Medicare Reimbursement Update:
Hot Trends for 2018 and Beyond

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Overview

• Worksheet S-10
• 340B Discount Pricing
• Nursing and Allied Health Education Audits
• Litigation Update
  – Allina
  – American Clinical Laboratory Association v. Azar
  – Florida Low Income Pool DSH Litigation
## Worksheet S-10

<table>
<thead>
<tr>
<th>Description</th>
<th>Uninsured patients</th>
<th>Insured patients</th>
<th>Total (col. 1 + col. 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charity care charges and uninsured discounts for the entire facility</td>
<td></td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>Cost of patients approved for charity care and uninsured discounts</td>
<td></td>
<td></td>
<td>21</td>
</tr>
<tr>
<td>Payments received from patients for amounts previously written off as</td>
<td></td>
<td></td>
<td>22</td>
</tr>
<tr>
<td>charity care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost of charity care (line 21 minus line 22)</td>
<td></td>
<td></td>
<td>23</td>
</tr>
</tbody>
</table>

- **Line 24**: Does the amount on line 20, column 2, include charges for patient days beyond a length-of-stay limit imposed on patients covered by Medicaid or other indigent care programs?

- **Line 25**: If line 24 is yes, enter the charges for patient days beyond the indigent care program’s length-of-stay limit (see instructions)

- **Line 26**: Total bad debt expense for the entire hospital complex (see instructions)

- **Line 27**: Medicare reimbursable bad debts for the entire hospital complex (see instructions)

- **Line 27.01**: Medicare allowable bad debts for the entire hospital complex (see instructions)

- **Line 28**: Non-Medicare bad debt expense (line 26 minus line 27.01)

- **Line 29**: Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)

- **Line 30**: Cost of uncompensated care (line 23 column 3 plus line 29)

- **Line 31**: Total unreimbursed and uncompensated care cost (line 19 plus line 30)
Where Things Stand

- 100% of Factor 3 in FY 2020 (2014, 2015 and 2016 data)
- “Tipping point”
  - SSI/Medicaid data no longer “better proxy”
  - Unfair to use low income days when some states did not expand Medicaid
- Opportunity to update FY 2014 and FY 2015 has now passed
- New instructions open to interpretation/give opportunity to plan ahead
Where Things Stand

• **Key S-10 Data Points**
  
  – S-10 Line 23 ("cost of charity care")
  
  – S-10 Line 29 ("cost of non-Medicare bad debt expense")
• Transmittal 10 – November 18, 2016
  – Clarified that hospitals may report any discounts given to uninsured patients who meet the hospital’s charity care criteria
  • Includes patients with coverage from an entity that does not have a contractual relationship with the provider.
What We Have Learned

• Transmittal 11 – September 29, 2017
• MLN Matters Special Edition article SE 17031
  – Discounts for uninsured patients under “financial assistance policy” are included.
    • Questions arose about treatment of non-discounted charges – are they amounts “expected to be received”?
    • MedLearn Example 7
  – Charity care charges attributable to deductibles and co-insurance are no longer reduced by CCR.
• Transmittal 11 – September 29, 2017
  – Charges for non-covered services for Medicaid enrollees and charges for days exceeding length-of-stay limit can be reported as charity care or FAP, if part of charity or FAP policy
  – Non-Reimbursable Medicare bad debt is no longer subject to CCR.
S-10 – What We Have Learned

• CMS Q&As on S-10
  – Clarifies “written off” in context of bad debts
  – Advised hospitals that did not amend FY 2014 and FY 2015 S-10s to ensure they clear new Level I edits
  – Employee, prompt pay and clergy discounts are not FAP
  – Provides additional guidance on MedLearn Example 7
What To Expect Ahead

• Desk audits beginning with FY 2017 cost reports
  – Review and revise charity care and financial assistance policies now
  – e.g., Q&A 6 -- state law discount requirements
  – e.g., Q&A 7 -- charges for non-covered services to Medicaid enrollees
    and charges beyond length of stay limits

• No desk audits of Worksheet S-10 data for cost reports
  preceding FY 2017
  – Are the instructions clear or are they subject to interpretation?
  – Will there be new instructions? Ability to amend FY 2016?
340B Discount Pricing
Developments in 2017

• CY 2018 OPPS rule -- separately payable drugs purchased under 340B priced at ASP -22.5%
  – Hospitals must identify 340B purchased drugs
  – Budget neutralized “savings” by increasing all other OPPS rates
  – Sought comment on future use of “savings”

• American Hospital Ass’n et al. v. Azar (D.C. Cir.)
  – Lawsuit dismissed for failure to “present” claims
  – On appeal to D.C. Circuit
  – Should hospitals appeal claims to preserve reimbursement?
House Energy & Commerce Report

• Findings
  • 340B does not require CEs to report use of savings
    • For most CEs, there are no limitations on use of “savings”
  • Congress did not clearly identify intent of program
    • Should low income/uninsured directly benefit?
    • Cited “340B revenue” generated by difference between acquisition and reimbursement rates, purchase of oncology clinics, etc.
  • HRSA lacks regulatory authority to clarify program requirements
    • Authority limited to ADR, CMPs for overcharging and standards for setting ceiling prices
    • Major questions unclarified – e.g., definition of “patient”
  • Growing trend toward prescribing more and more expensive drugs to Medicare Part B patients
House Energy & Commerce Report

• Recommendations:
  – HRSA should issue guidance and exercise its regulatory authority; Congress should give HRSA more authority to clarify “program requirements”
  – Create a mechanism to monitor level of charity care provided
    • Need to ensure low income/uninsured benefit from program
    • Need uniform definition of “charity care.”
  – Require CEs to disclose information about savings and/or revenue
  – Reassess whether DSH is appropriate for eligibility
  – Give HRSA more resources to audit and increase scope of audit authority
  – Providers should self-audit contract pharmacies once a year
Legislation and President’s Budget

• 340B PAUSE Act (House)
• HELP Act (Senate)
• Collins legislation out of House E&C
• Concepts:
  – Moratorium on new DSH CEs and new sites for current DSH CEs
  – Data reporting requirements on DSH hospitals
  – Narrowly defining “patient”
  – Diverting Medicare Part B savings to “charity care” hospitals
  – User fees
Nursing and Allied Health Education Audits
Why Is This a Hot Trend?

Nursing & Allied Health Educational Programs

Nursing & Allied Health (NAHE) programs legal operator statute
In accordance with 42 CFR 413.85(f)(1), in order to be considered the legal operator of an approved nursing/allied health educational program the provider must meet all of the following requirements:

- Provide and control both classroom instruction and clinical training (where classroom instruction is a requirement for program completion)

Nursing & Allied Health Programs

CMS has directed that costs be disallowed if the provider cannot document the above and reopen all available cost reports to disallow costs.

Absent evidence to the contrary, the provider that issues the degree, diploma, or other certificate upon successful completion of an approved education program is assumed to meet all of the criteria set forth previously and to be the operator of the programs.
N&AH Education Programs

• Under 42 CFR § 413.85(c), educational activities must:
  – be “operated” by the provider;
  – be recognized by a national approving body; and
  – enhance quality of inpatient care at the provider.

• Grandfathered hospitals can receive reimbursement for training costs as non-operators. § 413.85(g).

• CMS will not pay for normal operating expenses or community support activities. § 413.85(h), (d).
Programs Operated by a Provider

• The requirements of “operator” are fact-intensive.
• Five requirements of 42 CFR § 413.85(f):
  • Directly incur the training costs;
  • Have direct control of the program curriculum;
  • Control the administration of the program;
  • Employ the teaching staff; and
  • Provide and control both classroom instruction and clinical training.
• The key factor is the degree to which the provider controls all aspects of the program. 66 Fed. Reg. 3358, 3370 (Jan. 12, 2001).
Programs Operated by a Provider

- Directly incur training costs
  - Provider must incur the costs, not university
- Direct control of curriculum
  - Provider must determine requirements for graduation
- Control administration
  - Provider must control contracted functions
- Employ teaching staff
  - Think beyond W-2 employee
- Provide and control instruction and training
  - The importance of the “diploma presumption”
Legal Operator Issue: Areas of Focus

• Audits have been increasingly intensive.
• Review operating agreements with educational institutions to determine how control of the program is discussed and that it matches reality.
• Contractors have cited diplomas listing the provider’s and university’s name as violating the “operator” principle.
• Track funding to ensure provider is incurring all costs (i.e., avoid the community support prohibition)
Litigation to Watch 2018
Allina II Decision (7/25/17):

• Allina I (2014) Recap – D.C. Circuit Court:
  – Agreed with district court that 2004 regulation was invalid but held that the district court went too far in ordering CMS to recalculate the SSI fraction w/o MA days.
  – Court remanded to Administrator to address how to treat Part C days.
  – In the meantime, CMS applied the same policy in calculating 2012 SSI fractions.
Allina II Decision

• D.C. Circuit held that CMS *had* to undertake notice and comment rulemaking before continuing to apply the same policy of treating Part C days as Part A days.
  
  – CMS’s continued inclusion of Part C days violated the *Medicare statute*’s notice-and-comment rulemaking requirements
  
  – Medicare statute doesn’t incorporate the “interpretative rule” exception to N&C found in the APA.
Implications of Allina II

• Although case involved FYE 2012, logic would apply to all pre-10/1/13 FYE appeals as well, so the decision is far reaching.

• If decision stands, CMS could be forced to recalculate all pre-10/1/13 SSI fractions to exclude Part C days from both the numerator and denominator for hospitals with pending appeals of the issue and perhaps all hospitals.
Implications of *Allina II*

- The decision arguably creates a circuit-split.
- Secretary has been given additional time to request Supreme Court review
  - *cert* was predicted by Judge Kavanaugh during oral argument.
  - Chance SCOTUS would uphold D.C. Circuit’s decision.
Implications of *Allina II*

- **Statutory Interest**
  - A hospital that “prevail[s]” in federal court is entitled to interest.
  - If *Allina II* concludes favorably, any hospital with an appeal on the DSH Part C issue in federal court will have a strong argument for receiving statutory interest.
  - Interest awards are calculated separately for each appeal; 180-day timeline timeline trigger from NPR.
  - Appeals before PRRB are not sufficient to secure right to interest, must proceed with appeal (*i.e.*, EJR) to federal court.
Implications of Allina II

• Implications for providers today:
  – Consider mechanisms to secure statutory interest for pre-October 2013 – appeal must be in federal court.
  – Treatment of Part C days on cost reports (before and after 10-1-13).
Florida Low Income Pool Litigation

• Florida §1115 Medicaid waiver includes “low income pool” eligibility group (FY 2007-2013)
  – Payments made to hospitals for inpatient care to uninsured/underinsured.
  – CMS matches LIP program as “medical assistance”
• CMS does not permit FL hospitals to include LIP patient days in Medicaid inpatient day count for DSH.
• PRRB returned unfavorable decision on February 12, 2018 following hearing and significant briefing.
• Opportunity for further challenge to CMS Administrator or in federal court.
American Clinical Laboratory Ass’n. v. Azar, (D.D.C.)

• Protecting Access to Medicare Act
  – CMS collects private rate data from “applicable labs”
  – Uses data to set new Medicare CLFS rates.
• Applicable labs = majority of Medicare revenue derived from CLFS and PFS
  – CMS added separate NPI requirement
• Data collected used to set FY 2018 rates
American Clinical Laboratory Ass’n. v. Azar, (D.D.C.)

- NPI requirement excludes virtually all hospitals from reporting
  - Most hospitals do not have separate lab NPI.
  - 21 of ~7,000 hospital labs receiving CLFS payments reported.
  - Hospital labs receive 1.5 to 4 times higher private-sector payments than independent labs.
  - Deflated CY 2018 CLFS rates.

- **ACLA challenged Step 1**: Data collection rule is contrary to statute, unreasonable, and arbitrary and capricious.
Questions?