Hot Topics in Medi-Cal Audits and Appeals

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Topics

- Current Trends in Medi-Cal Reimbursement
- Medi-Cal Audit Hot Topics
  - Medi-Cal Electronic Health Record Incentive Payments
  - Adjustments of Neonatal Intensive Care Services to Nursery
  - Outlier Reconciliations
- Tips for Medi-Cal Audits
- Tips for Medi-Cal Appeals

DISCLAIMER: This presentation is intended to provide general information regarding pertinent healthcare issues. This presentation does not constitute legal advice, or the application of legal advice to specific facts. Attendees should consult with their own legal counsel and/or risk management for advice and guidance.

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Trends in Medi-Cal Reimbursement

- Approximately >80% of Medi-Cal beneficiaries are enrolled in Medi-Cal managed care
  - This means that about a quarter of Californians and 40% of children are enrolled in Medi-Cal managed care
  - Carve-in of California Children's Services in 21 counties
  - Anticipated carve-in of long term care throughout the State in 2021
- Fear not: Audits and Investigations will continue to have work!

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Why Do Cost Reports Still Matter?

- Private Acute Hospitals: establish the cost-to-charge ratio for the APR-DRG
- Designated Public Hospitals: continue to be paid based on costs
- FQHC/RHC Reimbursement: for PPS ratesetting purposes

Audits Hot Topic: Electronic Health Records Audits

- When launching the EHR Program, DHCS instructed hospitals to use fields from as-filed cost reports
- Later learned that certain fields were inaccurate (Worksheet S-3 days included unpaid days; Worksheet S-10 uncompensated care included bad debt)
- In response to 2016 OIG report, DHCS has committed to auditing EVERY HOSPITAL IN THE STATE
  - Replacing the data used in attestation with reconciled data

Audits Hot Topic: Electronic Health Records Audits

- Out of 60 hospitals audited in first round (pre early 2018), 30 filed appeals.
  - Methodological issues like whether to include admin days or IPPS psych or rehab days
  - Look carefully at the adjustments!
- Hospitals continue to appeal
  - Three adverse decisions at administrative level
  - Two cases are currently pending in trial court
  - Seven hospitals went to hearing last month

Audits Hot Topic: Electronic Health Records Audits

- Also on the outlook: audits of eligible professionals by the Medical Review Branch and those who work in FQHCs by the Financial Audits Branch
- Meaningful use audits typically conducted by CMS
- Medi-Cal audits to ensure that the provider met all financial and programmatic requirements based on risk factors
  - Verification of ownership and controlling
  - Review Medi-Cal percentage

Audits Hot Topic: NICU

- Audits and Investigations is reclassifying days, charges and/or costs associated with babies coded with revenue code 173 to nursery, even if treated in the NICU
- Competing Authorities Relating to NICU/Nursery
  - Health & Safety Code
  - American Academy of Pediatrics Guidelines for Perinatal Care
  - California Code of Regulations, Title 22

Confusion Begins

Health & Safety Code	American Academy of Pediatrics Guidelines	California Code of Regulations
"Intensive care newborn nursery services" includes "intensive, intermediate, and continuing care" . . . and "shall be based upon . . .the American Academy of Pediatrics Guidelines for Perinatal Care, 1983." § 1255.5(f)	NICU – 1:1 or 1:2 nurse/patient ratio Intermediate care – 1:3 or 1:4 nurse/patient ratio Continuing care – 1:4 nurse/patient ratio	NICU – Nurse/patient ratio of 1:2 or fewer at all times

Confusion Continues

Health & Safety Code	American Academy of Pediatrics Guidelines	California Code of Regulations	CMS Pub 15-1 Sections 2207, 2217
"Intensive care newborn nursery services" includes "intensive, intermediate, and continuing care" . . . and "shall be based upon . . .the American Academy of Pediatrics Guidelines for Perinatal Care, 1983." § 1255.5(f)	NICU – 1:1 or 1:2 nurse/patient ratio Intermediate care – 1:3 or 1:4 nurse/patient ratio Continuing care – 1:4 nurse/patient ratio	NICU – Nurse/patient ratio of 1:2 or fewer at all times	"If a neonatal unit qualifies as an intensive care type unit, the days are considered intensive care type days rather than nursery days." Provides methodology for reimbursing hospitals who place non-NICU patients in NICU for temporary overflow situations.

Most Confusing of All

Health & Safety Code	American Academy of Pediatrics Guidelines	California Code of Regulations	CMS Pub 15-1 Sections 2207, 2217	Medi-Cal Billing Manual
"Intensive care newborn nursery services" includes "intensive, intermediate, and continuing care" . . . and "shall be based upon . . .the American Academy of Pediatrics Guidelines for Perinatal Care, 1983." § 1255.5(f)	NICU – 1:1 or 1:2 nurse/patient ratio Intermediate care – 1:3 or 1:4 nurse/patient ratio Continuing care – 1:4 nurse/patient ratio	NICU – Nurse/patient ratio of 1:2 or fewer at all times	"If a neonatal unit qualifies as an intensive care type unit, the days are considered intensive care type days rather than nursery days." Provides methodology for reimbursing hospitals who place non-NICU patients in NICU for temporary overflow situations.	Revenue Code 174 – "used to bill medically necessary NICU services for the newborn. . . " Revenue Code 173 – "used to bill sick baby services for the newborn when staffing ratio is 1 staff to 3 or more patients and the mother is still an inpatient."

One More Wrinkle: Program Flexibility

- Many providers have been granted program flexibility, which allows (and often requires) certain staffing levels in the NICU
- This program flexibility can conflict with Medi-Cal's methodology for reimbursement
- DHCS' current position is that program flexibility dictates licensure but not reimbursement

Beyond 2017 – “Prudent Buyer Adjustment”

- NICU are governed by PRM-1, section 2202.7, as a special care unit
  - “If a neonatal unit qualifies as an intensive care type unit, the days are considered intensive care type days rather than nursery days.”
  - Arguing that these patients are overflow babies from nursery, receiving allegedly “excess” staffing and space
- DHCS “New” Adjustment – Based on Prudent Buyer Principle
  - Origin – Provider dispute, Chief ALJ Opinion

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Audits Hot Topic: NICU

- Substantial variation between providers
  - What is reassigned
  - Methods for determining the amounts to reassign
  - Importance of nurse staffing ratios
  - Whether to disregard intensive care status altogether

Audits Hot Topic: Outlier Reconciliation

- SFY 2016-17 APR-DRG payments made based on 2014 “as filed” cost to charge ratio
- Audits replacing cost to charge ratio with “as audited” 2016-17 cost to charge ratio (as applicable for dates of service)
  - e.g., provider with 12/31 fiscal year end will have cost to charge ratio for FYE 12/31/2016 applied for dates of service July 1 – Dec 31, 2016 and then the cost to charge ratio for FYET 12/31/2017 applied for dates of service Jan 1 – June 30, 2017 (as well as the first half of SFY 2018)

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Audits Hot Topic: Outlier Reconciliation

- State Plan establishes limitations on outlier reconciliation
  - Hospital received > $500,000 of outlier payments
  - Amount of reconciliation exceeds $10,000
- DHCS has found various different ways of diluting cost-to-charge ratio, e.g.,
  - Excluding psych days
  - Setting up non-reimbursable cost centers
- Impact on Medi-Cal managed care payments TBD

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Strategies and Tips for Audit Defense

- Respond to the auditor
  - In numerous recent cases, auditors have taken drastic action in reaction to perceived non-response.
- Memorialize communications in writing
- No reason to sign exit conference document
- Use the time to find additional documentation: DHCS is arguing that anything that was not raised in the context of the audit should be excluded from consideration
- Document premature “closure” of the audit due to auditor’s deadlines
- Think through your strategy if this is a recurring issue

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Strategies and Tips for Appeals

- Recent Hoag case: Broadly define your statement of disputed issues
  - In Hoag, the court held that the provider could not maintain an appeal of an issue not specifically identified in the statement of disputed issues
  - What level of specificity is needed? Nobody knows, so cover your bases
  - Make sure you review the audit work papers carefully to ensure you have identified all of the potential audit adjustments to appeal
- Assess whether going to informal is helpful or wastes time
- Consider raising legal issues at informal to ensure those grounds are preserved

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Outlook for Medi-Cal Audits

- Inconsistency between auditors and ignorance around Medi-Cal policies continue to be systemic issues
- With new outlier policy, audits and investigations will continue to be active at hospitals that serve (sick) Medi-Cal beneficiaries
- Without further accountability, appeals outcomes will continue to be highly deferential to auditors

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Medi-Cal Audits: Areas for Reform

- Training to ensure understanding of cost reporting, reimbursement and basic legal concepts (no underground rules)
- Consistency from one audit office to the next, let alone one auditor to the next auditor
- Compliance with Generally Accepted Government Accounting Standards
- Clarify standard of review for administrative law judges and increase accountability by requiring hearing decisions to be published online

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Outlook for Medi-Cal Audits (on the other side)

- More audit activity to be expected from Medi-Cal managed care plans
  - Some audit activity may trigger fee-for-service audit investigations
- Potential for increased disparities between Medi-Cal managed care plans and the Department (e.g., enrollment decisions, audit processes, findings)
- Lack of “due process” in the traditional sense because most plans are private entities

Questions?

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Thank You

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