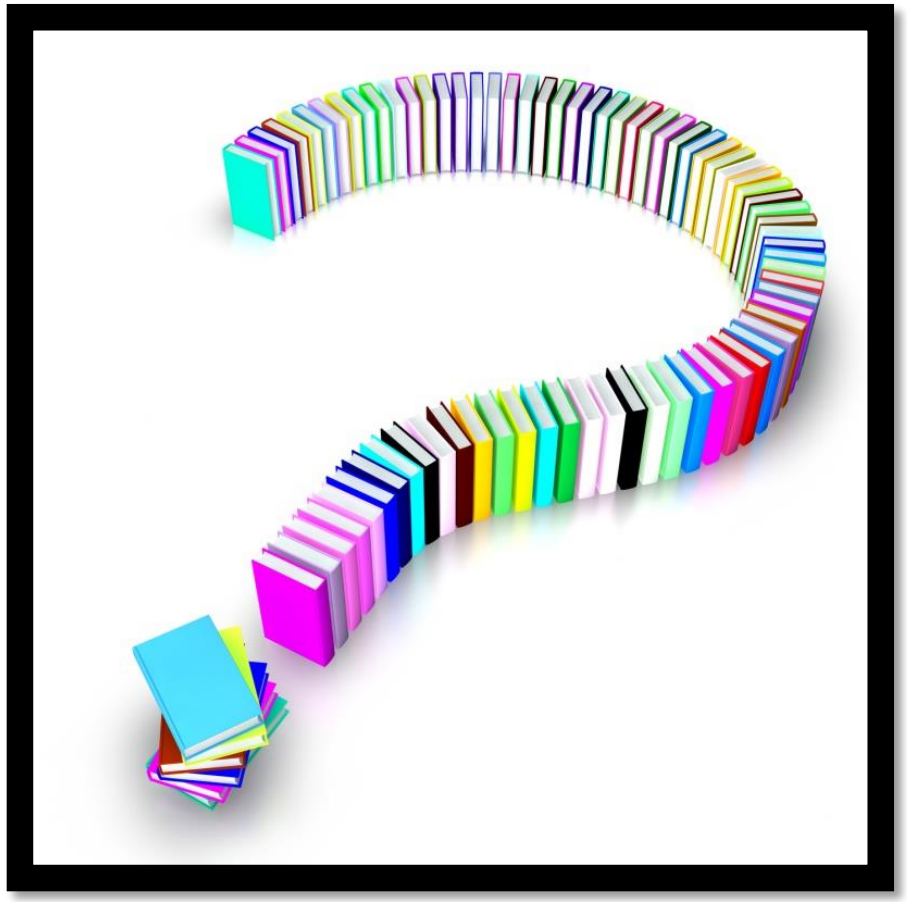
Q&A



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ATTORNEYS AND COUNSELORS

MHA
Michigan Health & Hospital Association

Leading Healthcare

2112 University Park Drive | Okemos, MI 48864

(517) 323-3443 | www.mha.org

Ken Marcus
313 465 7470
kmarcus@honigman.com

Vickie Kunz
(517) 703-8608
vkunz@mha.org