PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2010-D31

PROVIDER-
Medical College of Georgia Hospital

Provider No: 11-0034

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Cahaba Government Benefit
Administrators-GA

Cost Reporting Period Ended –
June 30, 2004

CASE NO.: 09-0072

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Issue Before the Board

Whether the Board has jurisdiction over the Provider's appeal of whether the disproportionate share (DSH) adjustment was incorrectly determined due to a significant error in the Supplemental Security Income (SSI) percentage where the appeal was not filed within 180 days of the issuance of the final determination.

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. In addition, a cost report may be reopened at any time if the determination was procured by fraud. 42 C.F.R. § 405.1885(b)(3)(2008).

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 provide for additional payment 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 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

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

individual was both a hospital inpatient and entitled to SSI 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 to identify SSI individuals.

Procedural History

This appeal asserts that the SSI percentage used to calculate the Provider's DSH adjustment for the fiscal year (FY) 2004 was understated due to several flaws in the data collection and matching process. The appeal was filed on October 16, 2008, more than 180 days after the issuance of the Notice of Program Reimbursement on September 28, 2006 but within the three-year reopening period defined in 42 C.F.R. § 405.1885. The Provider requests that the Board consider the appeal timely filed under 42 C.F.R. § 405.1885(b)(3) dealing with fraud.

Parties' Positions

The Provider believes that CMS was aware of significant fundamental errors when it computed and published the SSI percentage for this Provider. However, CMS failed to disclose or correct such significant errors when it gave the percentage to the Intermediary, which was used to calculate the DSH payment. The alleged errors include the following:

1) Patients who were deceased were not included in the Social Security file of SSI beneficiaries. Consequently CMS significantly understated the numerator of the "SSI" proxy.

2) Retroactive determinations of SSI eligibility were not reflected in the published "SSI proxy" and were not corrected to reflect such determinations.

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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.

3) The electronic match to the MEDPAR file used the HIC [health insurance claim account number], although the SSA file for the SSI beneficiary uses the Social Security number. The HIC number in some instances is not the same as the Social Security number and consequently several Medicare Part A beneficiaries who were entitled to SSI have been excluded from the numerator of the "SSI proxy."

The Intermediary asserts that the Provider is essentially basing its position that the Board has jurisdiction despite the late filing on the principles of equitable tolling. The Intermediary urges us to reject this position because to invoke equitable tolling, a party must demonstrate, at a minimum, that the doctrine applies and a party's failure to file a timely claim is based on the misconduct of the other party, citing Irwin v. Veteran's Administration, 498 U.S. 89 (1990). The Provider in this case cannot make either showing. Further, there is no evidence that the Intermediary "induced or tricked" the Provider to miss the filing deadline.

The Intermediary further argues that the Provider is simply attempting to take advantage of a new development in the law as a result of the decision in Baystate Medical Center v. Leavitt [4] (Baystate) in which the Court concluded that the data utilized by CMS for the DSH calculations was defective.

Findings of Fact, Conclusions of Law and Decision

The Provider relies only on the reopening regulation, 42 C.F.R. §405.1885(b)(3) (2008) dealing with fraud, as the basis to excuse late filing and did not respond to the Intermediary's jurisdictional brief. However, the Board has also considered whether the Provider's filing is timely under general equitable tolling principles and under the good cause provision of 42 C.F.R. §405.1836 (2008) but concludes that it was not. 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 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 (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

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[4] 545 F. Supp. 2d 20 (D.D.C. 2008), amended in part 587 F. Supp. 2d 37 (D.D.C. 2008) and 587 F. Supp. 2d 44 (D.D.C. 2008).

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. Even if the Board could consider an equitable remedy, the undisputed facts would compel a finding that Providers are not entitled to such relief.

Provider alleges it 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.[5] However, details of the flaws that Provider now relies on as the basis for its appeal were thoroughly analyzed in the Board's published 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.

Further, the Board issued a decision on the SSI issue in 1993 in Loma Linda Community Hospital v. Blue Cross of California[6] in which the provider challenged the SSI percentage as understated. This case was appealed to Federal court in Loma Linda Community Hospital v. Shalala, 907 F. Supp. 1399 (C.D. Cal. 1995) (Loma Linda). Loma Linda sought recalculation of its SSI percentage factor 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 its 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. There is no allegation the Providers made any attempt to examine the accuracy of their SSI percentage until October of 2008. Courts are "much less forgiving in receiving late filings where the claimant failed to exercise due diligence in preserving his legal rights,"[7] Waiting 1 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 issue were timely filed by other providers from intermediary determinations, can hardly constitute due diligence.

Fraud

The Provider asserts that under 42 C.F.R. § 405.1885(b)(3) the Board has the authority to permit late filing as the result of CMS' fraudulent concealment. The Provider alleges that CMS engaged in fraudulent concealment of the deficiencies in determining the published SSI ratios and took no steps to correct errors, all as evidenced in the D.C. District Court's Baystate decision. The decisions in Baystate did not result in a finding of fraud. Moreover, the reopening provision on which Provider relies, 42 C.F.R.

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[5] Id.

[6] PRRB Dec. 93-D50 (June 24, 1993), Medicare & Medicaid Guide (CCH) ¶ 41,576.

[7] Irwin v. Veteran's Administration, 498 U.S. 89, 96 (1990).

§405.1885(b)(3), must be read in conjunction with subsection (c). It provides that jurisdiction for reopening an intermediary determination is reserved to the intermediary or CMS.[8] There is no authority granted to the Board to reopen an intermediary determination and the Supreme Court has held that the Board does not have jurisdiction of an appeal of a denial of reopening.[9] Your Home Visiting Nurse Services, Inc. v. Shalala, 525 U.S. 449 (1998). Nothing in the reopening authority under section 405.1885(b)(3) provides for extending the Board's filing deadlines beyond the times expressly granted in the regulations. In addition, the Board has previously held in Morehouse General Hospital v. Louisiana Health Service and Indemnity Company[10] with regard to the Provider's contentions that the intermediary was guilty of fraud, that the Board's authority is to adjudicate reimbursement controversies, not to decide whether an entity acted fraudulently or unethically. However, we need not reach a decision here on the scope of the Board's authority with regard to making a determination of fraud because the filing would still have been late. As discussed above, the precise flaws in the SSI percentage calculation on which the Provider now relies were publicly revealed in the Board's Baystate decision of March 2006, well in advance of the Provider's filing deadline. Therefore, the undisputed facts reveal that Provider was not deceived into missing the filing deadline.

Good Cause

For the same reasons, the Board will not grant relief from the filing deadline under the good cause provisions of 42 U.S.C. §405.1836 (2008), which limits good cause to extraordinary circumstances beyond the provider's control, as the facts show the Provider was on notice of potential flaws in the SSI percentage calculation well in advance of its filing deadline. Moreover, the regulations expressly provide that the Board may not grant an extension for good cause based on a change arising from a court decision. See, 42 C.F.R. §405.1836(c)(1).

Jurisdiction

42 U.S.C. § 1395oo(a) establishes that a provider has a right to a hearing before the Board with respect to a timely filed cost report if it "files a request for a hearing within 180 days after notice of the intermediary's final determination " and meets other jurisdictional criteria. Thus, the time limit for filing is embedded in the legislation establishing the very right to hearing and clearly indicates Congress' intent that filing within the time specified is a condition precedent to the right to a hearing.

The Board has consistently treated the statutory 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:

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[8] The Board has jurisdiction for reopening its own determinations, however, there is no indication in the record that the Provider requested a reopening or that any revisions were made to the original NPR from which appeal could arise. See, 42 C.F.R. 6 405.1887(d).

[9] PRRB Dec. 81-D58 (March 19, 1981) Medicare & Medicaid Guide (CCH) ¶ 31,405.

> 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. §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 (11th Cir. 1990).[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 "The Board must make a preliminary determination of the scope of its jurisdiction (that is, whether the request for hearing was timely . . .) before conducting

[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).

[various enumerated proceedings]." A finding that the Board lacks jurisdiction requires dismissal. 42 C.F.R. § 405.1840(a)(4).

The Board finds that it lacks jurisdiction over the appeal and hereby dismisses the case. 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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<u>FOR THE BOARD</u>:

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Date: May 25, 2010