PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2011-D11

PROVIDER -
Coosa Valley Medical Center
Sylacauga, Alabama

Provider No.: 01-0164

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Cahaba Government Benefits
Administrators, LLC

DATE OF HEARING -
February 19, 2009

Cost Reporting Periods –
July 31, 2006; July 31, 2007

CASE NO.: 06-2033

INDEX

ISSUE:

Whether the Centers for Medicare and Medicaid Services (CMS), reversal of the Provider's rural referral center (RRC) classification was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395(h), 42 C.F.R. §§413.20 and 413.24.

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the proportion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the Prospective Payment System (PPS). The PPS statute contains a number of provisions that adjust reimbursement based upon hospital specific factors. See 42 U.S.C. §1395 ww(d)(5). This case involves two of those provisions.

Effective October 1, 1984, Congress established payment exceptions to the prospective payment system for rural hospitals with operating characteristics similar to those of urban hospitals in the same census region. The statute (42 U.S.C. §1395ww(d)(5)(C)) established the classification category of rural referral center, and stated "a hospital which is classified as a rural hospital may appeal to the Secretary to be classified as a rural referral center under this clause on the basis of criteria [established by the Secretary]." The statute provides a broad list of the criteria that may be used to classify a hospital as a rural referral center. Those criteria "may include wages, scope of services, service area, and the mix of medical specialties." The Secretary established criteria for rural hospitals to qualify as rural referral centers at 42 C.F.R. §412.96. To be classified as a referral center the hospital must be of a certain size, act as a referral hospital, receiving patients from other hospitals or nonaffiliated physicians, and have a certain percentage of its Medicare patients live more than 25 miles from the hospital. Alternatively, a hospital can qualify for rural referral center status under 42 C.F.R. §412.96(c), which evaluates the hospital's case mix index

in comparison to the national and regional case mix indices, the number of discharges, the medical specialties represented on the staff, as well as the source of patients and volume of referrals from other hospitals.

The issue in this case involves the interpretation of the regulation for the proper classification of a rural referral center.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Coosa Valley Medical Center (Provider) is a short term, acute care hospital located in Sylacauga, Talladega County, Alabama. The Provider was a part of the Baptist Health System through August 1, 2004 when the hospital was purchased by Sylacauga Health Care Authority. At the time of this change of ownership (CHOW), the Provider chose not to accept assignment of the prior owner's Medicare provider number (01-0072) and was issued a new provider number (01-0164) to satisfy the buyer's interest of liability limitation and assignment of billing responsibility. The Provider requested and was granted rural referral center status, effective August 1, 2005, under the alternative qualifications prescribed at 42 C.F.R. §412.96(c). This approval was based on cost report information for fiscal years when the Provider was owned by Baptist Health System and participated in the Medicare program under the old provider number 01-0072. CMS instructed Cahaba Government Benefits Administrators (Intermediary) to reverse the provider's rural referral center approval determination, effective with the beginning of the hospital's FY 2007. The Intermediary executed CMS' directive effective August 1, 2006. CMS' position is that the regulations require that the case mix index data be taken from the hospital's own billing records for Medicare discharges and that the number of discharges is to be derived from the same cost reporting period as the national and regional number of discharges in each year's annual notice of prospective payment rates. CMS' action was based on its interpretation that these requirements mean any hospital that is seeking rural referral center status must rely on its own history and data to qualify, not that of a prior owner.

The Board determination whether the provider met the jurisdictional requirements of 42 C.F.R. §§405.1835- 405.1841 is set forth below. The Provider was represented by Colin H. Luke, Esquire, of Balch and Bingham, LLP. The Intermediary was represented by James R. Grimes, Esquire, of BlueCross BlueShield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that, once RRC status is granted, CMS has no authority to reverse its determination. The Provider argues that, prior to June 11, 1998, CMS had regulatory authority to rescind a provider's status as a RRC for the following four reasons:

(a) upon voluntary request by a provider for cancellation of RRC status.[1]
(b) failure to meet applicable RRC criteria during a triennial review conducted by CMS.[2]

[1] 42 C.F.R. § 412.96(g), Oct. 1, 1997 Edition.
[2] 42 C.F.R. § 412.96(i)(4), Oct. 1, 1997 Edition.

(c) upon redesignation by the Office of Management and Budget ("OMB") of the provider's location as urban. [3]
(d) upon reclassification by the Medicare Geographic Classification Review Board ("MGCRB") of the provider as urban.[4]

CMS promulgated requirements for a triennial review of RRC status in 1984, one year after Congress authorized classification of providers as RRCs pursuant to Section 1886(d)(5)(C)(i) of the Social Security Act. The provider argues that when CMS was due to conduct its first triennial RRC status review in 1987, Congress intervened and enacted a moratorium on the review to prevent the potential loss of RRC status already granted to certain providers.[5] When the second and third triennial review cycles approached in 1990 and in 1993, Congress again imposed moratoria to prevent CMS from reviewing, and potentially revoking, previously granted RRC status.[6] In 1994, however, after the third triennial review moratorium expired, CMS conducted its first triennial RRC status reviews and revoked the RRC status of a number of providers.[7]

In 1994, Congress enacted the Balanced Budget Act of 1997 ("BBA"). The Provider asserts that, in addition to limiting CMS' authority to reverse RRC status determinations,[8] the BBA reinstated the RRC status of those providers whose status CMS had revoked through triennial reviews conducted after the third statutory moratorium expired in 1994.[9] To comply with the clear intent of Congress to remove CMS authority to revoke RRC status based on periodic reviews, CMS deleted 42 C.F.R. §§412.96(f) and (g)(1)-(2), which authorized triennial reviews, in a final rule published May 12, 1998.[10] In the same final rule, CMS also clarified that it "eliminated our policy that terminated RRC status for any hospital that is reclassified as urban by the MGCRB."[11]

The Provider further argues that, according to the statutory and regulatory changes effected by the BBA and regulations, CMS has only two sources of authority for revoking RRC status:

(a) acceptance of provider's voluntary request for cancellation (42 C.F.R. §412.96(g)(1)); or
(b) upon reclassification of the provider's area as urban by the OMB.

CMS approved Provider's request for RRC status pursuant to 42 C.F.R. §412.96(c) in a letter dated July 14, 2005;[12] Provider did not voluntarily request cancellation of its previously granted RRC status; and the Provider's service area remains classified as micropolitan (*i.e.*, not urban) by

[3] See 63 Fed. Reg. 26,317, 26,326 (May 12, 1998).
[4] *Id.*
[5] 63 Fed. Reg. at 26,326.
[6] *Id*.
[7] *Id.*
[8] Balanced Budget Act of 1997 § 4202; Pub. L. No. 105-33, 111 Stat. 251.
[9] Balanced Budget Act at § 4202(b); Provider Exhibit 10.
[10] 63 Fed. Reg. 26,317 (May 12, 1998).
[11] 63 Fed. Reg. at 26,326.
[12] Exhibit P-4.

OMB.[13] The Provider argues that CMS therefore had no authority to revoke its RRC status on June 20, 2006 and acted contrary to the clearly expressed intent of Congress in the statute and to the Secretary's regulation.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that while 42 U.S.C. §1395ww(d)(5)(C) established a rural referral center classification, the statute left to the Secretary the authority to establish rules for its implementation, including any adjustment to payment rates. The Secretary fulfilled the statutory instruction to establish criteria by which a hospital may be classified as a rural referral center through the enactment of 42 C.F.R. §412.96. The Intermediary argues that regulations pertaining to subsection (c), under which the Provider attempted to qualify, make it clear that the case mix index data is to be taken "from the hospital's own billing records for Medicare discharges"[14] and those billing records are specific to a provider number.[15] To qualify for RRC status, a hospital's case mix index for discharges during the most recent Federal fiscal year that ended at least one year prior to the beginning of the cost reporting period for which the hospital is seeking referral center status must be at least equal to the national or the regional case mix index. Similarly, the number of discharges is to be derived from the same cost reporting period used by CMS in computing the national and regional median number of discharges in each year's annual notice of prospective payment rates. In this case, the national and median discharges were computed using 2002 discharge data. The Provider's Medicare provider number 01-0164 did not have any discharge data in 2002. Furthermore, a hospital must have had at least 5,000 discharges. The Provider under provider number 01-0164 had not been in operation for a period ending at least one year prior to the beginning of the cost reporting period for which it was seeking rural referral status and as a result, did not qualify for rural referral status under the criteria set out in the regulations.

The Intermediary contends that the Provider's rural referral center status was reversed because the Provider never qualified under the regulations by using its own data. Rather, the Provider used the data of another provider to qualify, and when that was discovered, CMS reversed its earlier approval.[16] As a result, the Intermediary argues that the Provider is not and was never a rural referral center. The Intermediary did not dispute Provider's argument that the regulation at 42 C.F.R. §413.96 indicates that, once rural referral status is granted, it is permanent, and there is no provision for revoking or rescinding it.[17] However, the Intermediary argues that CMS awarded the Provider's rural referral status in error and the Provider never validly qualified as a rural referral center.

[13] See OMB Bulletin No. 08-01: Update of Statistical Area Definitions and Guidance on Their Uses.
[14] TR. p. 18.
[15] TR. p. 19.
[16] Exhibit P-6.
[17] TR. p. 104-05.

Jurisdiction:

At the hearing, the Board raised concerns about whether the Provider's appeal met the jurisdictional requirements established under 42 C.F.R. §405.1835.[18] Under the regulation, a provider is entitled to a Board hearing if the matter meets each of the following criteria:

> "(1) An intermediary determination has been made with respect to the provider; and (2) the provider has filed a written request for a hearing before the Board under the provisions described in §405.1841(a)(1); and (3) the amount in controversy (as determined in § 405.1839(a)) is $10,000 or more."

The Board questioned whether the Provider met the amount in controversy requirements because there appeared to be no reimbursement effect as a result of the RRC determination itself. Rather any reimbursement effect depends on the determination that the provider can be redesignated as urban. That determination was reached by a separate board, the MGCRB. The Board directed the Provider to supply a post-hearing statement in support of its jurisdictional claim. The parties' contentions as to jurisdiction follow:

In its submission, the Provider compared the circumstances of its appeal to the requirements established by the regulations:

1. Intermediary Determination - 42 C.F.R. §405.1835(a)(1)

The Provider explained that it was appealing a decision of the Intermediary to reverse its status as a rural referral center (RRC) for fiscal year 2007 and, in promulgating its final rule on "Provider Reimbursement Determinations and Appeals," DHHS made clear that the denial of an acute care hospital's request for RRC status constitutes an "intermediary determination" within the meaning of 42 C.F.R. §405.1835(a)(1).[19] Specifically, DHHS stated that "other determinations made by the intermediary or CMS for hospitals and other providers are appealable to the intermediary or Board (depending on the amount in controversy). These include … a denial of a PPS hospital's request to be classified as a … "rural referral center."[20] The parties jointly stipulated that the Intermediary's June 20, 2006 rescision of the Provider's RRC status constitutes an "intermediary decision' within the meaning of 42 C.F.R. §405.1835(a)(1).[21]

2. Request for a hearing before the Board - 42 C.F.R. §405.1835(a)(2)

42 C.F.R. §405.1841(a) requires that the Board hearing request must be filed with the Board within 180 days of the date the notice of the intermediary's determination was mailed to the provider. The Intermediary's notice of reversal of the Provider's RRC status was dated June 20, 2006.[22] The Provider filed its request for a Board hearing on June 28, 2006, eight days after the intermediary's notice, and was therefore timely filed under 42 C.F.R. §405.1841(a)(1).

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[18] TR. pp. 180-199.
[19] 73 Fed. Reg. 30190, 30,191 (May 23, 2008.)
[20] Id.
[21] Provider's Post-Hearing Brief, Exhibit A at ¶1.
[22] Exhibit P-6.

1. Amount in controversy - 42 C.F.R. §405.1835(a)(3)

The regulation states that the amount in controversy required for a Board hearing be at least $10,000. As a part of the Provider's post-hearing submission, the parties jointly stipulated that the matter before the Board satisfies the amount in controversy criteria.[23]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, the parties' contentions and the evidence presented, the Board majority finds and concludes as follows:

1. Jurisdiction.

At one time, an RRC designation guaranteed automatic urban redesignation for the purposes of using the other area's wage index value which would increase Medicare payments.[24] However, CMS removed that provision from the regulation when it created the MGCRB in 1994. The revised regulation now requires providers to apply for redesignation based on various criteria.

Here, the Provider applied for redesignation from rural to urban for fiscal years 2006 and 2007. The MGCRB denied the Provider's application despite the Provider's 2005 RRC status because MGCRB rules expressly prohibit a provider from relying on records generated under previous ownership and there was no official wage data for this hospital's provider no. 01-0164 for the three-year period used to calculated the wage index. Without the urban designation by the MGCRB, the CMS revocation of RRC status in dispute in this appeal had no reimbursement effect for 2006 and 2007.

Although the RRC status approval had been revoked effective August 1, 2006, the MGCRB nevertheless granted the Provider's application for redesignation for FFYs 2008-2011 based on the Provider's own records and other criteria. Those other criteria included whether there had been any prior designation of the Provider as a RRC.

Citing the MGCRB's action for 2008-2011, the Provider argues that designation as a RRC at any time allows a provider to "maintain" its designation as urban and, consequently, revocation involves a reimbursement effect which meets the jurisdictional requirement for an amount in controversy. The Intermediary stipulated that the future impact satisfies the jurisdictional criteria.

The parties also cite the preamble to the Secretary's new regulations governing Board procedures that list RRC denials as an appealable "intermediary determination."[25] The Board notes, however, that the preamble also references that the intermediary determination is appealable subject to or depending on the amount in controversy. As noted above, there is no cost report reimbursement effect based on a RRC determination absent the MGCRB redesignation process.

[23] Provider's Post Hearing Brief, Exhibit A at ¶4.
[24] 42 C.F.R.§412.96(d).
[25] 73 Fed. Reg. 30190, 30,191(May 23, 2008.)

Consequently, the Board majority concludes there is no payment amount in dispute for the fiscal years under appeal and finds that it does not have jurisdiction over this appeal.

Because the Intermediary holds a position on jurisdiction that is contrary to the Board's finding, the Board will address the merits, assuming arguendo that the Board has jurisdiction.

2. Rescision of RRC Status.

It is undisputed that the change in ownership would not have prevented the Provider from qualifying for RRC status under the old owners records if the Provider had not refused to accept the assignment of the existing Medicare provider number. There are pros and cons to not accepting assignment and instead obtaining a new Medicare provider number. One benefit is that a new Medicare provider number limits the successor provider's (i.e., buyer's) liability for its predecessor's (i.e., seller's) debts to Medicare. On the other hand, for Medicare reimbursement purposes, a new provider (i.e., the buyer) cannot rely on or otherwise utilize any data pertaining to the old provider (i.e., the seller). The Provider testified that it carefully evaluated its decision to obtain a new provider number and that its decision was "well thought out."[26]

The Provider, nevertheless, originally proffered the prior owner's records to justify its entitlement to RRC status and the Intermediary and CMS accepted that data. Indeed, the Provider's reliance on the prior owner's records was fully disclosed and was considered as a part of CMS' approval.[27] However, CMS later changed its interpretation to require the use of the new provider's own records only and determined that it had granted RRC status in error.

The Provider argues that, regardless of whether its RRC status was granted in error, the BBA permanently removed CMS' authority to reverse RRC status after it has been granted [28] and even reinstated the RRC status of those providers whose status CMS revoked through triennial reviews. The Intermediary responds that *revocation* of the original decision (as opposed to termination) is not addressed in the statute or regulations and, therefore, there is no prohibition on CMS correcting its error.[29] The Board notes that the Intermediary furnished no authority addressing whether government has inherent power to correct its error or the validity of a government decision which wrongly grants a benefit to which the recipient was never legally entitled. The Provider counters that even if revocation is appropriate, CMS made no such revocation but rather left the 2006 decision intact. Consequently, CMS' action was not a rescission or revocation taking away the status back to its inception but was rather a termination prohibited by the statute and regulations.

The Board does not find support for the Provider's position that once RRC status is granted, it is permanent. The BBA sections relied on for that premise only apply to providers with RRC status as of 1991.[30] The parties have not proffered any other authority to demonstrate that

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[26] TR., p.41.
[27] TR., pp. 50-52; see also Exhibit P-3.
[28] Balanced Budget Act of 1997 § 4202; Pub. L. No. 105-33, 111 Stat. 251.
[29] TR., pp.23-28.
[30] BBA at § 4202(b). See, Provider Exhibit 10.

Congress limited CMS' ability to terminate RRC status beyond those years specifically referenced in the statute. In addition, subsection (a) on which the provider also relies, does not deal with RRC determinations. Rather it applies to MGCRB criteria for geographic reclassification which can result in higher reimbursement. The Board finds no prohibition on CMS to terminate or reverse a decision regarding RRC status for providers after 1991. This does not end the Board's inquiry, however, because fact issues remain as to what action CMS and the Intermediary actually took and the effect of such action.

The issue as posed by the parties is "whether the CMS reversal of the Provider's rural referral center classification was proper." Under the BBA sections cited above, the relevant inquiry before the MGCRB (but linked to this appeal) would be whether the hospital "has *ever* been classified as a rural referral center." The Intermediary argues that the revocation/reversal of the original decision, though "on a prospective basis," means that the RRC status was "never valid."[31] CMS explained its position in a letter directed to the House of Representatives in which it said that the Provider "was incorrectly awarded RRC status on the basis of data under the old provider number. We expect to inform the Atlanta Regional Office to suspend the hospital's RRC status until it can be reconsidered using data under the new provider number."[32] That letter was furnished as an attachment to CMS' letter that advised the provider that CMS was "reversing" its RRC approval determination effective August 1, 2006, but that the reversal would not affect the Provider's 2006 cost report reimbursement.[33]

The Board finds that, regardless of the terminology used by the parties, both the Intermediary and CMS allowed the Provider's 2006 RRC designation to remain in force by stating: "… this reversal does not affect your reimbursement for the 2006 cost reporting period during which time you were determined to be a rural referral center."[34] The Board finds these circumstances do not constitute an annulment of the CMS decision that granted RRC status to the Provider.[35] The decision was left intact for FY-2006 and, therefore, was not deemed invalid from the inception as the Intermediary argues. Consequently, the Intermediary's action regarding RRC status for 2007 does not deprive Provider of the criteria the MGCRB relies on for future years' classification: whether the Provider has ever been classified as an RRC.

The Board finds no basis for or prohibition against the Intermediary/CMS to revoke/reverse/suspend the prior decision for 2007. However, the Intermediary did not follow the process as detailed in 42 C.F.R. §405.1885 which outlines the specific requirements for reopening of an intermediary determination. In accordance with this regulation, the Intermediary/CMS may reopen its determination or decision for findings on matters at issue – RRC status approval granted in error or any other corrective action. The Intermediary did not follow this process and is now barred by the three year reopening limitation. Therefore, the Board concludes that the Intermediary/CMS' action of reversing the Provider's rural referral

[31] The Intermediary notes that there is no explanation why the revocation was prospective only. (See Intermediary Post Hearing brief, p. 5).
[32] Exhibit P-6.
[33] Id.
[34] Id.
[35] Exhibit P-4.

center status classification was not in accordance with the regulatory requirements and was, therefore, improper.

DECISION AND ORDER

1. Jurisdiction

There is no direct reimbursement impact based on an RRC determination absent the MGCRB redesignation which the MGCRB denied. Consequently, there is no payment amount in dispute for the fiscal year under appeal. The Board, therefore, does not have jurisdiction over this controversy.

2. Rescision of RRC Status

The Board finds no prohibition on the Intermediary/CMS' termination or reversal of a decision regarding RRC status for providers after 1991 provided the action complies with regulatory requirements for reopening. However, the Intermediary/CMS failed to follow the reopening provisions required by the Secretary in 42 C.F.R. §405.1885 and is now barred by the three year limitation on reversing its July 2005 determination to grant RRC status.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes
Keith E. Braganza, C.P.A. (Dissenting Opinion on Jurisdiction)
John Gary Bowers, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: November 22, 2010

Coosa Valley Hospital
Dissenting Opinion of Keith E. Braganza

I respectfully dissent from the opinion of the majority because I believe that the Provider does indeed meet the regulatory requirements for jurisdiction before the Provider Reimbursement Review Board (Board). The basis for my dissent is as follows.

The preamble to the regulation, 73 Fed. Reg. 30101, May 28, 2008 states:

> In addition to the NPR, other determinations made by the intermediary or CMS for hospitals and other providers are appealable to the intermediary or Board (depending on the amount in controversy). These include: . . . a denial of a PPS hospital's request to be classified as a sole community hospital (see §412.92) or a rural referral center."

In this case, the denial of the Provider's classification as a rural referral center, Exhibit P-6, was clearly appealable to the Board.

The denial letter from CMS states:

> For an FY 2007 reclassification, the data would have to be from the CMS wage survey used to construct the FY 2006 wage index. The CMS wage survey used to construct the FY 2006 wage index was based on the fiscal year ending 2002 cost report data. Because the hospital was first certified in 2004 under its current provider number, Coosa Valley Medical Center does not have the necessary wage data used to construct the FY 2006 wage index for its reclassification application. Without such data the hospital can not meet the regulatory threshold criteria and, therefore, will be ineligible for reclassification in FY 2007.

The denial of the Provider's RRC status was for FY 2007, i.e., the fiscal year beginning August 1, 2006.

The statute requires that any hospital desiring a change in geographic classification submit its request to the Medicare Geographic Classification Review Board (MGCRB). In rendering its decisions, the MGCRB follows guidelines published by the Secretary. Those guidelines include a special provision for a hospital which has ever been classified as a rural referral center. §1886(d)(10)((D)(iii). In this case, the Provider's previous classification as a RRC would assist in its request to the MGCRB.

The majority states:

> ". . . there is no direct reimbursement impact based on an RRC determination absent MGCRB redesignation process. Consequently, the Board concludes there is no payment amount in dispute for the fiscal year under appeal and finds that it does not have jurisdiction over this controversy."

I believe the majority places an incorrect emphasis on the interpretation of the word "direct". I agree that the Board's decision alone would have no effect on reimbursement, but that is not a bar to jurisdiction. The Board often renders decisions which do not have a "direct" reimbursement effect. For example, decisions "subject to audit by the fiscal intermediary" do not have a direct reimbursement effect on the Provider. An additional step is necessary (i.e., a satisfactory audit) before reimbursement is affected. Nevertheless, it can not be said that those Board decisions have no reimbursement effect. In other cases, a provider may appeal and request that if it prevails, the case be remanded to the intermediary. In those cases there is no "direct" reimbursement effect of the Board's favorable decision, but clearly the Board would have jurisdiction.

Equally significant, the majority emphasis on a "direct reimbursement impact" would render meaningless the preamble (73 Fed. Reg. 30191, May 23, 2008), which states that denial of a hospital's request to be classified as a rural referral center is appealable to the Board. In all such cases, a Board decision would still have to be followed by a positive decision of the MGCRB before reimbursement was affected. Therefore, if there was a requirement for a "direct" effect, the Board would never have jurisdiction. There would be no point in making the CMS denial of RRC status appealable, since jurisdiction could never be granted.

The majority also states that the amount in controversy is not met since the reimbursement effect is not in the same fiscal year as the subject of the decision being appealed. In my opinion, the relevant factor is the cause-and-effect relationship between the final determination being appealed and reimbursement to the hospital. For this purpose, the fiscal year is not relevant. The key is that the decision being appealed is the cause of the payment reduction to the hospital – and hence there is an amount in controversy.

In my opinion, in considering the amount in controversy, appeal of the denial of rural referral center status must take into account (simply for determining the amount in controversy) a favorable decision by the MGCRB. Since that decision would affect reimbursement to the Provider, there is an amount in controversy. I believe the Board has jurisdiction over the Provider's appeal.

Keith E. Braganza