KING & SPALDING

Client Alert

Healthcare Practice Group

August 29, 2014

CMS Makes Global Offer to Settle All Acute Care Inpatient Claims on Appeal

On August 29, 2014, CMS issued settlement terms to acute care hospitals with pending appeals of denials for inpatient claims. CMS is offering to settle **all qualifying claims at *68 percent* of the "net paid amount" of such claims within 60 days of CMS's execution of an "Administrative Agreement."** The global settlement offer has the potential to unclog the massive backup in claims appeals that has tied up hundreds of millions, if not billions, of dollars in hospital reimbursement. However, the terms of the global settlement pose additional reimbursement questions that hospitals must carefully consider before proceeding. This Client Alert addresses the terms of CMS's offer and its key implications. King & Spalding will also host a Healthcare Roundtable on September 5, 2014 to address these issues in greater detail. A copy of the Administrative Agreement and other relevant documents can be found **here**. CMS provides that hospitals should submit their settlement requests by **October 31, 2014**.

The King & Spalding RAC Coalition, comprised of hospital and health system clients, has been lobbying CMS and Congress for more than a year to reform the Recovery Audit Contractor (RAC) program and to take aggressive steps to address the systemic backlog of inpatient claims on appeal caused by RAC auditors. The global settlement offer appears to be CMS's response to the pressure the agency has faced from the provider community and Congress to fix a broken system.

Which Types of Facilities are Eligible to Submit a Settlement Request?

The following types of facilities are eligible to submit a settlement request:

- Acute Care Hospitals, including those paid via the Prospective Payment System, Periodic Interim Payments, and Maryland waiver; and
- Critical Access Hospitals.

The following types of facilities are ***not*** eligible to submit a settlement request:

- Psychiatric hospitals paid under the Inpatient Psychiatric Facilities Prospective Payment System;
- Inpatient Rehabilitation Facilities;

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- Long-Term Care Hospitals;
- Cancer hospitals; and
- Children's hospitals.

In addition, CMS states that certain hospitals may be excluded from the settlement opportunity due to pending False Claims Act litigation or investigations.

What Claims Qualify for Payment Under the Administrative Agreement?

The global settlement offer applies only to "eligible claims." CMS defines eligible claims as those that meet all of the following criteria:

- The claim was denied by an entity that conducted a review on behalf of CMS
- The claim was ***not*** for items/services furnished to a Medicare Part C enrollee
- The claim was denied based on an "inappropriate setting determination" – *i.e.*, that the services furnished to the patient were medically necessary, but not in the inpatient setting
- The first day of admission was ***before*** October 1, 2013
- The claim denial was timely appealed by the provider
- The appeal remains pending, as of the date the executed Administrative Agreement is submitted to CMS, at the Medicare Administrative Contractor (MAC), Qualified Independent Contractor (QIC), Administrative Law Judge (ALJ), or the Departmental Appeals Board (DAB), and/or the provider has not yet exhausted its appeal rights at the MAC, QIC, ALJ, or DAB levels
- The provider did not receive payment for the services through the Part B Rebilling program

Importantly, CMS states that hospitals may ***not*** choose to settle some claims and continue to appeal others.

What is the Process for Submitting A Settlement Request and Receiving Payment?

To request a settlement agreement, a hospital must submit an Administrative Agreement and spreadsheet of eligible claims. CMS outlines a three-step process whereby CMS (and its Contractors) will review and reconcile each submission and claim spreadsheet.

CMS will make payment of 68 percent of the "net paid amount" of the denied inpatient claims included in a provider's settlement. CMS defines the "net paid amount" as Medicare's portion of the claim payment, exclusive of beneficiary cost-sharing. While providers may retain beneficiary deductibles and/or coinsurance already paid, providers ***may not*** bill beneficiaries for any unpaid cost-sharing amounts. In the event a provider had not repaid some or all of the denied claim amount, CMS will pay the difference between the retained amount and the 68 percent settlement amount. **Providers will not need to rebill any of the denied claims to receive payment.**

CMS will make one lump-sum payment to a provider within 60 days of ***both*** parties executing an Administrative Agreement. When a provider submits its signed Administrative Agreement and the list of eligible claims, CMS will review that list against its records to determine if the provider's list of claim appeals matches CMS's records with respect to each level of the administrative appeals process. CMS states that it will work with providers to resolve any discrepancies between the parties' lists of eligible claims, and then will countersign the Administrative Agreement when the two lists match. CMS will not pay interest on settled claims unless the agency does not make payment within the 60-day timeframe.

The relevant appeals tribunals will receive notice from CMS of the affected claims, and will dismiss those claims with prejudice. Providers will retain the right to reinstate those appeals if CMS fails to perform its obligations under the

Administrative Agreement. Timely processing deadlines for reinstated appeals will commence anew beginning with the date the appeals are reinstated.

What Are Some Initial Questions for Consideration?

The Administrative Agreement's payment methodology also raises important questions:

- **How much are providers really receiving?** Despite the lengthy delays in processing appeals, providers typically have been successful in appealing inpatient denials and have received payment in full when the denials are overturned. CMS's offer here is 68 cents on the dollar in exchange for forfeiting appeal rights. It is generally recognized that on rough average the Part B services provided during a denied claim are equal to approximately 30 percent of the inpatient claim. In effect, CMS is offering an additional 38 cents on the dollar under the Administrative Agreement. Providers must weigh whether forfeiting their appeal rights is worth an additional 38 percent. Part of this analysis will hinge on the case mix of a provider's claims under appeal. For example, providers that have appealed a large number of high-dollar surgical admissions may wish to maintain those appeals and pursue payment in full.

- **How timely will payment actually be?** The Administrative Agreement states that CMS must pay the settlement amount to a provider within 60 days ***of a fully executed Administrative Agreement***. However, CMS sets no timetable for when it must countersign an Administrative Agreement after reconciling a provider's list of eligible claims. Reconciling thousands of appeals submitted by thousands of hospitals will likely be a resource-intensive process and CMS does not propose to hold itself to any deadline to complete that analysis before executing an Administrative Agreement. This is an important consideration for those hospitals that are willing to compromise strong claims in order to receive a payout more quickly than they would otherwise potentially realize through the pursuit of appeals.

- **What about other reimbursement implications?** Providers will not rebill eligible claims in order to receive the settlement payment. CMS will simply make a lump-sum settlement payment separate and apart from ordinary payment for services. Because there will be no rebilling or processing of claims, questions are raised as to how these settled claims will appear in a provider's PS&R report. The answer to these questions will have implications on other Medicare payment provisions. For instance:

    - Will the claims count toward a provider's Medicare Part A patient percentage for graduate medical education payments and Medicare-dependent hospital status?

    - Will these claims be excluded from a provider's Medicare Share and per-discharge payment amount under the Medicare EHR Incentive Program? How will the denied claims affect provider participation in Medicare quality and readmissions programs?

    - If a provider may not bill a beneficiary for outstanding deductible/coinsurance amounts, may the provider claim unpaid accounts as Medicare bad debts?

King & Spalding will continue to evaluate the terms of the Administrative Agreement and intends to hold a Healthcare Roundtable on **September 5, 2014** to address these issues in greater detail. In the meantime, we encourage providers to review their pool of pending appeals to determine whether CMS's offer represents a favorable resolution.

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