PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2020-D24

PROVIDER –
Physicians Alliance Hospital

Provider No.: 19-2037

HEARING DATE –
December 18, 2018

Cost Reporting Period Ended –
January 31, 2011

vs.

MEDICARE CONTRACTOR –
WPS Government Health Administrators (J-5)

CASE NO. – 13-0394

INDEX

ISSUE STATEMENT

Whether the Medicare Contractor's adjustment to the outlier reconciliation adjustment determination is proper.[1]

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor's adjustment to reconcile the outlier payments of Physicians Alliance Hospital ("Physicians Alliance" or "Provider") for fiscal year ending January 31, 2011 ("FYE 1/31/2011") was proper.

INTRODUCTION

Physicians Alliance is a 40-bed long term care hospital ("LTCH") located in Houma, Louisiana.[2] The Provider's assigned Medicare contractor[3] is WPS Government Health Administrators ("Medicare Contractor").

The Provider disputes the Medicare Contractor's Adjustment No. 12 in the final settled cost report for FYE 1/31/2011. This adjustment reduced the operating outlier payments by $957,549 and assessed interest in the amount of $43,910 to the operating outliers. The total amount at issue is $1,001,459.[4]

Physicians Alliance timely appealed the issue to the Board, and met the jurisdictional requirements for a hearing. The Board conducted a live hearing on December 18, 2018. Physicians Alliance was represented by Michael Freeman of TFG Consulting, LLC. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

STATEMENT OF FACTS

42 U.S.C. § 1395ww(m) establishes an inpatient prospective payment system for long term care hospitals ("LTCH PPS") for operating costs under Medicare Part A. Under the LTCH PPS, each case is categorized into a long term care diagnostic-related group ("LTC DRG").[5] Each LTC DRG has a payment weight assigned to it based on the average resources used to treat Medicare patients in that LTC DRG.[6] In addition to the LTC DRG payment, LTCHs can receive several other payments, one of which is an operating outlier payment for cases that are unusually costly. These unusually costly cases are described in 42 C.F.R. § 412.525(a) (2011) which states, in relative part:

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[1] Transcript ("Tr") at 5.
[2] Provider's Final Position Paper at 3.
[3] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate.
[4] *See* Provider's Final Position Paper at 5. *See also* Exhibit P-2.
[5] 42 C.F.R. §§ 412.503, 412.508(b), 412.513.
[6] 42 C.F.R. §§ 412.523(a), (c)(1), (c)(2).

> *(a) Adjustments for high-cost outliers.* (1) CMS provides for an additional payment to a long-term care hospital if its estimated costs for a patient exceed the adjusted LTC-MS-DRG payment plus a fixed-loss amount. For each long-term care hospital prospective payment system payment year, as described in § 412.503, CMS determines a fixed-loss amount that is the maximum loss that a hospital can incur under the prospective payment system for a case with unusually high costs.
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> (2) The fixed-loss amount is determined for the long-term care hospital prospective payment system payment year . . . using the LTC-MS-DRG relative weights that are in effect at the start of the applicable long-term care hospital prospective payment system payment year. . . .
>
> (3) The additional payment equals 80 percent of the difference between the estimated cost of the patient's care (determined by multiplying the hospital-specific cost-to-charge ratio by the Medicare allowable covered charge) and the sum of the adjusted LTCH PPS Federal prospective payment and the fixed-loss amount.

More simply stated, to receive an outlier payment, an LTCH's estimated costs for a patient must exceed the applicable LTC PPS payment plus a fixed-loss amount, which is established by CMS annually. In general terms, the ratios of an LTCH's costs to its charges ("CCRs") (*i.e.*, the ratio of operating costs to operating charges, in addition to the ratio of capital costs to capital charges) are applied to the "covered charges" of a particular costly case to determine if it exceeds the fixed-loss threshold.

The regulation at 42 C.F.R. § 412.84(i)(2) (2011) provides the rules for applying cost-to-charge ratios at the time a claim is processed, and states:

> (2) For discharges occurring on or after October 1, 2003, the operating and capital cost-to-charge ratios applied at the time a claim is processed are based on either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the latest cost reporting period.

The regulation at 42 C.F.R. § 412.525(a)(4)(iv) (2011) also addresses the CCRs applicable to outlier determinations and, in pertinent part, states:

> (iv) For discharges occurring on or after October 1, 2006, high-cost outlier payments are subject to the following provisions:

> (A) CMS may specify an alternative to the cost-to-charge ratio otherwise applicable under paragraph (a)(4)(iv)(B) of this section. A hospital may also request that its fiscal intermediary use a different (higher or lower) cost-to-charge ratio based on substantial evidence presented by the hospital. A request must be approved by the CMS Regional Office.
>
> (B) The cost-to-charge ratio applied at the time a claim is processed is based on either the most recent settled cost report or the most recent tentatively settled cost report, whichever is from the latest cost reporting period.

The regulation at 42.C.F.R. § 412.84(i)(4) (2011) allows for reconciliation and final settlement of outlier payments using actual CCRs based on the cost reporting period being settled:

> (i)(4) For discharges occurring on or after August 8, 2003, any reconciliation of outlier payments will be operating and capital cost-to-charge ratios calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled.

In the LTCH PPS final rule published on June 6, 2003, CMS revised the methodology used to determine payments for high-cost outlier and short-stay outlier cases that are made to Medicare-participating LTCHs under the LTCH PPS.[7] The policies for determining outlier payments under the LTCH PPS are modeled after the outlier payment policies under the Acute Care Hospital Inpatient Prospective Payment System.[8]

As noted above, 42 C.F.R § 412.525(a)(1) (2011) requires that CMS make an adjustment for additional payments for outlier cases that have extraordinarily high costs relative to the costs of most discharges.

Under 42 C.F.R. § 412.525(a)(4)(iv)(D), reconciliation of high-cost outlier payments to LTCHs is made as follows:

> (D) Any reconciliation of outlier payments is based on the cost-to-charge ratio calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled.

Under the regulations at 42 C.F.R § 412.529 (2011), CMS makes an adjustment for additional payments for short-stay outlier cases, and explains the adjustment method:

> (b) *Adjustment to payment*. CMS adjusts the hospital's Federal prospective payment to account for any case that is determined to

[7] 68 Fed. Reg. 34122, 34143-34146 (June 6, 2003).
[8] *Id.* at 34144.

be a short-stay outlier, as defined in paragraph (a) of this section, under the methodology specified in paragraph (c) of this section.

* * * *

(c)(2) *Discharges occurring on or after July 1, 2006 and before July 1, 2007 and discharges occurring on or after December 29, 2007 and before December 29, 2012.* For discharges from long-term care hospitals described under § 412.23(e)(2)(i) occurring on or after July 1, 2006 and before July 1, 2007 and discharges occurring on or after December 29, 2007 and before December 29, 2012, the LTCH prospective payment system adjusted payment amount for a short-stay outlier case is the least of the following amounts:

(i) One hundred and twenty (120) percent of the LTC–DRG specific per diem amount determined under paragraph (d)(1) of this section.

(ii) One hundred (100) percent of the estimated cost of the case determined under paragraph (d)(2) of this section.

(iii) The Federal prospective payment for the LTC–DRG as determined under paragraph (d)(3) of this section.

(iv) An amount payable under subpart O computed as a blend of an amount comparable to the hospital inpatient prospective payment system per diem amount determined under paragraph (d)(4)(i) of this section and the 120 percent of the LTC–DRG specific per diem payment amount determined under paragraph (d)(1) of this section.

(A) The blend percentage applicable to the 120 percent of the LTC–DRG specific per diem payment amount determined under paragraph (d)(1) of this section is determined by dividing the covered length-of-stay of the case by the lesser of five-sixths of the geometric average length of stay of the LTC–DRG or 25 days, not to exceed 100 percent.

(B) The blend percentage of the amount determined under paragraph (d)(4)(i) of this section is determined by subtracting the percentage determined in paragraph (A) from 100 percent.

The Medicare Claims Processing Manual, CMS Pub. 100-04 ("MCPM"), Ch. 3, § 150.26[9] provides instructions for reconciliation, as follows:

[9] (Rev. 2111, Issued 12-03-10, Effective 04-01-11, Implementation 04-04-11) (copy at Exhibit I-3).

A. General

For all LTCHs, reconciliation is effective beginning with discharges occurring in a hospital's first cost reporting period beginning on or after October 1, 2003.

Subject to the approval of the CMS Central Office, Medicare contractors shall reconcile a LTCH[']s outlier claims at the time of cost report final settlement if they meet the following criteria:

1. The actual CCR is found to be plus or minus 10 percentage points from the CCR used during that cost reporting period to make outlier payments, and

2. High cost outlier payments made under 42 C.F.R. § 412.525 and short-stay outlier payments under 42 C.F.R. § 412.529 combined exceed $500,000 in that cost reporting period.

To determine if a LTCH meets the criteria above, the Medicare contractor shall incorporate all the adjustments from the cost report, run the cost report, calculate the revised CCR and compute the actual CCR prior to issuing a Notice of Program Reimbursement (NPR). If the criteria for reconciliation are not met, the cost report shall be finalized. If the criteria for reconciliation are met, the Medicare contractor shall follow the instructions below in §150.28. The NPR cannot be issued nor can the cost report be finalized until outlier reconciliation is complete. The criteria above replaces the criteria published in §III of PM A-03-058.

As stated above, if a cost report is reopened after final settlement and as a result of this reopening there is a change to the CCR (which could trigger or affect outlier reconciliation and outlier payments), Medicare contractors shall notify the CMS Regional and Central Office for further instructions. Notification to the CMS Central Office shall be sent to the address and email address provided in §150.24 (B).

Even if a LTCH does not meet the criteria for reconciliation, subject to approval of the CMS Regional and Central Office, the Medicare contractor has the discretion to request that a LTCH's outlier payments in a cost reporting period be reconciled if the LTCH's most recent cost and charge data indicate that the outlier payments to the hospital were significantly inaccurate. The Medicare contractor sends notification to the CMS Central Office

> via the address and email address provided in §150.24 (B). Upon approval of the CMS Regional and Central Office that a LTCH's high cost and short stay outlier claims need to be reconciled, Medicare contractors shall follow the instructions in §§150.27 and 150.28.

In this case, the Medicare Contractor determined that Physicians Alliance's outlier claims were subject to a reconciliation adjustment since, at the time of final cost report settlement, they met the criteria outlined above. The actual CCR (.310), was found to be plus or minus 10 percentage points, specifically -10.4%, from the CCR used the during the cost reporting period to make outlier payments (.414). Additionally, the combined high cost outlier payments of $1,044.512 and short stay outlier payments of $519,791 totaled $1,564,303; far exceeding the $500,000 threshold for the cost reporting period.[10]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

Physicians Alliance asserts that the Medicare Contractor's Outlier Reconciliation adjustment was based on a cost report that contained several material errors that are inconsistent with law, regulations and rulings.[11] The Provider states that the Medicare Contractor was notified of the material misstatement of cost report items during the desk review process, but declined to make the revisions as the approaching deadline for the issuance of the Notice of Program Reimbursement ("NPR") did not allow the Medicare Contractor sufficient time for review of the requested revisions.[12]

Physicians Alliance explains that the misstated cost report items resulted in a cost-to-charge ratio variance of greater than the requisite 10 percent, and that this resulted in an outlier reconciliation that was not proper and did not meet the requirements of MCPM, Ch. 3, §§ 150.26 and 150.27. Physicians Alliance also alleges that the cost report was not settled in accordance with the regulations at 42 C.F.R. §§ 413.24 and 413.100(c)(2), as well as the Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), §§ 2105.9, 2136.1 and 2108.1. Physicians Alliance further contends that it did not meet the outlier reconciliation threshold specified in MCPM, Ch. 3, § 150.26.[13]

Physicians Alliance argues that the Medicare Contractor's position ignores the objective of a cost report and the definition and purpose of the desk review. Cost reports are prepared and settled to accurately determine the allowable costs of providing services to Medicare beneficiaries. Ignoring information submitted during the desk review and issuing an NPR with knowledge of material misstatements of costs is in stark violation of program goals and objectives.[14]

Physicians Alliance maintains that the desk review should have determined the cost report's adequacy, completeness, and accuracy. Hence, when Physicians Alliance notified the Medicare

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[10] Exhibit I-2. *See also* Medicare Contractor's Post Hearing Brief at 4.
[11] Provider's Final Position Paper at 5.
[12] *Id.* at 3.
[13] *Id.* at 5.
[14] *Id.* at 7.

Contractor of an issue with the reported costs, there was an inherent obligation to review and make a determination and/or correction. If the Medicare Contractor could not ensure the adequacy, completeness and accuracy of Physicians Alliance's cost report at the desk review, they had an obligation to perform an in-house or field audit rather than turn a blind eye and issue an NPR knowing that it contained misstatements.[15]

Physicians Alliance contends that the actual CCR described in MCPM, Ch. 3, § 150.26 can only be determined if the calculation does not include material misstatements of costs. It is for this reason that §150.26 includes the requirement that: "The Medicare Contractor shall incorporate all the adjustments from the cost report…" when determining if the criteria are met. According to Physicians Alliance, the correct process would have been for the Medicare Contractor to adjust the cost report upon notification of the material misstatements and review of the supporting documentation. Then the Medicare Contractor would have "incorporated all adjustments" when recalculating the actual CCR and simply reversed the outlier adjustment because the criteria were not met by the recalculated CCR.[16]

Physicians Alliance also rejects the Medicare Contractor's argument that it had the discretion to request that an LTCH's outlier payments be reconciled if the LTCH's most recent cost and charge data indicate that the outlier payments to the hospital were significantly inaccurate. According to Physicians Alliance, the Medicare Contractor 's Outlier Reconciliation Adjustment is improper because (1) the Medicare Contractor does not have the authority to approve an outlier reconciliation as they can only request a reconciliation from CMS by providing the actual CCR and then demonstrating that the outlier payments were significantly inaccurate; (2) the Medicare Contractor did not notify CMS of the revised CCR incorporating the cost report adjustments; (3) the Medicare Contractor did not advise CMS that the 10 percentage point threshold was not met and did not demonstrate that payments received by Physicians Alliance were significantly inaccurate; and (4) the Medicare Contractor presented no evidence that the outlier payments in the current period were significantly inaccurate.[17]

Physicians Alliance states that the Medicare Contractor has not provided the written approval issued from the CMS Central Office for an outlier reconciliation. Without that approval, none of the reconciliation steps described in 150.27 and 150.28 were effectuated. Without CMS approval entered into the record, Physicians Alliance contends that a ruling should be made in the Provider's favor. Additionally, Physicians Alliance states that the Medicare Contractor has also never entered into the record the communication from the Medicare Contractor to the hospital notifying them that their claims were to be reconciled, contrary to the established procedure.[18]

The Medicare Contractor contends that it followed the reconciliation process described in the MCPM, Ch. 3, § 150.26 through § 150.28. The Medicare Contractor notes that Physicians Alliance is challenging the accuracy of the underlying cost report data used as a source for the outlier reconciliation. Physicians Alliance argues that five errors exist within the final settled cost report, resulting in a misstatement of costs. Of these five, it would require a combination of the

[15] *Id.* at 8.
[16] *Id.* at 10.
[17] *Id.* at 15-16.
[18] Provider's Post-Hearing Brief at 9-10.

first (most material) claimed error and one of the remaining four errors to be reversed for the cost-to-charge ratio to fall outside of the reconciliation threshold. The Medicare Contractor states that it was entitled to expect that the Provider's cost report was current and accurate when submitted, as required by PRM 15-1 § 2304.[19]

The Medicare Contractor explains that the purported errors were not the result of audit adjustments by the Medicare Contractor.[20] Rather, Physicians Alliance claims to have filed their cost report incorrectly, essentially requesting to amend its as-filed cost report.[21] The Medicare Contractor argues that, even if these errors had been corrected with the filed cost report, the Medicare Contractor still had the discretion to request that a LTCH's outlier payments be reconciled if the LTCH's most recent cost and charge data indicate that the outlier payments to the hospital were significantly inaccurate, in accordance with the Federal Register and Claims Processing Manual.[22] In this regard, the Medicare Contractor asserts that, considering that Physician Alliance had a prior year history of outlier reconciliation adjustments and that Physician Alliance's proposed adjustments would bring the cost-to-charge ratio to an amount just slightly below the threshold, such discretion to request the approval of the reconciliation adjustment from CMS would not be unreasonable.[23]

First, the Board rejects Physicians Alliance's argument that the Medicare Contractor was inherently obligated to review the cost items which Physicians Alliance presented to the Medicare Contractor subsequent to receiving its final adjustments and which Physicians Alliance alleges were errors in its as-filed cost report, as these items were effectively self-disallowed. Physicians Alliance could have, and should have, availed itself of its opportunity to file an amended cost report.[24] The PRM 15-1 § 2931.2(A) states in pertinent part:

> A provider may file or an intermediary may require an amended cost report to:
>
> 1. *correct material errors detected subsequent to the filing of the original cost report.*
>
> 2. comply with the health insurance policies or regulations, or
>
> 3. reflect the settlement of a contested liability;[25]

When Physicians Alliance discovered errors in its as-filed cost report, it had the option to file an amended cost report, but failed to do so. The Board notes that the Medicare Contractor allowed Physicians Alliance sufficient time to review the adjustments resulting from its desk review. In

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[19] Medicare Contractor's Final Position Paper at 8-9.
[20] *Id.*
[21] *Id.*
[22] *Id.* at 10 (citing 68 Fed. Reg. 34493, 34503 (Aug. 8, 2003)).
[23] *Id.*
[24] PRM 15-1 §2931.2A.
[25] (Emphasis added.)

its response, Physicians Alliance submitted entirely new cost items that were *not* part of the as-filed cost report and, thus, were never within the Medicare Contractor's scope of review.[26]

In weighing its decision in this case, the Board took into account the following CMS response in the June 9, 2003 Final Rule:

> In addition, most of the changes in this regulation will apply for approximately the last 2 months of FY 2003. We intend to limit the impact of this provision during FY 2003 to ensure that the limited resources of fiscal intermediaries are focused upon those hospitals that appear to have disproportionately benefited from the time lag in updating their cost-to-charge ratios and to maintain the overall predictability of FY 2003 payments for most hospitals. Accordingly, we intend to issue a program instruction in the near future to assist fiscal intermediaries in implementing this provision during the remainder of FY 2003.
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> ***In the same program instruction**, we will issue thresholds for fiscal intermediaries to reconcile outlier payments for other hospitals during FY 2003.*
>
> For cost reporting periods beginning during FY 2004, we are *considering* instructing fiscal intermediaries to conduct reconciliation for hospitals whose actual cost-to-charge ratios are found to be *plus or minus 10 percentage points* from the cost-to-charge ratio used during that time period to make outlier payments, and that have total FY 2004 outlier payments that exceed $500,000. We believe these thresholds would appropriately capture those hospitals whose outlier payments will be substantially inaccurate when using the ratio from the contemporaneous cost reporting period. Hospitals exceeding these thresholds during their applicable cost reporting periods would become subject to reconciliation of their outlier payments. These thresholds would be reevaluated annually and, if necessary, modified each year. However, *fiscal intermediaries would also have the administrative discretion to reconcile additional hospitals' cost reports based on analysis that indicates the outlier payments made to those hospitals are significantly inaccurate*.[27]

Consistent with this preamble discussion, CMS did issue such guidance in the MCPM. The Board finds that the Medicare Contractor, in making its reconciliation decision, as it was required to do, correctly followed the instructions in MCPM, Ch. 3, §§ 150.26 – 150.28.

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[26] Moreover, it is unclear whether the Physicians Alliance was cherry picking, *i.e.*, whether there may have been other "errors" or "misstatements" in Physicians Alliance as-filed cost report which were outside the scope of the desk review and which would have resulted in adjustments to offset, in whole or in part, the very adjustments Physicians Alliance was requesting.

[27] 68 Fed. Reg. at 34503 (emphasis added).

Because the annual weighted average CCR of 0.414 (which was used to calculate the Physician Alliance's outlier payments) was more than plus or minus 10 percentage points from 0.310, the actual CCR calculated by the Medicare Contractor in 2011, and the total outlier payments exceeded $500,000 ($1,564,303 as calculated by the Medicare Contractor), the Medicare Contractor properly determined that reconciliation was appropriate.

Notwithstanding these facts, the Board finds that the Medicare Contractor had the discretion to request that Physicians Alliance's outlier payments be reconciled if its most recent cost and charge data indicated that the outlier payments to the hospital were significantly inaccurate in accordance with the Federal Register[28] and MCPM. The Board finds credence in the Medicare Contractor's argument that considering the Provider's prior year history of outlier reconciliation adjustments, and the fact that the Provider's proposed adjustments would bring the cost-to-charge ratio to an amount just slightly below the threshold, such discretion to request the approval of the reconciliation adjustment from CMS would not be unreasonable.[29]

The Board also finds that the Medicare Contractor paid Physicians Alliance correctly, *i.e.*, based on the actual CCR, not an estimate (*i.e.*, the annual average weighted CCR). In this regard, the Board points to MCPM, Ch. 3, § 150.28 entitled "Procedure for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments" which states, in pertinent part:

> 4) Prior to running claims in the *Lump Sum Utility, Medicare contractors shall update the applicable provider record in the Provider Specific File (PSF) by entering the final settled CCR from the cost report in the -25- Operating Cost to Charge Ratio field. No other elements in the PSF shall be updated for the applicable provider records in the PSF that span the cost reporting period being reconciled aside from the CCR.
>
> *__NOTE__: The FISS Lump Sum Utility is a Medicare contractor tool that, depending on the elements that are input, will produce an extract that will calculate the difference between the original PPS payment amounts and the revised PPS payment amounts into a Microsoft Access generated report. The Lump Sum Utility calculates the original and revised payments offline and will not affect the original claim payment amounts as displayed in various systems (such as NCH).[30]

For the Board to direct the Medicare Contractor to use an estimated CCR rather than the actual CCR would be contrary to the instructions in MCPM, Ch. 3, § 150.28.

Finally, the Board rejects Physicians Alliance's argument that there is no evidence in the record that CMS Central Office granted approval for the Medicare Contractor to perform an outlier

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[28] *Id.*
[29] Indeed, a plain reading of the regulation itself provides CMS with discretion on whether to conduct a reconciliation and does not itself impose any threshold (rather the 10 percent threshold is specified in the MCPM).
[30] Copy at Exhibit I-3.

reconciliation, thus negating the Medicare Contractor's outlier reconciliation and providing justification for the Board to rule in the Provider's favor.[31] The Board finds documentary evidence in the record wherein the Medicare Contractor stated that it did, in fact, receive approval to proceed with an outlier reconciliation adjustment.[32]

DECISION AND ORDER

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor's adjustment to reconcile outlier payments of Physician Alliance for FYE 1/31/2011 was proper.

BOARD MEMBERS:

Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

9/24/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

[31] Provider's Final Position Paper at 16. *See also* Tr. at 60 – 61.
[32] *See* Provider's Post Hearing Brief, Exhibit PH-17, at.7 (an email from the Medicare Contractor personnel to the Provider stating "I have completed an outlier review for Physicians Alliance Hospital, #19-2037 FYE 01/31/11. We have been given the OK to readjust these based on revised data by CMS and process them to be NPR'd.").