PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2009-D12

PROVIDER -
SRI 1987-1994 DSH SSI% GROUP

Provider Nos: Various

vs.

INTERMEDIARY -
Blue Cross Blue Shield Association/
National Government Services (IL)

Cost Reporting Periods Ended -
Various

CASE NO.: 08-2907G

INDEX

ISSUE:

Whether the Board has jurisdiction over a challenge to the validity of the Supplemental Security Income percentage under the doctrine of equitable tolling where the appeals were not filed within three years of the issuance of Providers' Notices of Program Reimbursement.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This dispute arises under the Medicare Program which is a Federal medical insurance program for the aged and disabled and is administered by the Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration. 42 U.S.C. §§ 1395-1395cc. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due providers under the Medicare law and interpretative guidelines published by CMS. See, 42 U.S.C. § 1395(h), 42 C.F.R. §§ 413.20-413.24. Providers have 180 days after the issuance of the intermediary final determination of program reimbursement to file an appeal with the Provider Reimbursement Review Board (Board). See, 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835- 405.1840 (2008).[1] The regulation at section 405.1836 permits late filing upon a showing of good cause provided the request for extension of the time limit is received within three years of the date of the final determination from which the appeal is filed.

Hospitals are paid for services to Medicare patients under a prospective payment system (PPS). Under PPS, the inpatient operating costs are reimbursed based on a prospectively determined formula taking into account national and regional operating costs. The PPS legislation contains a number of provisions that adjust reimbursement based on hospital specific factors. See, 42 U.S.C. § 1395ww(d)(5). This case involves one of the hospital specific adjustments, the disproportionate share adjustment.

The "disproportionate share" or "DSH" adjustment, effective in 1986, requires the Secretary to provide increased PPS reimbursement to hospitals that serve a "significantly disproportionate number of low-income patients." 42 U.S.C. § 1395ww(d)(5)(F)(i)(I). Whether a hospital qualifies for the DSH adjustment, and the amount of adjustment it receives, depends on the hospital's "disproportionate patient percentage." See, 42 U.S.C. § 1395ww(d)(5)(F)(v).

The "disproportionate patient percentage" is the sum of two fractions (expressed as percentages), the "Medicare and Medicaid fractions," for a hospital's cost reporting period. 42 U.S.C. §1395ww(d)(5)(F)(vi). This dispute involves the Medicare fraction, also often referred to as the Supplemental Security Income (SSI) fraction because it captures the number of Medicare patients who are also eligible for SSI. The statute at section 1395ww(d)(5)(F)(vi) establishes that the numerator of the Medicare fraction is the number of days that an individual was both a hospital inpatient and entitled to SSI

[1] See, revisions to subpart R of Title 42, 73 Fed. Reg. 30190 (May 23, 2008), effective August 21, 2008.

benefits. The denominator is the total number of days of hospital inpatient care furnished to Medicare Part A beneficiaries.[2] CMS calculates the fraction and notifies the provider and the Intermediary.

The SSI program is administered by the Social Security Administration (SSA); therefore, identifying patients who were entitled to SSI during their hospitalization requires access to SSA's SSI data. Regulations provide that the number of patient days of those patients entitled to both Medicare Part A and SSI will be determined by matching data from the Medicare Provider Analysis and Review (MEDPAR) file,[3] which is Medicare's database of hospital inpatients, with a file created for CMS by SSA (SSA file) to identify SSI individuals.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY

This appeal, brought by a group of unrelated hospitals (Providers), asserts that the SSI percentage calculated for their DSH adjustment for the fiscal years (FYs) 1987-1994 was understated due to several flaws in the data collection and matching process. The appeal was filed on September 26, 2008. There is no dispute that the Notices of Program Reimbursement (NPRs) from which this appeal is based were issued more than three years before the request for hearing was filed. Providers request that the Board nevertheless consider the appeal timely filed under the doctrine of equitable tolling.

The Board has previously held in Anaheim Memorial Hospital v. BCBSA/Blue Cross of California,[4] that it does not have authority to apply the equitable tolling doctrine. Providers anticipate a consistent decision here but, in addition to challenging the rationale of the Anaheim decision, they also urge the Board to simply hold this appeal in abeyance until the Federal district court resolves another case involving what the Provider claims are the same issues as in this appeal.[5] Providers also contend that the Board's holding in Anaheim was not a jurisdictional determination but one merely addressing the scope of the Board's equitable powers. They therefore propose that, as there is no jurisdictional impediment, as an alternative to abeyance and in the interest of judicial economy, the Board should hear the case on the merits but make relief contingent on Providers successfully establishing they meet the requirements for equitable tolling in subsequent proceedings before the CMS Administrator or Federal courts. Providers also request that the Board permit discovery to aid development of the evidence regarding whether equitable tolling is appropriate.

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[2] 42 U.S.C. § 1395ww(d)(5)(F)(vi)

[3] 52 Fed. Reg. 33143, 33144 (September 1, 1987) CMS uses the term PATBILL (Part A Tape Bill] and MEDPAR [Medicare Provider Analysis and Review] file interchangeably. The Agency states that the MEDPAR file contains the same data as the PATBILL file but it is in a simplified reformatted record layout.

[4] Anaheim Memorial Hospital v. Blue Cross Blue Shield Association/Blue Cross of California, PRRB Dec. 2000-D72 (July 3, 2000) Medicare and Medicaid Guide (CCH) ¶ 80,527.

[5] Providers identify the district court case but do not identify the Board decision from which the federal court appeal arises. Although Providers represent that the "same issues" are in this and the case pending in district court, the precise issues are not identified nor do Providers explain how resolution of the court case will be "instructive and may even be determinative" of the instant case as they claim.

PROVIDER'S POSITION

Providers claim their failure to timely file an appeal of their SSI fraction was the result of CMS' knowing and unlawful refusal to inform hospitals paid under PPS that the SSI percentages were understated. They also assert that CMS made the following false statements:

(a) CMS made false representations in the proposed and final rule "that SSA, not CMS computes the SSI fractions and that SSA does not release the underlying data to CMS;"

(b) CMS knew that its "record retention failures" made it impossible for hospitals to demonstrate the financial impact caused by the flaws in the process; and

(c) CMS published misleading information about whether it counted HMO days in the SSI fraction.

Providers allege CMS' conduct "tricked or induced" them not to appeal the SSI percentage within the regulatory time limits. Providers claim they became aware of a "viable cause of action" relating to flaws in the SSI calculations only upon publication of the District Court's decision in Baystate Medical Center v. Leavitt[6] (Baystate) and they acted diligently in filing their appeal within 180 days of that decision.

Providers rely on the Supreme Court's decisions in Irwin v. Veteran's Administration, 498 U.S. 89 (1990) (Irwin), and Bowen v. City of New York, 476 U.S.467 (1986) (New York) for support that equitable tolling is available in suits against the Federal government under circumstances alleged here.[7] In New York, the time limit under 42 U.S.C. §405(g) for filing suit for judicial review of disability claims was tolled where the Government's "clandestine policy" prevented claimants from knowing of a violation of their rights. Id. at 481. Section 405(g) required a civil action to be filed against the Secretary in Federal district court "within sixty days . . . or within such further times as the Secretary may allow." By allowing the Secretary to extend the deadline, the Court found Congress had expressed the "clear intention to allow tolling in some cases." Id. at 480. Providers point to the "good cause" extension in 42 C.F.R. §405.1836[8] that allows late filing of an appeal to the Board in some cases as a similar manifestation of the Secretary's intent to allow tolling in some cases. They also assert that the regulatory extension establishes that the filing deadline is not jurisdictional. Providers also note that the Board's application of the equitable tolling

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[6] 545 F. Supp. 2d 20 (D.D.C 2008), amended in part 2008 W.L. 4831216 (D.D.C. Nov. 8, 2008) and 2008 WL .5120771 (D.D.C. Dec. 8, 2008).

[7] Although Providers cite Irwin for application of equitable tolling where plaintiffs claimed to have been tricked or induced to miss the deadline, Irwin did not involve these circumstances and the Court rejected equitable tolling in that case. However, the Irwin Court did reference Glus v. Brooklyn Eastern District Terminal, 359 U.S. 231 (1959) and Holmberg v. Armbrecht, 327 U.S. 392 (1946), as cases where equitable tolling has been "sparingly" applied in such circumstances.

[8] The statutory 180 day deadline does not contain the "good cause" waiver of the time limit and has been held invalid in two Circuit Court decisions. See footnote 11, infra.

doctrine in Bradford Regional Medical Center v. Blue Cross of Western Pennsylvania, PRRB Dec. No 99-D19 (January 7, 1999), Medicare & Medicaid Guide ¶80,152, was affirmed in Bradford Hospital v. Shalala, 108 F.Supp. 2d 473 (W.D. Pa 2000) (Bradford).

Providers further allege that not applying the equitable tolling doctrine will result in the Providers' payment based on an incorrect SSI percentage and, therefore, non-Medicare patients will subsidize the costs of Medicare beneficiaries in violation of 42 U.S.C. §1395x(v)(1)(A).

INTERMEDIARY'S POSITION

The Intermediary asserts that Providers' failure to file within the time limits imposed by the statute and regulations deprives the Board of jurisdiction over the appeal. The regulatory extension of the filing deadline for good cause limits the Board's consideration of good cause to three years after the issuance of the NPR. The Intermediary likens the good cause extension of the 180 day statutory time limit to a statute of repose which "grants immunity 'to relieve potential defendants from anxiety – and liability – over acts committed long ago,'" citing Spohn v. HHS, 1996 WL 532610 (Sept 6, 1996). The Intermediary explains that a statute of repose bars the right to bring an action after the lapse of a specified period, unrelated to the time when a claim might accrue, whereas a statute of limitations generally bars bringing an action after the passage of a given period of time following the accrual of the claim. Because the regulations establishes a maximum of three years for filing, the equitable tolling doctrine cannot be applied. The Intermediary contends the Bradford case is not applicable because it involved timeliness of the provider's request to the Intermediary for redetermination of a hospital-specific rate, not the timeliness of an appeal, and did not involve a specific, final deadline for filing the request.

The Intermediary also urges the Board to reject equitable tolling in this case because this doctrine is applicable only where, at a minimum, there is misconduct by the other party. It asserts there is no evidence that Providers were tricked or induced to miss the filing deadlines nor is there evidence that CMS even knew 20 years ago that the data was flawed.

FINDINGS OF FACT, CONCLUSION OF LAW AND DISCUSSION

The Board concludes that it does not have authority to apply equitable tolling of the statutory and regulatory filing deadlines and the failure to timely file deprives the Board of jurisdiction.

Equitable Tolling

A firmly established principle of administrative law is that an agency is but a creature of statute. An agency's power is therefore no greater than that delegated to it by Congress. Lyng v. Payne, 476 U.S. 926, 937, (1986); see also Gibas v. Saginaw Mining Co., 748 F.2d 1112, 1117 (6th Cir.1984) (administrative agencies are vested only with the authority given to them by Congress), cert. denied, 471 U.S. 1116 (1985); Atchison, Topeka & Santa Fe Ry. Co. v. Interstate Commerce Comm'n, 607 F.2d 1199, 1203 (7th

Cir.1979) (same). Though an agency may promulgate rules or regulations pursuant to authority granted by Congress, no such rule or regulation can confer on the agency any greater authority than that conferred under the governing statute. Bowen v. Georgetown Univ. Hosp., 488 U.S. 204, 208, (1988); Ernst & Ernst v. Hochfelder, 425 U.S. 185, 213-14, (1976).

The Board is an administrative forum that does not have general equitable powers but rather has only the powers granted to it by statute and regulation. Congress imposed time limits for filing appeals to the Board and did not confer power to apply equitable tolling principles to extend that time. The Board notes that the Supreme Court cases relied on by Providers involved equitably tolling the limitations period for filing actions in Federal court, not in administrative tribunals.

Even if the Board could consider an equitable remedy, further development of evidence through discovery or subsequent proceedings as the Providers suggest would prove they were mislead is unnecessary. The undisputed facts compel a finding that Providers are not entitled to such relief.

Providers allege they could not have known that the SSI percentage was understated until the flaws in the SSI percentage calculation were revealed in the District Court's decision in Baystate[9] and they acted diligently in filing their appeal within 180 days of that decision. However, details of the flaws that Providers now rely on as the basis for their appeal were thoroughly analyzed in the Board's decision which gave rise to the District Court's decision. See, Baystate Medical Center v. Mutual of Omaha, PRRB Dec. 2006-D20 (March 17, 2006) Medicare & Medicaid Guide (CCH) ¶81,468.

Providers' submission in this case shows they also had actual knowledge of the decision in Loma Linda Community Hospital v. Shalala, 907 F. Supp. 1399 (C.D. Cal. 1995) (Loma Linda).[10] Loma Linda sought recalculation of its SSI percentage based on its independent evaluation of the data on which the percentage should have been based, indicating that CMS' calculation was significantly understated (14% calculated by CMS versus 21% calculated by the hospital). The court ruled that the hospital was entitled to determine its SSI factor independently and recognized Provider's right to obtain access to the underlying data used by CMS in calculating the SSI percentage. Although the 1995 Loma Linda Federal court decision did not identify what caused the understatement of the SSI factor, it put Providers on notice of potential flaws in their SSI calculation. The Board's decision revealed the same facts in 1993. Loma Linda Medical Center v. Blue Cross of California, PRRB Dec. 93-D50 (June 24, 1993), Medicare & Medicaid Guide (CCH) ¶41,576. Despite Providers' knowledge that the SSI percentages were coming under attack, there is no allegation they made any attempt to examine the accuracy of their own SSI percentage until September 2008. As Providers acknowledge, courts are "much less forgiving in receiving late filings where the claimant failed to exercise due diligence in preserving his legal rights," citing Irwin, at 96. Waiting 2 1/2 years from the Board's decision in Baystate and over 15 years from the Board's Loma Linda decision, while meantime hundreds of appeals of the

[9] See note 6, supra.
[10] Provider's Opposition at p. 10-11

issue were filed by other providers, can hardly constitute due diligence. Rather, the Providers failure to file their appeal sooner appears to be more akin to what the Supreme Court in Irwin described as "garden variety" negligence. Irwin at 96.

Jurisdiction

42 U.S.C. § 1395oo(a) establishes that a provider has a right to a hearing before the Board with respect to a cost claimed on a timely filed cost report "if" it is dissatisfied with the final determination of the intermediary, the amount in controversy is $50,000 or more for a group and the provider "files a request for a hearing within 180 days after notice of the intermediary's final determination . . ." The time limit for filing is embedded in the legislation establishing the very right to a hearing and clearly indicates Congress' intent that filing within the time specified is a condition precedent to the right to a hearing.

Likewise, the Secretary's grant of authority to the Board in 42 C.F.R. § 405.1836(b)(2) (2008) allowing it to consider good cause for late filing is not unlimited. The Board must receive the request within 3 years after the date of the intermediary determination the provider seeks to appeal. The Board is not at liberty to enlarge the regulatory terms.

The Board has consistently treated these three criteria -- dissatisfaction, amount in controversy, and timeliness -- as jurisdictional requirements. Federal courts have supported that view. In St. Joseph's Hospital v. Heckler, 786 F.2d 848 (8th Cir. 1986), the Court explained the jurisdictional nature of the timely filing requirement as follows:

> The Hospitals admit they have not complied with the clear requirements of section 1395oo(a). Specifically, they have not complied with the mandatory requirement of section 1395oo(a) which unambiguously specifies that a provider "may obtain a hearing" on its claim "if . . . a request for a hearing [is filed] within 180 days . . . of the intermediary's final determination." 42 U.S.C. Sec. 1395oo(a)(3). The imperative nature of this provision is underscored by the legislative history of the Medicare Act which states:
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> > Any provider of services which has filed a timely cost report may appeal an adverse final decision of the fiscal intermediary with respect to the period covered by such a report to the Board where the amount in controversy is $10,000 or more. The appeal *must* be filed within 180 days after notice of the fiscal intermediary's final determination.
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> H.R.Rep. No. 231, 92d Cong., 2d Sess., reprinted in 1972 U.S.Code Cong. & Ad.News 4989, 5094 (1972) (emphasis added). Clearly, had Congress intended the 180 day limitation of section 1395oo(a)(3) to be less than mandatory, it could have easily provided that a request for a hearing be filed "within days . . . or within such further time as the Secretary may

> allow" as it did when defining this court's jurisdiction to review social security disability claims. See 42 U.S.C. Sec. 405(g).
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> Because section 1395oo(a) specifically defines those situations in which a provider may seek review, it also necessarily defines those situations in which the Board will have jurisdiction to review a claim. See, Highland District Hospital v. Secretary of Health and Human Services, 676 F.2d 230, 235 (6th Cir. 1982). Thus, in this case, because the Hospitals have not complied with and cannot comply with the jurisdictional requirements of section 1395oo(a) and have no right to seek Board review, the Board itself is without jurisdiction to address the Hospitals' claims.

St. Joseph's at 851-852. See also Alacare Home Health Serv. v. Sullivan, 891 F.2d 850, 852-853.[11]

The regulations also reflect the Secretary's understanding that timely filing is jurisdictional. 42 C.F.R. §405.1840 (2008), entitled "Board jurisdiction," provides at subsection (a)(2) that "[t]he Board must make a preliminary determination of the scope of its jurisdiction (that is, whether the request for hearing was timely . . .) before conducting [various enumerated proceedings]." A finding that the Board lacks jurisdiction requires dismissal. 42 C.F.R. §405.1840(a)(4).

Having no jurisdiction, the Providers' request that the Board hold the case in abeyance to await resolution of other cases pending in Federal court or, alternatively, that the Board allow Providers to go forward on the merits and conduct discovery to develop evidence regarding equitable tolling criteria must be denied.

DECISION AND ORDER

The Board concludes that it has no power to grant relief under the doctrine of equitable tolling. Failure to timely file as required by 42 U.S.C. §1395oo(a) and 42 C.F.R. §§405.1835-405.1840 deprives the Board of jurisdiction. The Board hereby dismisses the appeal.

Review of this determination is available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§405.1875-405.1877.

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[11] These cases also held the Secretary's good cause regulation to be invalid as beyond the statutory authority granted to the agency. Alacare at 856; St Joseph's at 852-853. But see, Western Medical v. Heckler, 783 F.2d 1376 (9th Cir. 1986) (contra).

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