CMS Offers Global Settlement of Inpatient Status Claims with Pending Appeals

On August 29, 2014,[1] the Centers for Medicare & Medicaid Services ("CMS") announced a global settlement offer to acute care and critical access hospitals with currently pending appeals of inpatient status claims denials. Citing the burden of current appeals on both hospitals and the Medicare system, CMS is offering to settle all eligible claims for 68% of the "net paid amount" of such claims.[2] Only currently pending appeals of denials based on improper inpatient status with admission dates prior to October 1, 2013 are eligible to be settled under this offer.

Background

So-called "short inpatient stays," inpatient stays of two days or fewer, have long been a target of Medicare payment audits. Audit contractors have targeted short inpatient stays on the belief that such services should be provided, and therefore billed, on an outpatient, rather than an inpatient basis. In an attempt to clarify Medicare standards for inpatient billing, CMS issued the "Two Midnight Rule" in August 2013, which defined inpatient level care to mean that, upon admission, a physician (1) expects the beneficiary to require a hospital stay that crosses at least two midnights and (2) admits the beneficiary to the hospital based upon that expectation.[3] However, existing uncertainty prior to the issuance of the Two Midnight Rule gave rise to a significant increase in the volume of claims denials on the grounds that, though the services may have been reasonable and necessary, the Medicare contractor found that the inpatient billing was inappropriate. Appeals from these denials have contributed to "the unprecedented growth in claim appeals [that] continues to exceed the available adjudication resources to address [such] appeals…."[4]

According to *The New York Times*, there is currently a backlog of approximately 800,000 appeals with a resolution period of approximately 18 months per appeal.[5] In an effort to ease the administrative burden of current appeals, CMS is now offering to settle all such appeals with dates of admission prior to October 1, 2013.

Eligible Facilities

Eligibility to submit a settlement request is limited to Acute Care Hospitals (including those paid via the Prospective Payment System, Periodic Interim Payments, and Maryland waiver) and Critical Access Hospitals.

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[1] Announcement available here.
[2] For cases denied during post-payment review, CMS will pay 68% of the net paid amount of the denied claim. For cases denied during pre-payment review, CMS will pay 68% of the approximate amount that would have been paid (calculated based on the fee schedule, the hospital's zip code and the codes listed on the claim).
[3] Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Long Term Care; Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Payment Policies Related to Patient Status; Final Rule, 78 Fed. Reg. 50496, 50944-52 (Aug. 19, 2013). The Final Rule is available here. We note that CMS has suspended enforcement of the Two Midnight Rule pending resolution of the question as to how to bill short inpatient stays. *See* Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Prospective Payment System and Proposed Fiscal Year 2015 Rates; Quality Reporting Requirements for Specific Providers; Reasonable Compensation Equivalents for Physician Services in Excluded Teaching Hospitals; Provider Administrative Appeals and Judicial Review; Enforcement Provisions for Organ Transplant Center; and Electronic Health Record (EHR) Incentive Program; Proposed Rule, 79 Fed Reg. 27978, 28169-70 (May 15, 2014); CMS, Inpatient Hospital Reviews, Updates as of 5-12-2014, *available here* (last visited Sept. 4, 2014).
[4] Federal Register Notice release by Office of Medicare Hearings and Appeals (OMHA), January 3, 2014. The Notice is available here.
[5] Abelson, Reed, "Medicare Will Settle Short-Term Care Bills," *The New York Times* (August 29, 2014), *available at*http://www.nytimes.com/2014/08/30/business/medicare-will-settle-appeals-of-short-term-care-bills.html.

The settlement is ***not*** open to psychiatric hospitals paid under the Inpatient Psychiatric Facilities Prospective Payment System, inpatient rehabilitation facilities, long-term care hospitals, cancer hospitals, or children's hospitals.

Eligible Claims[6]

In order to be eligible for the settlement, a claim must satisfy each of the following criteria:

- the claim was denied by any entity that conducted a review on behalf of CMS;
- the claim was not for items or services furnished to a Medicare Part C (Medicare Advantage) enrollee;
- the claim was denied based on an inappropriate setting determination, that is, on the basis that the service might have been reasonable and necessary, but treatment on an inpatient basis was not;
- the first day of the admission was before October 1, 2013;
- the hospital timely appealed the denial;
- as of the date of an executed agreement submitted to CMS by the hospital, the appeal decision was still pending at the Medicare Administrative Contractor ("MAC"), Qualified Independent Contractor ("QIC"), Administrative Law Judge ("ALJ"), or Departmental Appeals Board ("DAB") level of review, or the hospital had not yet exhausted its appeal rights at such level of review; and
- the hospital did not receive payment for the service as a Part B claim.

Settlement Process

Hospitals who choose to accept the settlement must agree to settle ***all*** eligible claims. CMS has reserved the right to exclude certain hospitals from the settlement due to pending False Claims Act litigation or investigations. In order to participate in the settlement, hospitals must complete and file an Administrative Agreement along with a spreadsheet containing all eligible claims (the "Eligible Claim Spreadsheet"[7]) with CMS by October 31, 2014 (extensions may be available upon request). The CMS payment for resolved eligible claims covered by each Administrative Agreement will be made in a single lump sum payment per hospital provider number or per owner of multiple setting hospitals.

Once the Administrative Agreement and Eligible Claim Spreadsheet are received by CMS, appeals of all eligible claims will be stayed. CMS will return a signed copy of the Administrative Agreement covering all claims where the information submitted by the hospital matches CMS's own records, and the affected appeals will be dismissed. Payment in an amount equal to 68% of the original inpatient claim net paid amount (out-of-pocket obligations that are included in the "gross" or "allowable" amounts are excluded) will occur within 60 days of the execution of the Administrative Agreement by CMS. In addition, CMS will refund to the hospital all interest on any submitted eligible claims that CMS has collected from the hospital as of the Effective Date. CMS will not pay interest on settled claims unless CMS does not make payment within the 60-day time frame.[8]

Where there is a discrepancy between the claim information submitted by the hospital and CMS's own records, the hospital will have an opportunity to submit a revised spreadsheet and Administrative Agreement within two

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[6] Eligibility criteria are set forth in the Administrative Agreement, available here, and the Hospital Participant – Settlement Instructions, available here.

[7] The Eligible Claim Spreadsheet Form is available here (Microsoft Excel file). Hospital Participant Settlement Instructions are available here.

[8] In that event, the interest rate will be the Current Value of Funds Rate.

weeks of receiving notice of the discrepancy. If the discrepancy persists, CMS and the hospital must negotiate the disagreement until they can reach agreement, at which point CMS will execute the second Administrative Agreement, issue payment in accordance with the settlement offer's procedures, and dismiss the affected appeals.

Each settlement will be reviewed *ex post* by either a MAC (for claims pending at the MAC or QIC level), or an ALJ or the DAB. If the ALJ or DAB identify any errors in the settlement, it will request that CMS initiate action to recover any overpayments due to ineligible claims or pay the hospital for eligible claims that were inadvertently omitted from the settlement. The parties' obligations under the agreement become binding upon execution of the agreement.

CMS's payments represent payment in full. While providers may retain beneficiary deductibles and/or coinsurance that they have already collected, they may not bill Medicare beneficiaries for any unpaid cost-sharing amounts. CMS also retains the right to recoup any duplicate or incorrect payments made for claims that were included in the Administrative Agreement but should not have been.

Relevant Considerations for Hospitals Weighing the Settlement Offer

Each hospital must make an individualized determination regarding whether to take advantage of CMS' global settlement offer. The following are a few general items that all hospitals may consider:

- **Appeal Success Rate**: Providers have generally enjoyed a high success rate in appeals of inpatient denials. A successful appeal results in full payment of the claim, whereas the global settlement offer will provide only 68 cents on the dollar. Providers also will want to evaluate the case mix of their appeals; some might be more likely than others to be successful at the ALJ level.
- **Timing of Payment**: Payments under the global settlement offer will be made 60 days after the execution of the Administrative Agreement by CMS, whereas appeals may not be resolved for approximately 18 months. However, CMS has not provided a timetable for execution of the Administrative Agreement, which makes the actual timetable for payment under the global settlement offer uncertain.
- **Allocation of Resources**: The global settlement offer relieves hospitals of the administrative burden of handling a large number of Medicare appeals, and frees staff and resources to focus on other issues.

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We continue to monitor developments with respect to the CMS global settlement offer, including CMS's position on the Medicare reimbursement implications of the settled claims. Should you have questions regarding this alert, the CMS global settlement offer, or Medicare payment matters generally, please contact your usual Ropes & Gray advisor.