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Client Alert

Healthcare Practice Group

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Provider Reimbursement Review Board Issues 60 Day Deadline to Supplement Record in All DSH Medicaid Eligible Days Appeals

On May 23, 2014, the CMS Office of Hearings released **Alert 10**, notifying providers of an important new 60 day deadline concerning certain appeals before the Provider Reimbursement Review Board (PRRB or Board). By the end of this deadline, providers must supplement the record in all appeals in which providers seek to add additional Medicaid eligible days to their cost reports. **Providers that do not meet this deadline may have their appeals dismissed for lack of jurisdiction**.

By Tuesday, **July 22, 2014**, providers with pending Medicaid eligible day appeals must submit documentation to the PRRB to satisfy the Board that it has jurisdiction over the Medicaid eligible days issue. The PRRB is vague as to what particular documents must be submitted but is relatively prescriptive regarding what those documents must prove. In particular, providers with Medicaid eligible day appeals must submit, at a minimum, documentation that:

- describes the process the provider used to identify Medicaid eligible days filed on the cost report;
- lists the number of additional Medicaid eligible days for inclusion in its DSH adjustment; and
- explains in detail why the provider could not verify these additional days at the time its cost report was filed.

Background

The Medicaid eligible days issue relates to the calculation of the Medicare DSH adjustment. When a patient is eligible for Medicaid, all of the days the patient stays in non-excluded units of the hospital are included in the numerator of the Medicaid fraction of the DSH adjustment regardless of whether Medicaid paid for these services. But the state must verify that the patient was eligible for Medicaid at the time of the patient's hospital stay. Because states are often not able to provide such verification by the time a provider's cost report is due, providers either self-disallow or leave unclaimed the full amount of their Medicaid eligible days, resulting in an understatement of the provider's DSH adjustment.

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For many years, providers have worked with fiscal intermediaries to resolve Medicaid eligible day appeals favorably after filing an appeal. In recent cases, however, fiscal intermediaries have challenged whether the PRRB has jurisdiction over such appeals, claiming that because the Medicaid eligible days were not claimed on the initial cost report, there was no adjustment to the provider's cost report for such days and, therefore, no final, appealable determination.

In February 2014, the PRRB ruled on this issue in *Danbury Hospital v. BlueCross BlueShield Association*, PRRB Dec. No. 2014-D3, Feb. 11, 2014. In *Danbury*, the provider claimed additional Medicaid eligible days that it had not included on its as-filed 2005 cost report. The fiscal intermediary challenged that no adjustment was made to Medicaid eligible days on the provider's NPR, so the PRRB did not have jurisdiction. The PRRB concluded that it did in fact have jurisdiction over the appeal, but only if the provider could demonstrate that data to verify the Medicaid eligible days was not available at the time the cost report was filed. The PRRB asked Danbury to provide detailed information that would explain by category of day why Danbury could not verify eligibility before the cost report was filed. When Danbury did not make such a demonstration, the PRRB held that it had no jurisdiction over the case.

Alert 10 – Detailed Documentation Requirements

On May 23, 2014, the PRRB issued Alert 10 which effectively applies the *Danbury* decision to all pending Medicaid eligible day appeals. Alert 10 can be found at this link: http://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB_Alerts.html

In order to satisfy itself that it has jurisdiction over such appeals, the PRRB through Alert 10 has ordered providers to supplement the record in their appeals by **July 22, 2014** (60 days after May 23, 2014), with the same information that was requested in *Danbury*, specifically:

- **A detailed description of the process that the provider used to identify and accumulate the actual Medicaid paid and unpaid eligible days that were reported and filed on the Medicare cost report at issue.**

  While the PRRB's order is less than clear, it would appear that providers should include in their response a description of their engagements with third party consultants to identify such days for providers and a detailed description of their process for identifying and accumulating such days. **Providers should make sure their description is sufficiently detailed.** In the *Danbury* appeal, the PRRB rejected the provider's statement that it used state paid claims reports or other such internal reports to prepare its cost report. According to the Board, this explanation was insufficient and perfunctory.

- **The number of additional Medicaid paid and unpaid eligible days that the provider is requesting to be included in the DSH calculation.**

  Though this appears to be a simple request, the actual number may be difficult to discern. Often the number of Medicaid eligible days a provider requests in its hearing may involve a netting out of days that the provider is no longer seeking in its appeal. Further, Alert 10 suggests that providers are to identify separately those days that were not included in the cost report. Providers may or may not have specific information that explains all of this. Providers should also take care to identify as specifically as possible days that are "Medicaid paid" or "Medicaid eligible unpaid" days. If the cost reporting period ends on or after December 31, 2008, it is possible that the PRRB will want to see a demonstration that the requested days were protested or self-disallowed on the provider's as-filed cost report.

- **A detailed explanation why the additional Medicaid paid and unpaid eligible days at issue could not be verified by the state at the time the cost report was filed. If there is more than one explanation/reason, identify how many of these days are associated with each explanation/reason.**

  This is the heart of the PRRB's order and the place where providers are most likely to misstep. The provider in *Danbury* was asked to respond to the same question, and the PRRB's opinion that the responses were lacking resulted in the PRRB's finding of no jurisdiction. Thus, a detailed response will be imperative for establishing PRRB jurisdiction. Ideal documentation would include specific communications from states addressed to providers explaining the delay in verification, or Remittance Advices dated after the provider's cost report was due. Based upon the Board's decision in *Danbury*, it would appear that broad generalizations of difficulty identifying days or obtaining information from the state will not be satisfactory.

What Should Providers Do If They Do Not Have The Requisite Documentation?

It is questionable whether the PRRB has the legal authority to impose a documentation requirement of this type for establishing Board jurisdiction over an appeal, particularly long after the cost report was filed. Providers that do not have the requested documentation or whose documentation does not prove that the Medicaid eligible days they are appealing could not have been claimed on their "as-filed" cost reports should consider consulting with legal counsel to determine whether and how to file and preserve a legal challenge with the Board to Alert 10. Providers should try to make this assessment before the 60-day response deadline.

Alert 10 Leaves Many Questions Unanswered

The text of Alert 10 is sparse and merely includes the generic documentation requirements, a reference to the *Danbury* case and the 60 day deadline. Many questions are left unanswered. For example:

- Does Alert 10 apply only to appeals with fiscal years beginning prior to December 31, 2008 or does it apply to appeals for fiscal years after that date? Is a provider required to comply with Alert 10 if it filed its Medicaid eligible days under protest?

  In 2008, the PPRB rules were changed so that providers were required to protest unallowable items and costs on the cost report in order to preserve their appeal rights. If providers followed these new rules to protest unclaimed but eligible days, do they have to comply with Alert 10? Alert 10 is unclear on these points, but the broad wording of Alert 10 suggests that it applies to all pending appeals regardless of fiscal year.

  Because it is ambiguous, Alert 10 imposes many traps for the unwary. For example, providers may be under the impression that they do not need to respond to Alert 10 because they listed Medicaid eligible days as a protested item in disclosure letters with their cost reports. But often providers may provide fiscal intermediaries with information including a higher number of Medicaid eligible days than appear as a protested item. Alert 10 is unclear as to how this situation should be handled, and providers should carefully consider how to respond to Alert 10 in this situation.

- Does Alert 10 apply to appeals that are the subject of Joint Scheduling Orders (JSOs)?

  Alert 10 states that it applies to "all" appeals that include the unpaid/eligible Medicaid day issue. This suggests it may apply to appeals that are the subject of JSOs.

- What about providers that have already submitted final position papers or are awaiting a PRRB decision following a hearing? Again, Alert 10 is unclear, but it does purport to apply to "all" appeals including the Medicaid eligible day issue and there is no express limitation

While the *Danbury* decision has been appealed to the federal district court in the District of Connecticut, the outcome of that case will not be known for some time. Therefore, providers should make every effort to meet the July 22, sixty day deadline in order to preserve their appeal rights.

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