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RECENT MEDICARE WINS FOR PROVIDERS – CHALLENGING CMS OVERREACH PAYS OFF!

Recently providers have had success challenging CMS rules, as well as its failure to properly promulgate them. In Ruling 1727-R, issued April 23, 2018, CMS acquiesced to the decision in *Banner Heart v. Burwell,* invalidating CMS's regulation prohibiting appeals unless they stemmed from a cost report adjustment or a protested item. In *Banner*, the court held that appeals can proceed if, 1) the MAC lacked authority to allow the costs sought by the provider, and 2) the provider "self-disallowed" the costs, meaning they neither claimed nor protested them on the cost report.

Another case receiving substantial press of late is *Allina v. Burwell*. If it stands, *Allina* has significant favorable implications for Medicare providers, as the D.C. Circuit found that CMS must go through proper notice and comment rulemaking for its rules to be valid. CMS recently asked the Supreme Court to review *Allina* though, so the final outcome is to be continued.

CMS RULING 1727-R AND *BANNER HEART*

CMS Ruling 1727-R eliminates the jurisdictional requirement to claim or protest costs in submitted cost reports for appeals in place on or after April 23, 2018. While limited to appeals for cost reports that end on or after December 31, 2008 and begin before January 1, 2016, it is welcome relief to providers facing jurisdictional challenges who "self-disallowed" costs barred by CMS policy instead of protesting or claiming those costs.

The ruling invalidates CMS's regulation, effective for cost reports ending on or after December 31, 2008, which revised the statutory dissatisfaction requirement that must be met for appeals. 42 C.F.R. § 405.1835 (a)(1)(i) and (ii) required providers to preserve their right to claim "dissatisfaction" either by claiming the costs they believed were in accord with Medicare policy or by protesting them in the cost report.

In *Banner,* the hospitals challenged this requirement after the Board ruled their appeal could not proceed because they failed to protest the outlier issue in their cost reports. The court examined the statute and reviewed prior case law, then applied the Supreme Court's ruling in *Bethesda Hospital*, which held if the MAC had no authority to allow the costs sought by the provider (in other words, it would be futile), the statutory dissatisfaction requirement was met.

While we can chalk this up as a win for providers who challenge CMS policy, including regulations they believe exceed the statutory authority granted by Congress, providers should not be complacent. More challenges will need to be mounted for cost reports beginning on or after January 1, 2016 when CMS implemented a new regulation. Now, 42 C.F.R. § 413.24 makes preservation of appeal rights a substantive cost report requirement that can only be met by either claiming costs or protesting costs not allowed by CMS policy in the cost report. As a result, providers should continue to protest costs or include costs that can be properly claimed in their cost reports.

ALLINA AND ITS IMPLICATIONS

The issue in *Allina* dates to 2004 when CMS promulgated a rule requiring Medicare Part C days (now Medicare Advantage days) be counted in the Medicare fraction of the Disproportionate Share Hospital ("DSH") calculation. The 2004 rule was an about face from what CMS had originally proposed, and had the effect of substantially decreasing most hospitals' DSH reimbursement.

Providers initially received a favorable ruling that vacated the 2004 rule, which CMS then tried to circumvent. More recently, providers received another even more favorable ruling in July 2017 when the D.C. Court of Appeals ruled that "HHS unlawfully failed to provide for notice and comment" as required under the Medicare Act. The significance here, in addition to striking down CMS's Part C days rule, is the seemingly wide reach of the court's decision quoting the Medicare Act below to support its conclusion that CMS must provide for proper notice and comment rulemaking:

"No rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this subchapter shall take effect unless it is promulgated by the Secretary by regulation . . ." *Allina*, pgs.

11 and 12.

Providers will have to wait a little longer for the final word on this, as CMS filed a request at the end of April 2018 asking the U.S. Supreme Court to review this case.

CHILDREN'S HOSPITAL ET AL. MEDICAID DSH VICTORY

In the recent *Children's Hospital Association of Texas, et al.* case, the D.C. District Court ruled that CMS exceeded its statutory authority when it issued a final rule requiring commercial insurance and Medicare payments to be included in hospitals' Medicaid DSH cap calculations. Originally, CMS had only published Frequently Asked Questions (FAQs 33 and 34) on its website. These FAQs required states to include commercial and Medicare payments when calculating DSH cap limits. Several hospitals in multiple states challenged the FAQs, which led to multiple federal district courts ruling that the FAQs were unenforceable because CMS failed to follow notice and comment rulemaking.

To cover their tracks, CMS finalized a rule in early 2017 that codified FAQs 33 and 34 as a retroactive "clarification" of existing policy. The D.C. District Court rejected CMS's position, finding CMS went beyond what Congress authorized in the statute. To date, CMS has appealed this and other unfavorable court decisions.

PRACTICAL TAKEAWAYS

Providers should examine the underlying statutory authority related to CMS policies and rules, and consider appealing instances where CMS may have overreached either by exceeding the authority granted to it by Congress or by disregarding proper notice and comment rulemaking requirements.

1. Providers with pending appeals where a jurisdictional challenge was raised based on failure to claim or protest costs should take steps to ensure CMS Ruling 1727-R is applied to their case. Providers whose appeals were dismissed by the Board if still within the 60-day appeal window should consider further action.
2. Providers should continue to appeal DSH Medicare Part C/Advantage days until the final outcome in the *Allina* case is known. In anticipation of success, providers should properly shadow bill Part C days, request their 118/Part C Days Report from their MACs, obtain their Medpar DSH data and preserve their records that verify dual eligible Part C days so those days can be included in the DSH Medicaid numerator. Providers needing assistance with any of these steps or wanting to obtain our Protest Toolkit to calculate your potential amount in controversy, please contact us.
3. Providers whose state Medicaid programs previously determined they had exceeded their DSH cap based on commercial insurance and Medicare payments being in the DSH cap calculation should consider pursuing litigation to recover those payments. The same applies to 2014 Medicaid DSH payments if your state decides to pursue recovery or has already.

If you have questions regarding the impact of these developments, please contact:

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