survey and anecdotal information) is often only available through independent consultants whose analysis considers market factors, service reimbursement and other measures that result in reliable fair market value information. Using accurate fair market value measures and benchmarks is critical to having financially sustainable compensation plans and satisfying compliance requirements.

Compliant

The three main compliance requirements for tax-exempt health systems related to provider compensation are: the Stark laws, the Anti-Kickback laws and the Internal Revenue Service requirements for tax-exempt entities. Compliance with one set of these laws will generally support compliance with the other laws and compliance with these laws reduces false claims risk. Health care law enforcement has focused significant attention and resources on physician compensation arrangements resulting in several multi-million dollar settlements and damages awards.

Health systems seeking assurance of compliance with these laws must check compliance at the onset of a new compensation plan and ongoing analysis confirming that the total compensation to each physician (inclusive of all payments, benefits and other incentives) is fair market value and commercially reasonable, is based on the physician's personal efforts (excluding all ancillary service revenue) and contains no consideration or reward for referrals of services. Physician employers can effectively test and model different compensation models, but only qualified independent consultants can provide reliable opinions regarding fair market value *and commercial reasonableness* while legal counsel provides a legal assessment and opinion regarding compliance with the relevant laws. Independent (non-physician) board approval of all compensation plans and monitoring for compliance is critical in maintaining compliance and effective oversight.

In summary, health systems that employ providers should periodically update their compensation plans to include incentives that align with system goals, adjust plans to correspond with reimbursement changes imposed by payers and confirm the plan's compliance with relevant laws.

How to Navigate the Narrow Path to Reimbursement Appeal

How Providers' Recent Court Win Favorably Impacts Medicare Appeal Rights

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During recent years, providers have felt the gradual narrowing of their rights to appeal Medicare underpayments and recoupments. Various amendments to the U.S. Department of Health and Human Services ("HHS") regulations governing provider appeals have sought to impose an increasing number of significant and complicated "hoops" through which providers must jump. However, a recent provider court victory provides a welcome – and significant – bit of relief.

On August 6th, the U.S. District Court for the District of Columbia issued three injunctions, each prohibiting HHS, the PRRB and CMS's Medicare contractors from applying one such impediment to provider appeals. HHS is enjoined from applying its "self-disallowance" regulation to certain appeals. The injunctions were issued in three related cases filed on behalf of over 40 hospitals by members of the Squire Patton Boggs Medicare Reimbursement Team in Denver and Washington, DC. The hospitals' underlying reimbursement claims involve the Medicare outlier supplemental payment program and certain rural floor, budget neutrality adjustments.

Background

By statute, providers have two timing options for appealing Medicare underpayments:

- Option 1 – appeal within 180 days of receiving an NPR; or
- Option 2 – appeal within 180 days of the deadline for the agency to issue an NPR, where none is timely issued. The deadline is one year from the date the hospital's cost report is filed.

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Since 2008, however, the Secretary has enforced a self-disallowance regulation (42 C.F.R. § 405.1835(a)(1)) which effectively requires a hospital to "pre-appeal" challenges to a CMS regulation, manual, or ruling. According to the Secretary, this pre-appeal must be reflected on the hospital's cost report, and must follow the requirements for filing a cost report "under protest," as set forth in CMS's PRM, Part II, § 115. According to the Secretary, this pre-appeal is necessary to "preserve" a hospital's right to express dissatisfaction with its reimbursement at such later time as an appeal is filed with the PRRB. Without the pre-appeal, the Secretary says, the PRRB does not have jurisdiction to hear the hospital's eventual appeal.

The Injunctions and Their Significance

A group of more than 40 providers each sought reversal of Provider Reimbursement Review Board orders that had dismissed their claims for lack of jurisdiction for asserted noncompliance with the self-disallowance regulation. The 40 providers had appealed under Option 2.

On appeal, the hospitals argued that the Secretary's self-disallowance regulation was invalid for a number of reasons, including that it seeks to impose a dissatisfaction requirement where the statute does not. Following the parties' exchange of some dispositive motions, Judge Rosemary Collyer issued a series of Show Cause orders, basically asking the Secretary to explain why the Court should not enjoin any further enforcement of the Self-disallowance regulation. The Secretary's subsequent concessions then led to the above three injunctions.

Hospitals that wish to appeal issues – especially those that involve challenges to one or more of the Secretary's regulations, manual provisions, or rulings – but which did not comply with the Secretary's Self-disallowance regulation when filing their cost reports – may file their appeals in the absence of a timely NPR (*i.e.,* within 180 days of the first anniversary of filing their cost reports). As to such appeals, the Secretary is now enjoined from enforcing the self-disallowance regulation, which will no longer be a barrier to PRRB jurisdiction.

To put this option into perspective, at a recent AHLA presentation, the author asked for a show of hands from those in the audience whose hospitals had, since 2003, received a timely NPR – one hand was raised.

Secretary's Final 2015 IPPS Regulation

On May 15th, the Secretary published her proposed 2015 IPPS Regulation, which included a partial future rescission of her self-disallowance regulation as a condition of PRRB jurisdiction, but also introduced an even more demanding set of self-disallowance requirements – this time styled as a condition precedent to a "complete" cost report. Counsel for the hospitals brought these proposals to the Court's attention and submitted comments in opposition.

As published on August 22nd, the regulation characterized the self-disallowance regulation as applied to Option 2 appeals as an "inadvertent error", and will makes a "technical correction" of same. The correction will be offered with a retroactive effective date of October 1, 2008.

In addition, the Secretary will defer further action on her proposed cost report regulation, and will decline to respond to applicable comments filed by Counsel to the hospitals and others.

Significance of Final 2015 IPPS Regulation

Hospitals which have had Option 2 PRRB appeals dismissed, by the Board or the CMS Administrator, may seek to have those adverse decisions reopened, and the Secretary's "technical correction" applied. Presently, the Secretary seeks to limit this relief to jurisdictional dismissal decisions issued no more than 3 years before the October 1, 2014 effective date of her final 2015 IPPS Regulations.

Additional Challenges – Ongoing

A smaller group of 30 hospitals are presently challenging the validity of the Secretary's self-disallowance regulation to Option 1 PRRB appeals. These cases are also before Judge Collyer.

Parting Thoughts

1. For providers with fiscal years ending on December 31, the timeframe for filing 2012 appeals under Option 2 is still open – until roughly the end of November (depending on the actual date of filing of their FY 2012 cost report). Providers should review the potential appeal issues that are likely to implicate a challenge to one or more Medicare regulations or manual provisions and consider whether they should file Option 2 appeals for issues that were not (or may not have been adequately) self-disallowed.
2. Providers that have had their appeals dismissed by the PRRB (or the CMS Administrator) – for failure to self-disallow – should consult with counsel to see whether these decisions can be reopened.
3. Providers with pending appeals that will likely trigger the self-disallowance issue or who have received, or expect to receive jurisdictional challenges from the Board, may respond to such challenges armed with this recent development.
4. As Providers prepare their cost reports for 2014, analyze potential appeal issues that are likely to implicate a challenge to one or more Medicare regulations or manual provisions and the language (and calculations) which should be used on the cost report to protest these issues.

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