DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2670

Phone: 410-786-2671
Internet: www.cms.gov/PRRBReview FAX: 410-786-5298

Refer to:

NOV 01 2013

CERTIFIED MAIL

Quality Reimbursement Services
J. C. Ravindran, President
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: Baptist Medical Center
Provider No. 10-0088
FYE 09/30/1998
as a participant in QRS 1998 DSH/SSI Proxy Group 3, PRRB Case No.: 08-2906G

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced appeal, and on its own motion noted a jurisdictional impediment to one of the participants in the group. The jurisdictional determination of the Board is set forth below.

Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a)(2004) and 42 C.F.R. §§ 405.1835 – 405.1841, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of the NPR.

Baptist Medical Center (participant #3) filed an appeal dated March 28, 2002 from both an original and a revised Notice of Program Reimbursement.[1] The original appeal request did not address the SSI Percentage issue, nor did the Provider submit any evidence showing the SSI issue was added to the individual appeal prior to the December 22, 2009 request to transfer the issue to the subject group appeal.

Consequently, the Board finds that it does not have jurisdiction over the SSI Percentage issue for Baptist Medical Center and hereby dismisses this participant from the group appeal.

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

[1] The original NPR was dated September 29, 2001 and the revised NPR was dated November 15, 2001.

Enclosed, please find a Standard Remand of the SSI Percentage issue for the remaining participants in the group.

Board Members
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Standard Remand of the SSI Percentage

cc: Kevin D. Shanklin, Executive Director, BCBSA

Wisconsin Physicians Service
Byron Lamprecht
Cost Report Appeals
P.O. Box 1604
Omaha, NE 68101

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Refer to:

NOV 01 2013

13-1177GC
Certified Mail

Christopher L. Keough, Esq.
Akin, Gump, Strauss, Hauer & Feld
Robert S. Strauss Building
1333 New Hampshire Avenue, NW
Washington, DC 20036-1564

RE: Eastern Niagara 2008 Rural Floor Budget Neutrality Group
Provider Nos. Various
FFY 12/31/2008 (appeal encompasses Federal FYs 2007 & 2008)
PRRB Case No. 13-1177GC

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' June 4, 2013 request for expedited judicial review (EJR) (received June 5, 2013) and the Providers' September 17, 2013 response (received September 18, 2013) to the Board's June 28, 2013 letter asking for comments on the Board's jurisdiction. On October 1, 2013, the employees of the Office of Hearings, including the staff of the Board were furloughed as the result of the lack of either a Federal fiscal year 2014 appropriation or continuing resolution. The Board resumed operating on October 17, 2013. Pursuant to the regulation 42 C.F.R. § 405.1803(d)(2008), the furlough extended the time to respond to the Providers' EJR request. This regulation states:

> (d) *Calculating time periods and deadlines*. In computing any period of time or deadline prescribed or allowed under this subpart or authorized by a reviewing entity the following principles are applicable:
>
> (1) The day of the act, event, or default from which the designated time period begins to run is not included.
>
> (2) Each succeeding calendar day, including the last day, is included in the designated time period, *except that, in calculating a designated period of time for an act by a reviewing entity, a day is not included where the reviewing entity is unable to conduct business in the usual manner due to extraordinary circumstances beyond its control such as* natural or other catastrophe, weather conditions, fire, or ***furlough***. In that case, the designated time period resumes

> when the reviewing entity is again able to conduct business in the usual manner. (emphasis added)

The time to respond to the Providers' EJR was extended for the 16 days during which the Board was unable to conduct business as a result of the furlough.

Background

The common issue in this group appeal concerns the budget neutrality adjustment to the standardized amount paid under the inpatient hospital prospective payment system (IPPS) to account for the effects of the rural floor on the PPS wage index. The Providers believe that the standardized amount[1] under IPPS was significantly understated due to errors in calculating the rural floor[2] budget neutrality[3] adjustment (RFBNA). As a result, the Providers' contend that their IPPS payments and related add-on payments were improperly reduced in the final determination of program reimbursement. The Providers are seeking a correction of their IPPS payments consistent with the decision in *Cape Cod Hospital v. Sebelius,* 630 F.3d 203 (D.C. Cir. 2011) (*Cape Cod).* In *Cape Cod,* the Court vacated the Federal fiscal year (FFY) 2007 and 2008 rules that yielded calculation errors for those years. The Centers for Medicare & Medicaid Services (CMS) corrected the error for later periods,[4] but has not made the corrections in the Notices of Program Reimbursement (NPR) under appeal here.

This group appeal contains two Providers, Inter-Community Memorial Hospital (provider number 33-0025) and Lockport Memorial Hospital (provider number 33-0163). Both Providers have a fiscal year ending (FYE) December 31st and both Providers filed a timely appeal of its NPR for FYE December 31, 2008.

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[1] The statute, 42 U.S.C. § 1395ww(d)(2)(A), required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The base-year cost data were used in the initial development of the standardized amounts for PPS which were then used to compute the Federal rates. The standardized amounts are based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. § 1395ww(d). Section 1395ww(d)(2)(C) requires that updated base-year per discharge costs be standardized in order to adjust data which might cause variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments (for Alaska and Hawaii), indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994).

[2] Section 4410 of the Balanced Budget Act of 1997 (BBA of 1997) established the rural floor by requiring that the wage index of a hospital in any urban area cannot be less than the wage index determined for the state's rural area. Since Federal fiscal year (FFY) 1998, CMS has implemented the budget neutrality requirement of this provision by adjusting the standardized amounts. 72 Fed. Reg. 24680, 24787 (May 3, 2007). In establishing the PPS standardized amount for FFY 2007 and for prior Federal fiscal years, CMS adjusted the standardized amount downward to account for the effects of the rural floor. *See e.g.,* 71 Fed. Reg. 48145-48 (August 18, 2006).

[3] Budget neutrality is determined by comparing aggregate IPPS payments before and after making changes that are required to be budget neutral (e.g., reclassifying and recalibrating the diagnostic related groups (DRGs)). Outlier payments are also included in the simulations. *Id.* at 48147.

[4] *See* 76 Fed. Reg. 51476, 51788-9 (August 18, 2011). The Secretary made a correction to 1.1 percent adjustment to the standardized amount in the FFY 2012 final IPPS rules in recognition of the decision in *Cape Cod.*

Pursuant to 42 C.F.R. § 405.1835(a)(1)(ii) (2008), effective with cost reporting periods that end on or after December 31, 2008, where a provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy, the provider must file these items under protest on its cost report. 42 C.F.R. § 405.1835(b)(1)(iii) specifies that, for an initial hearing request involving self-disallowed costs, the provider must include the "amount of each self-disallowance and the reimbursement or payment sought for each item."

In its June 28, 2013 letter, the Board asked whether the Providers included the RFBNA issue on their respective cost reports as a protested item, and, if they did, to furnish the cost report pages evidencing this claim. Further, if the Providers did not believe that 42 C.F.R. § 405.1835(a)(1)(ii) is applicable in this case, they were to submit a jurisdictional brief explaining their position.

Providers' Position

The Providers concede that they did not claim the RFBNA as a protested item on their respective cost reports.[5] The Providers assert that the Board has jurisdiction over the issue for the reasons set forth below.

No Access to Data

The Providers have claimed dissatisfaction with their Medicare payments as required by 42 C.F.R. § 405.1835(a)(1). They complied with cost report instructions when they included an inaccurate and understated amounts resulting from the agency's error when it calculated the RFBNA. They believe this meets the regulatory requirement to present this issue in their cost reports. Further, they posit that, at the time they filed their cost reports, they lacked access to the information that would have enabled them to discover the underpayment because, although the CMS had made an error, it had not accurately described the payment calculation that produced the errors or notified hospitals of the error.[6] The Providers believe this created a practical impediment to self-disallowance on their cost reports which is similar to a legal impediment in claiming dissatisfaction.

The Providers point out that 42 C.F.R. § 405.1835(b)(2)(i), which specifies the contents of a hearing request, requires a provider to explain why its believes the payment is incorrect for each disputed item or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment. In addition, the Providers point to Board Rule 7 which addresses the contents of hearing requests that are appealing self-disallowed items. Board Rule 7.2.A[7] requires that providers identify the authority which predetermined that the self-disallowed item would not be allowed and Board Rule 7.2.C requires that, for cost reporting periods ending on or after December 31, 2008, providers protest self-disallowed costs. But the Providers believe that Rule 7.2.B recognizes that a provider may not claim an item on its cost report because it lacks the underlying information necessary to make a claim.[8] The Providers contend that this was the circumstance present here, namely that they simply were not aware of the underlying problem.

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[5] Providers' Juris. Br. at 2.
[6] *Id.* at 11.
[7] The Board's Rules can be found on the internet at www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB_Instructions.html.
[8] Providers' Juris. Br. *at 14.*

Application of *Bethesda Hospital Ass'n v. Bowen, 485 U.S., 485 U.S. 399 (1988) (Bethesda)*

Requirement to Claim Costs

The Providers believe that the Supreme Court decision in *Bethesda* is applicable to this case because this is a case in which the Providers could claim dissatisfaction, within the meaning of the statute, without first incorporating their challenge in the cost report. The Providers argue that the Secretary is bound by the Court's unambiguous text and interpretation. The Secretary cannot limit mandatory jurisdiction conferred by Congress in 42 U.S.C. § 1395oo(a)(1)(A) where a provider is entitled to a hearing where it "is dissatisfied with a final determination" as to the amount of payment or the "amount of total reimbursement due the provider . . . for the period covered by the cost report." The Providers point out that in *Bethesda* the Supreme Court stated that there is no statutory requirement that expressly mandates that a challenge to the validity of a regulation first be submitted to the intermediary. The Court also noted that the Board could hear matters that were not considered by the intermediary. The Providers assert that they included the disputed item (DRG payment amounts) in their cost reports but limited the amounts included in conformance with CMS rules. They are now challenging dissatisfaction with the final determination of the amount of program reimbursement.

Further, the Court in *Bethesda* stated that the "language and design of the statute as a whole" confirms that Congress did not intend to divest the Board of jurisdiction over matter merely because they were "not contested" before the intermediary.[9] The Court noted that the statute expressly contemplates that the Board can engage in its own fact finding and make decisions using not only "evidence considered by the intermediary" but also "such other evidence as may be obtained by the Board. 42 U.S.C. § 1395oo(d). This statute also permits the Board to "affirm, modify, or reverse a final determination "over matters covered by the cost report" even though such matters were not considered by the intermediary in making such final determination." *Id.* The Providers assert that the *Bethesda* Court's "prior judicial construction of the statute trumps any contrary agency construction."[10]

Ambiguity

The Providers assert that even if the statutory language is ambiguous (which they assert it is not), the ambiguity must be resolved in favor of the Providers. The finding of jurisdiction in this case is not a prelusion to administrative review, but judicial review. There would be no administrative review because the Providers are requesting a finding that the Board lacks the authority to decide the question and that EJR is appropriate. The Providers note that there is a strong presumption that Congress intends judicial review of administrative actions. Since the statute's dissatisfaction requirement does not require presentment to the intermediary of an undiscoverable error related to CMS' setting the PPS regulations for 2008, which is beyond the scope of the Board's authority, it cannot be interpreted to preclude the Board's jurisdiction on the basis of failure to present their challenges to the Intermediary.[11]

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[9] *Bethesda* at 485 U.S. at 405-406.
[10] Providers' Juris. Br. *at 17.*
[11] *Id. at 17-18.*

Declining to Issue an EJR Determination Based on Lack of Jurisdiction

The Providers contend that because the statute confers jurisdiction on the Board to decide this appeal, the Board cannot decline to issue a determination on EJR on the grounds that the regulation limits its jurisdiction. They argue that Congress alone controls the Board's jurisdiction and CMS may not "conjure up new 'jurisdictional' limitations to require or allow the Board to 'refus[e] to adjudicate cases on the false premise that it lack[s] power to hear them'."[12] The Providers do not believe that rules and regulations that are inconsistent with the Medicare Act can be enacted and the Board has no discretion to reject and appeal that is within the scope of 42 U.S.C. § 1395oo.

The Providers assert that this case involves different circumstances from cases in which the courts have held that the Board has discretion to decide the question before it under 42 U.S.C § 1395oo(d). They reason that the Board does not have the power to accept or reject appeals where the statutory requirements of § 1395oo(a) have been met. The Board should decide that EJR is appropriate.

The Providers point out that the decision in *Cape Cod* was not issued until 2011, consequently they could not have known there was a problem with the RFBNA nor could they have protested the issue on their cost reports (which were filed with the Intermediary in 2009).

Denial of Jurisdiction Would be Arbitrary, Capricious and Unreasonable

The Providers contend that the protest requirement rests on an internally inconsistent rationale and unreasonably requires exhaustion before the intermediary when it would be entirely futile. Further, in these cases, protesting rests on an internally inconsistent rationale and unreasonably requires exhaustion before the Intermediary, when to do so would be futile. Protesting was impossible due to the Agency's actions and Providers' the inability to obtain data to support any claim related to the RFBNA. It is particularly irrational to demand exhaustion where the error at issue is "a system wide, unrevealed policy that was inconsistent with established regulations."[13]

The Secretary acknowledged in the preamble to the May 23, 2008, final Board regulations in the Federal Register, that there may be instances in which a provider may be uncertain as to whether Medicare payment is incorrect because it does not have access to the underlying data.[14] The Providers believe the Secretary is aware of the practical difficulties in discovering errors in underlying government data. Consequently, it would be arbitrary and capricious for the Board to ignore the fact the Providers lacked access, at the time the cost report was filed, to the data needed to identify the disputed items.

To the extent that the regulation requiring protest of an item on a cost report and failure to do so is to deny hospitals the right to appeal and the regulation is invalid as applied. The Providers point out that CMS cannot credibly contend that it did not have all the notice regarding the problem before this appeal was filed in 2013, since the D.C. Circuit court ruled in favor of the providers for the FFYs 2007 and 2008.[15]

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[12] *Id.* at 18 citing *Union Pac.R.Co. v. BHD of Locomotive Engineers & Trainmen Gen Comm.of Adjustment, Cent. Reg.*, 558 U.S. 67, 86 (2009). *See also Luna v. Holder*, 637 F. 3d 85, 100 (2d Cir. 2011) ("The power to establish jurisdictional bars resides with Congress alone.").

[13] Providers' Juris. Br. at 23, citing *Bowen v. City of New York*, 476 U.S. 467, 485 (1986).

[14] 73 Fed. Reg. at 30,194.

[15] Providers' Juris. Br.. *at 25.*

Denial of Jurisdiction would be Unconstitutional

The constitutional question arises where all review is precluded simply because, not through lack of diligence, but lack of data to precisely identify the agency's errors the Providers are precluded from obtaining review. This gives rise to due process claims and the Providers do not believe Congress intended to preclude judicial review in these circumstances. The regulation, 42 C.F.R. § 405.1835(a)(1)(ii), is inconsistent with 42 U.S.C. § 1395oo which, the Providers assert, permits jurisdiction over the RFBNA issue. Reimbursement is a property interest protected by the constitution, and the regulation cannot be applied to constrict statutorily conferred jurisdiction. Since CMS knew of the error, it should have corrected it before the Notices of Program Reimbursement were issued in 2012.[16]

Decision of the Board

The Board concludes that it lacks jurisdiction over the Providers' appeal of the RFBNA issue. Since jurisdiction is a prerequisite to granting EJR, the Providers' request for EJR is hereby denied. Pursuant to 42 C.F.R. § 405.1867, the Board is bound by the requirements of the regulations. The regulation, 42 C.F.R. § 405.1835(a)(1)(ii), requires that for cost reporting periods ending on or after December 31, 2008, self-disallowed costs must be claimed as protested amounts on a provider's cost report. The Board cannot circumvent this requirement because there are no exceptions permitted under the regulation as promulgated.

The Providers point to 42 C.F.R. § 405.1835(b)(2)(i) (and Board Rule 7.2 which mirrors this regulation) which requires a provider to explain why it believes its Medicare payment is incorrect for each disputed item, or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to the underlying information concerning the calculation of its payment. However, the Providers did not include the introductory paragraph to this section of the regulation 42 C.F.R. § 405.1835(b)(1) which requires a provider appeal to:

> Demonstrate that the provider satisfies the requirements for a Board hearing as specified in paragraph [42 C.F.R. § 405.1835] (a) of this section . . .

Paragraph 405.1835(a) includes the requirement for claiming self-disallowed costs as protested amounts. The Providers have conceded that they did not comply with this requirement. The Board is bound by the specific requirement that a provider must claim any self-disallowed costs, even if the provider does not know the exact amount of reimbursement it would have received if it had full access to the information that gave rise to the dispute.

The Providers also point to the Supreme Court's decision in *Bethesda* to support the proposition that entitled to a Board hearing does not require a claim for dissatisfaction on the cost report, where a provider complied with the regulations in filing its cost report. Further, they note the Court pointed out the language and design of the statute, taken as a whole, was not intended to divest the Board of jurisdiction over matters merely because they were not considered by the intermediary. In addition, 42 U.S.C. § 1395oo(d) permits the Board to engage in its own fact finding and make

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[16] *Id. at 27-28.*

decisions using not only evidence considered by the intermediary, but other evidence obtained by the Board. The Board can affirm modify or reverse a final determination of the intermediary even though such matters were not considered by the intermediary.[17]

However, this argument omitted other language in *Bethesda* in which the Court noted that had a regulatory requirement to claim costs been in place, it could have changed the outcome of the case:

> . . . it is clear, however, that the submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations. No statute or regulation expressly mandates that a challenge to the validity of a regulation be submitted first to the intermediary . . . .Thus, [the providers in *Bethesda*] stand on different ground than to providers who bypass clearly prescribed exhaustion requirements or who fail to request from the intermediary reimbursement for cost to which they are entitled under the applicable rules. While such defaults might well establish that a provider was satisfied with the amounts requested in its cost report and awarded by the intermediary, those circumstances are not present here.[18]

In the preamble to the Board's new regulations, the Secretary noted that the Court recognized than an exhaustion requirement could be imposed by regulation, and that a provider who fails to claim all costs to which it is entitled may fail to meet the jurisdictional prerequisite of dissatisfaction.[19] There is nothing in the statute indicating that the Secretary cannot interpret the dissatisfaction requirement must be expressed with respect to each claim.[20] The final determination, which here is the NPR, is not just the total amount of program reimbursement. Rather, it is composed of many individual calculations representing the various items which a provider seeks payment. Providers generally challenge discrete reimbursement items. Thus dissatisfaction with total reimbursement is based on dissatisfaction with items that result in total reimbursement. Consequently, the Secretary believes it is reasonable under 42 C.F.R. § 1395oo(a) to require dissatisfaction be shown with respect to each issue being appealed.[21] In light of this and the requirements of the regulation, the RFBNA must be claimed as a protested item and the Providers failed to comply with this requirement.

The fact that the Providers believe that to deny jurisdiction over this appeal would be unconstitutional is not a question that can be addressed by the Board. The Board is required to follow the regulations issued by the Secretary. The regulations require that the Providers claim dissatisfaction with the RFBNA issue as a protested item on their cost reports.

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[17] *Id.* at 16.
[18] *Bethesda* at 404-405.
[19] 73 Fed. Reg. at 30196.
[20] *Id.* at 30197.
[21] *Id.*

The Board notes that the cost report (including the procedures for filing a cost report under protest) are based on the provider's obligation to provide information that the Secretary requires to determine payment. In this regard, 42 U.S.C. § 1395g(a) specifies in pertinent part:

> (a) The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it . . . ; except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.

CMS has historically set forth the rules governing items filed under protest in Provider Reimbursement Manual (PRM) 15-2 § 115 *et seq.* and specified what information providers are required to furnish for items under protest in PRM 15-2 §§ 115.1 and 115.2:

> 115.1 **Provider Disclosure of Protest**.--When you file a cost report under protest, the disputed item and amount *for each issue* must be specifically identified in footnotes to the settlement worksheet and the fact that the cost report is filed under protest must be disclosed.
>
> 115.2 **Method for Establishing Protested Amounts**.--The effect of *each nonallowable cost report item is estimated* by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. In addition, *you must submit*, with the cost report, *copies of the working papers used to develop the estimated adjustments* in order for the contractor/contractor to evaluate the reasonableness of the methodology for purposes of establishing whether the cost report is acceptable. The cumulative effect on reimbursement for all disputed issues is shown as an adjustment to balance due to the program (provider) in the reimbursement settlement computation. The actual effect on reimbursable cost(s) is determined after final adjudication of the issue(s).[22]

For purposes of IPPS providers, filing a cost report under protest is achieved by entering such costs on Worksheet E, Part A, Line 30 of the cost report. In this regard, PRM 15-2 § 3630.1 requires that IPPS providers:

> Enter the program reimbursement effect of the protested items. Estimate the reimbursement effect of the

[22] (Italics emphasis added.)

> nonallowable cost items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process (See § 115.2). Attach a schedule showing the details and the computation for this line.

Effective with cost report periods that end on or after December 31, 2008, CMS amended the regulations governing cost report appeals to incorporate PRM 15-2 § 115 *et seq.* into the regulations at 42 C.F.R. § 405.1835(a)(1)(ii) (2008) by specifying that, where a provider seeks payments that it believes may not be allowable or may not be in accordance with Medicare policy, the provider must claim the items as self-disallowed costs "by following the applicable procedures for filing a cost report under protest." In promulgating this regulation, CMS included the following discussion in the preamble to the final rule published on May 23, 2008 ("2008 Final Rule")[23]:

> **Comment:** One commenter recommended that the text of section 115 *et seq.* of the PRM, Part II, be placed in the regulations. The commenter noted that these sections of the PRM have not changed since 1980. . . .
>
> **Response:** We are adopting the proposal, which is essentially a codification of the protested amount line procedures set forth in section 115 *et seq.* of the PRM, Part II.[24]

Thus, the preamble to the 2008 Final Rule confirms CMS' intent that 42 C.F.R. § 405.1835(a)(1)(ii) codified the PRM 15-2 rules governing cost reports filed under protest. Here, the Providers failed to preserve their right to appeal the RFBNA issue by following the PRM 15-2 rules governing cost reports filed under protest in compliance with 42 C.F.R. § 405.1835(a)(1)(ii). As a result, the Board concludes that it lacks jurisdiction over the Providers' appeal of the RFBNA issue.

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[23] 73 Fed. Reg. 30190 (May 23, 2008).

[24] *Id.* at 30195. Similarly, the preamble to the 2008 Final Rule states the following regarding the documentation requirements for filing a cost report under protest: "We are attempting to strike a balance between, on the one hand, having provider present enough information so as to put the intermediaries on notice as to the actual or potential reimbursement disputes, and, on the other hand, not making it unduly burdensome for providers to file cost reports." *Id.* The preamble further states: "We believe it reasonable to require provider to notify their intermediaries, via their cost report submission, of all items for which they potentially may be claiming reimbursement." *Id.* at 30198.

Since there are no other issues pending before the Board in this case, the case is closed. Review of this determination is available under the provisions 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating

Michael W. Harty
John Gary Bowers, CPA
L. Sue Anderson, Esq.

FOR THE BOARD:

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kyle Browning, NGS (w/Schedule of Providers)
Kevin Shanklin, BCBSA (w/Schedule of Providers)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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13-0986G
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NOV 01 2013

Christopher L. Keough, Esq.
Akin, Gump, Strauss, Hauer & Feld
Robert S. Strauss Building
1333 New Hampshire Avenue, NW
Washington, DC 20036-1564

RE: # 4. Brooklyn Hospital Center, Provider No. 33-0056, FYE 12/31/2008
5. United Memorial Medical Center, Provider No. 33-0073, FYE 12/31/2008
6. Glenn Falls Hospital, Provider No. 33-0191, FYE 12/31/2008
7. Erie County Medical Center, Provider No. 33-0219, FYE 12/31/2008
8. Woman's Christian Association Hospital, Provider No. 33-0239, FYE 12/31/2008
9. Hospital for Special Surgery, Provider No. 33-0270, FYE 12/31/2008
#10. Catskill Regional Medical Center, Provider No. 33-0386, FYE 12/31/2008

as participants in the

Akin Gump 2008 Rural Floor Budget Neutrality Group[1]
FFY 2008
PRRB Case Number 13-0986G

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' June 4, 2013 request for expedited judicial review (EJR) (received June 5, 2013) and the Providers' September 17, 2013 response (received September 18, 2013) to the Board's June 28, 2013 letter asking for

[1] The Providers listed below were also included on the Schedule of Providers for this group appeal:
1. Piedmont Henry, Provider No. 11-0191, FYE 6/30/2008
2. Kalispell Regional Medical Center, Provider No. 27-0051, FYE 3/31/2008
3. University of New Mexico Hospital, Provider No. 32-0001, FYE 6/30/2008
#11. CarolinaEast Medical Center, Provider No. 34-0131, FYE 9/30/2008
#12. Tuality Community Hospital, Provider No. 38-0021, FYE 9/30/2008
#13. Oconee Medical Center, Provider 42-0009, FYE 9/30/2008
They have been dismissed from the appeal in a separate decision because the Board concluded it lacked jurisdiction over these Providers on a different basis than discussed in this determination. In the jurisdiction decision for the Providers identified in this footnote, the Board determined it lacked jurisdiction over the appeal of the budget neutrality adjustment under 42 U.S.C. § 1395oo(g) and 42 C.F.R. § 405.1804.

comments on the Board's jurisdiction. On October 1, 2013, the employees of the Office of Hearings, including the staff of the Board, were furloughed as the result of the lack of either a Federal fiscal year 2014 appropriation or continuing resolution. The Board resumed operating on October 17, 2013. Pursuant to the regulation 42 C.F.R. § 405.1803(d)(2008), the furlough extended the time to respond to the Providers' EJR request. This regulation states:

> (d) *Calculating time periods and deadlines*. In computing any period of time or deadline prescribed or allowed under this subpart or authorized by a reviewing entity the following principles are applicable:
>
> (1) The day of the act, event, or default from which the designated time period begins to run is not included.
>
> (2) Each succeeding calendar day, including the last day, is included in the designated time period, *except that, in calculating a designated period of time for an act by a reviewing entity, a day is not included where the reviewing entity is unable to conduct business in the usual manner due to extraordinary circumstances beyond its control such as* natural or other catastrophe, weather conditions, fire, or ***furlough***. In that case, the designated time period resumes when the reviewing entity is again able to conduct business in the usual manner. (emphasis added)

The time to respond to the Providers' EJR was extended for the 16 days during which the Board was unable to conduct business as a result of the furlough.

Background

The common issue in this group appeal concerns the budget neutrality adjustment to the standardized amount paid under the inpatient hospital prospective payment system (IPPS) to account for the effects of the rural floor on the PPS wage index. The Providers believe that the standardized amount[2] under IPPS was significantly understated due to errors in calculating the

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[2] The statute, 42 U.S.C. § 1395ww(d)(2)(A), required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The base-year cost data were used in the initial development of the standardized amounts for PPS which were then used to compute the Federal rates. The standardized amounts are based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. § 1395ww(d). Section 1395ww(d)(2)(C) requires that updated base-year per discharge costs be standardized in order to adjust data which might cause variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments (for Alaska and Hawaii), indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994).

rural floor[3] budget neutrality[4] adjustment (RFBNA). As a result, the Providers' contend that their IPPS payments and related add-on payments were improperly reduced in the final determination of program reimbursement. The Providers are seeking a correction of their IPPS payments consistent with the decision in *Cape Cod Hospital v. Sebelius,* 630 F.3d 203 (D.C. Cir. 2011) (*Cape Cod).* In *Cape Cod,* the Court vacated the Federal fiscal year (FFY) 2007 and 2008 rules that yielded calculation errors for those years. The Centers for Medicare & Medicaid Services (CMS) corrected the error for later periods,[5] but has not made the corrections in the Notices of Program Reimbursement (NPR) under appeal here.

This group appeal contains seven Providers, with cost report periods ending on December 31, 2008. Pursuant to 42 C.F.R. § 405.1835(a)(1)(ii) (2008), effective with cost reporting periods that end on or after December 31, 2008, where a provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy, the provider must file these items under protest on its cost report. 42 C.F.R. § 405.1835(b)(1)(iii) specifies that, for an initial hearing request involving self-disallowed costs, the provider must include the "amount of each self-disallowance and the reimbursement or payment sought for each item."

In its June 28, 2013 letter, the Board asked whether the Providers included the RFBNA issue on their respective cost reports as a protested item, and, if they did, to furnish the cost report pages evidencing this claim. Further, if the Providers did not believe that 42 C.F.R. § 405.1835(a)(1)(ii) is applicable in this case, they were to submit a jurisdictional brief explaining their position.

Providers' Position

The Providers concede that they did not claim the RFBNA as a protested item on their respective cost reports.[6] The Providers assert that the Board has jurisdiction over the issue for the reasons set forth below.

No Access to Data

The Providers have claimed dissatisfaction with their Medicare payments as required by 42 C.F.R. § 405.1835(a)(1). They complied with cost report instructions when they included an inaccurate and understated amounts resulting from the agency's error when it calculated the RFBNA. They believe this meets the regulatory requirement to present this issue in their cost reports. Further, they

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[3] Section 4410 of the Balanced Budget Act of 1997 (BBA of 1997) established the rural floor by requiring that the wage index of a hospital in any urban area cannot be less than the wage index determined for the state's rural area. Since Federal fiscal year (FFY) 1998, CMS has implemented the budget neutrality requirement of this provision by adjusting the standardized amounts. 72 Fed. Reg. 24680, 24787 (May 3, 2007). In establishing the PPS standardized amount for FFY 2007 and for prior Federal fiscal years, CMS adjusted the standardized amount downward to account for the effects of the rural floor. *See e.g.,* 71 Fed. Reg. 48145-48 (August 18, 2006).

[4] Budget neutrality is determined by comparing aggregate IPPS payments before and after making changes that are required to be budget neutral (e.g., reclassifying and recalibrating the diagnostic related groups (DRGs)). Outlier payments are also included in the simulations. *Id.* at 48147.

[5] *See* 76 Fed. Reg. 51476, 51788-9 (August 18, 2011). The Secretary made a correction to 1.1 percent adjustment to the standardized amount in the FFY 2012 final IPPS rules in recognition of the decision in *Cape Cod.*

[6] Providers' Juris. Br. at 2.

posit that, at the time they filed their cost reports, they lacked access to the information that would have enabled them to discover the underpayment because, although the CMS had made an error, it had not accurately described the payment calculation that produced the errors or notified hospitals of the error.[7] The Providers believe this created a practical impediment to self-disallowance on their cost reports which is similar to a legal impediment in claiming dissatisfaction.

The Providers point out that 42 C.F.R. § 405.1835(b)(2)(i), which specifies the contents of a hearing request, requires a provider to explain why its believes the payment is incorrect for each disputed item or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment. In addition, the Providers point to Board Rule 7 which addresses the contents of hearing requests that are appealing self-disallowed items. Board Rule 7.2.A[8] requires that providers identify the authority which predetermined that the self-disallowed item would not be allowed and Board Rule 7.2.C requires that, for cost reporting periods ending on or after December 31, 2008, providers protest self-disallowed costs. But the Providers believe that Rule 7.2.B recognizes that a provider may not claim an item on its cost report because it lacks the underlying information necessary to make a claim.[9] The Providers contend that this was the circumstance present here, namely that they simply were not aware of the underlying problem.

Application of *Bethesda Hospital Ass'n v. Bowen, 485 U.S., 485 U.S. 399 (1988) (Bethesda)*

Requirement to Claim Costs

The Providers believe that the Supreme Court decision in *Bethesda* is applicable to this case because this is a case in which the Providers could claim dissatisfaction, within the meaning of the statute, without first incorporating their challenge in the cost report. The Providers argue that the Secretary is bound by the Court's unambiguous text and interpretation. The Secretary cannot limit mandatory jurisdiction conferred by Congress in 42 U.S.C. § 1395oo(a)(1)(A) where a provider is entitled to a hearing where it "is dissatisfied with a final determination" as to the amount of payment or the "amount of total reimbursement due the provider . . . for the period covered by the cost report." The Providers point out that in *Bethesda* the Supreme Court stated that there is no statutory requirement that expressly mandates that a challenge to the validity of a regulation first be submitted to the intermediary. The Court also noted that the Board could hear matters that were not considered by the intermediary. The Providers assert that they included the disputed item (DRG payment amounts) in their cost reports but limited the amounts included in conformance with CMS rules. They are now challenging dissatisfaction with the final determination of the amount of program reimbursement.

Further, the Court in *Bethesda* stated that the "language and design of the statute as a whole" confirms that Congress did not intend to divest the Board of jurisdiction over matter merely because they were "not contested" before the intermediary.[10] The Court noted that the statute expressly contemplates that the Board can engage in its own fact finding and make decisions using not only "evidence considered by the intermediary" but also "such other evidence as may be obtained by the Board. 42 U.S.C. § 1395oo(d). This statute also permits the Board to "affirm, modify, or reverse a

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[7] *Id.* at 2-3.
[8] The Board's Rules can be found on the internet at www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB_Instructions.html.
[9] Providers' Juris. Br. *at 14.*
[10] *Bethesda* at 485 U.S. at 405-406.

final determination "over matters covered by the cost report" even though such matters were not considered by the intermediary in making such final determination." *Id.* The Providers assert that the *Bethesda* Court's "prior judicial construction of the statute trumps any contrary agency construction."[11]

Ambiguity

The Providers assert that even if the statutory language is ambiguous (which they assert it is not), the ambiguity must be resolved in favor of the Providers. The finding of jurisdiction in this case is not a prelusion to administrative review, but judicial review. There would be no administrative review because the Providers are requesting a finding that the Board lacks the authority to decide the question and that EJR is appropriate. The Providers note that there is a strong presumption that Congress intends judicial review of administrative actions. Since the statute's dissatisfaction requirement does not require presentment to the intermediary of an undiscoverable error related to CMS' setting the PPS regulations for 2008, which is beyond the scope of the Board's authority, it cannot be interpreted to preclude the Board's jurisdiction on the basis of failure to present their challenges to the Intermediary.[12]

Declining to Issue an EJR Determination Based on Lack of Jurisdiction

The Providers contend that because the statute confers jurisdiction on the Board to decide this appeal, the Board cannot decline to issue a determination on EJR on the grounds that the regulation limits its jurisdiction. They argue that Congress alone controls the Board's jurisdiction and CMS may not "conjure up new 'jurisdictional' limitations to require or allow the Board to 'refus[e] to adjudicate cases on the false premise that it lack[s] power to hear them'."[13] The Providers do not believe that rules and regulations that are inconsistent with the Medicare Act can be enacted and the Board has no discretion to reject an appeal that is within the scope of 42 U.S.C. § 1395oo.

The Providers assert that this case involves different circumstances from cases in which the courts have held that the Board has discretion to decide the question before it under 42 U.S.C § 1395oo(d). They reason that the Board does not have the power to accept or reject appeals where the statutory requirements of § 1395oo(a) have been met. The Board should decide that EJR is appropriate.

The Providers point out that the decision in *Cape Cod* was not issued until 2011. Consequently, the Providers could not have known there was a problem with the RFBNA nor could they have protested the issue on their cost reports (which were filed with the Intermediary in 2009).

Denial of Jurisdiction Would be Arbitrary, Capricious and Unreasonable

The Providers contend that the protest requirement rests on an internally inconsistent rationale and unreasonably requires exhaustion before the intermediary when it would be entirely futile. Further, in these cases, protesting rests on an internally inconsistent rationale and unreasonably requires exhaustion before the Intermediary, when to do so would be futile. Protesting was impossible due to the Agency's actions and the Providers' inability to obtain data to support any claim related to the

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[11] Providers' Juris. Br. at 17.
[12] *Id. at 17-18.*
[13] *Id.* at 19 (citing *Union Pac.R.Co. v. BHD of Locomotive Engineers & Trainment Gen Comm.of Adjustment, Cent. Reg.*, 558 U.S. 67, 86 (2009)). *See also Luna v. Holder*, 637 F. 3d 85, 100 (2d Cir. 2011) ("The power to establish jurisdictional bars resides with Congress alone.").

RFBNA. It is particularly irrational to demand exhaustion where the error at issue is "a system wide, unrevealed policy that was inconsistent with established regulations."[14]

The Secretary acknowledged in the preamble to the May 23, 2008, final Board regulations in the Federal Register, that there may be instances in which a provider may be uncertain as to whether Medicare payment is incorrect because it does not have access to the underlying data.[15] The Providers believe that the Secretary is aware of the practical difficulties in discovering errors in the underlying government data. Consequently, it would be arbitrary and capricious for the Board to ignore the fact that the Providers lacked access, at the time the cost report was filed, to the data needed to identify the disputed items.

To the extent that the regulation requiring protest of an item on a cost report and failure to do so is would deny the Providers' right to appeal this matter, the Providers contend that that regulation is invalid as applied. The Providers point out that CMS cannot credibly contend that it did not have complete notice of the problem before this appeal was filed in 2013, since the D.C. Circuit court ruled in favor of the *Cape Cod* providers for the FFYs 2007 and 2008.[16]

Denial of Jurisdiction would be Unconstitutional

The constitutional question arises where all review is precluded simply because, not through lack of diligence, but lack of data to precisely identify the agency's errors the Providers are precluded from obtaining review. This gives rise to due process claims and the Providers do not believe Congress intended to preclude judicial review in these circumstances. The regulation, 42 C.F.R. § 405.1835(a)(1)(ii), is inconsistent with 42 U.S.C. § 1395oo which, the Providers assert, permits jurisdiction over the RFBNA issue. Reimbursement is a property interest protected by the constitution, and the regulation cannot be applied to constrict statutorily conferred jurisdiction. Since CMS knew of the error, it should have corrected it before the Notices of Program Reimbursement were issued in 2012.[17]

Decision of the Board

The Board concludes that it lacks jurisdiction over the Providers' appeal of the RFBNA issue. Since jurisdiction is a prerequisite to granting EJR, the Providers' request for EJR is hereby denied. Pursuant to 42 C.F.R. § 405.1867, the Board is bound by the requirements of the regulations. The regulation, 42 C.F.R. § 405.1835(a)(1)(ii), requires that for cost reporting periods ending on or after December 31, 2008, self-disallowed costs must be claimed as protested amounts on a provider's cost report. The Board cannot circumvent this requirement because there are no exceptions permitted under the regulation as promulgated.

The Providers point to 42 C.F.R. § 405.1835(b)(2)(i) (and Board Rule 7.2 which mirrors this regulation) which requires a provider to explain why it believes its Medicare payment is incorrect for each disputed item, or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to the underlying

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[14] Providers' Juris. Br. at 23 (citing *Bowen v. City of New York*, 476 U.S. 467, 485 (1986)).
[15] 73 Fed. Reg. at 30194.
[16] Providers' Juris. Br. *at 26.*
[17] *Id. at 29.*

information concerning the calculation of its payment. However, the Providers did not include the introductory paragraph to this section of the regulation 42 C.F.R. § 405.1835(b)(1) which requires a provider appeal to:

> Demonstrate that the provider satisfies the requirements for a Board hearing as specified in paragraph [42 C.F.R. § 405.1835] (a) of this section . . .

Paragraph 405.1835(a) includes the requirement for claiming self-disallowed costs as protested amounts. The Providers have conceded that they did not comply with this requirement. The Board is bound by the specific requirement that a provider must claim any self-disallowed costs, even if the provider does not know the exact amount of reimbursement it would have received if it had full access to the information that gave rise to the dispute.

The Providers also point to the Supreme Court's decision in *Bethesda* to support the proposition that entitled to a Board hearing does not require a claim for dissatisfaction on the cost report, where a provider complied with the regulations in filing its cost report. Further, they note the Court pointed out the language and design of the statute, taken as a whole, was not intended to divest the Board of jurisdiction over matters merely because they were not considered by the intermediary. In addition, 42 U.S.C. § 1395oo(d) permits the Board to engage in its own fact finding and make decisions using not only evidence considered by the intermediary, but other evidence obtained by the Board. The Board can affirm modify or reverse a final determination of the intermediary even though such matters were not considered by the intermediary.[18]

However, this argument omitted other language in *Bethesda* in which the Court noted that had a regulatory requirement to claim costs been in place, it could have changed the outcome of the case:

> . . . it is clear, however, that the submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations. No statute or regulation expressly mandates that a challenge to the validity of a regulation be submitted first to the intermediary . . . .Thus, [the providers in *Bethesda*] stand on different ground than to providers who bypass clearly prescribed exhaustion requirements or who fail to request from the intermediary reimbursement for cost to which they are entitled under the applicable rules. While such defaults might well establish that a provider was satisfied with the amounts requested in its cost report and awarded by the intermediary, those circumstances are not present here.[19]

In the preamble to the Board's new regulations, the Secretary noted that the Court recognized than an exhaustion requirement could be imposed by regulation, and that a provider who fails to claim all

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[18] *Id.* at 17.
[19] *Bethesda* at 404-405.

costs to which it is entitled may fail to meet the jurisdictional prerequisite of dissatisfaction.[20] There is nothing in the statute indicating that the Secretary cannot interpret the dissatisfaction requirement must be expressed with respect to each claim.[21] The final determination, which here is the NPR, is not just the total amount of program reimbursement. Rather, it is composed of many individual calculations representing the various items which a provider seeks payment. Providers generally challenge discrete reimbursement items. Thus dissatisfaction with total reimbursement is based on dissatisfaction with items that result in total reimbursement. Consequently, the Secretary believes it is reasonable under 42 C.F.R. § 1395oo(a) to require dissatisfaction be shown with respect to each issue being appealed.[22] In light of this and the requirements of the regulation, the RFBNA must be claimed as a protested item and the Providers failed to comply with this requirement.

The fact that the Providers believe that to deny jurisdiction over this appeal would be unconstitutional is not a question that can be addressed by the Board. The Board is required to follow the regulations issued by the Secretary. The regulations require that the Providers claim dissatisfaction with the RFBNA issue as a protested item on their cost reports.

The Board notes that the cost report (including the procedures for filing a cost report under protest) are based on the provider's obligation to provide information that the Secretary requires to determine payment. In this regard, 42 U.S.C. § 1395g(a) specifies in pertinent part:

> (a) The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it . . . ; except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.

CMS has historically set forth the rules governing items filed under protest in Provider Reimbursement Manual (PRM) 15-2 § 115 *et seq.* and specified what information providers are required to furnish for items under protest in PRM 15-2 §§ 115.1 and 115.2:

> 115.1 **Provider Disclosure of Protest**.--When you file a cost report under protest, the disputed item and amount *for each issue* must be specifically identified in footnotes to the settlement worksheet and the fact that the cost report is filed under protest must be disclosed.
>
> 115.2 **Method for Establishing Protested Amounts**.--The effect of *each nonallowable cost report item is estimated* by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal

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[20] 73 Fed. Reg. at 30196.
[21] *Id.* at 30197.
[22] *Id.*

> cost finding process. In addition, *you must submit*, with the cost report, *copies of the working papers used to develop the estimated adjustments* in order for the contractor/contractor to evaluate the reasonableness of the methodology for purposes of establishing whether the cost report is acceptable. The cumulative effect on reimbursement for all disputed issues is shown as an adjustment to balance due to the program (provider) in the reimbursement settlement computation. The actual effect on reimbursable cost(s) is determined after final adjudication of the issue(s).[23]

For purposes of IPPS providers, filing a cost report under protest is achieved by entering such costs on Worksheet E, Part A, Line 30 of the cost report. In this regard, PRM 15-2 § 3630.1 requires that IPPS providers:

> Enter the program reimbursement effect of the protested items. Estimate the reimbursement effect of the nonallowable cost items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process (See § 115.2). Attach a schedule showing the details and the computation for this line.

Effective with cost report periods that end on or after December 31, 2008, CMS amended the regulations governing cost report appeals to incorporate PRM 15-2 § 115 *et seq.* into the regulations at 42 C.F.R. § 405.1835(a)(1)(ii) (2008) by specifying that, where a provider seeks payments that it believes may not be allowable or may not be in accordance with Medicare policy, the provider must claim the items as self-disallowed costs "by following the applicable procedures for filing a cost report under protest." In promulgating this regulation, CMS included the following discussion in the preamble to the final rule published on May 23, 2008 ("2008 Final Rule")[24]:

> **Comment**: One commenter recommended that the text of section 115 *et seq.* of the PRM, Part II, be placed in the regulations. The commenter noted that these sections of the PRM have not changed since 1980. . . .
>
> **Response**: We are adopting the proposal, which is essentially a codification of the protested amount line procedures set forth in section 115 *et seq.* of the PRM, Part II.[25]

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[23] (Italics emphasis added.)
[24] 73 Fed. Reg. 30190 (May 23, 2008).
[25] *Id.* at 30195. Similarly, the preamble to the 2008 Final Rule states the following regarding the documentation requirements for filing a cost report under protest: "We are attempting to strike a balance between, on the one hand, having provider present enough information so as to put the intermediaries on notice as to the actual or potential reimbursement disputes, and, on the other hand, not making it unduly burdensome for providers to file cost reports."

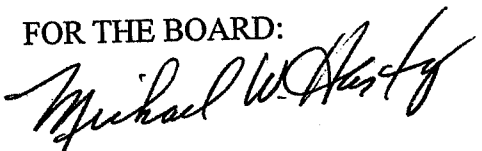
Thus, the preamble to the 2008 Final Rule confirms CMS' intent that 42 C.F.R. § 405.1835(a)(1)(ii) codified the PRM 15-2 rules governing cost reports filed under protest. Here, the Providers failed to preserve their right to appeal the RFBNA issue by following the PRM 15-2 rules governing cost reports filed under protest in compliance with 42 C.F.R. § 405.1835(a)(1)(ii). As a result, the Board concludes that it lacks jurisdiction over the Providers' appeal of the RFBNA issue.

Since there are no other issues pending before the Board in this case, the case is closed. Review of this determination is available under the provisions 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating

Michael W. Harty
John Gary Bowers, CPA
L. Sue Anderson, Esq.

FOR THE BOARD:



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kyle Browning, NGS
Kevin Shanklin, BCBSA

Id. The preamble further states: "We believe it reasonable to require provider to notify their intermediaries, via their cost report submission, of all items for which they potentially may be claiming reimbursement." *Id.* at 30198.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to:

13-0986G
CERTIFIED MAIL

NOV 01 2013

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RE: # 1. Piedmont Henry, Provider No. 11-0191, FYE 6/30/2008[1]
2. Kalispell Regional Medical Center, Provider No. 27-0051, FYE 3/31/2008
3. University of New Mexico Hospital, Provider No. 32-0001, FYE 6/30/2008
#11. CarolinaEast Medical Center, Provider No. 34-0131, FYE 9/30/2008
#12. Tuality Community Hospital, Provider No. 38-0021, FYE 9/30/2008
#13. Oconee Medical Center, Provider 42-0009, FYE 9/30/2008

as participants in the

Akin Gump 2008 Rural Floor Budget Neutrality Group[2]
FFY 2008 (encompasses Federal FYs 2007 and 2008)
PRRB Case No. 13-0986G

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' June 4, 2013 request for expedited judicial review (EJR) (received June 5, 2013) and

[1] In response to the Group Representative's September 24, 2013 correspondence asking to incorporate the entire cost reporting period for Piedmont Henry in the Board decision, the Board hereby notifies the Group Representative that the entire cost reporting period for Piedmont Henry Hospital, Provider No. 11-0191, FYE 6/30/2008 (the period 7/1/2007 through 6/30/2008) is included in this decision.

[2] The Providers listed below were also included on the Schedule of Providers for this group appeal:
4. Brooklyn Hospital Center, Provider No. 33-0056, FYE 12/31/2008
5. United Memorial Medical Center, Provider No. 33-0073, FYE 12/31/2008
6. Glenn Falls Hospital, Provider No. 33-0191, FYE 12/31/2008
7. Erie County Medical Center, Provider No. 33-0219, FYE 12/31/2008
8. Woman's Christian Association Hospital, Provider No. 33-0239, FYE 12/31/2008
9. Hospital for Special Surgery, Provider No. 33-0270, FYE 12/31/2008
#10. Catskill Regional Medical Center, Provider No. 33-0386, FYE 12/31/2008
They have been dismissed from the appeal in a separate decision because the Board concluded that it lacked jurisdiction over the Providers on a different basis than discussed in this determination. The Providers listed in this footnote failed to claim reimbursement for the Rural Floor Budget Neutrality adjustment as a protested item as required by 42 C.F.R. § 405.1835(a)(1)(ii).

the Providers' September 24, 2013 response (received September 25, 2013) to the Board's June 28, 2013 letter asking for comments on the Board's jurisdiction. On October 1, 2013, the employees of the Office of Hearings, including the staff of the Board, were furloughed as the result of the lack of either a Federal fiscal year 2014 appropriation or continuing resolution. The Board resumed operating on October 17, 2013. Pursuant to the regulation 42 C.F.R. § 405.1803(d)(2008), the furlough extended the time to respond to the Providers' EJR request. This regulation states:

> (d) *Calculating time periods and deadlines.* In computing any period of time or deadline prescribed or allowed under this subpart or authorized by a reviewing entity the following principles are applicable:
>
> (1) The day of the act, event, or default from which the designated time period begins to run is not included.
>
> (2) Each succeeding calendar day, including the last day, is included in the designated time period, *except that, in calculating a designated period of time for an act by a reviewing entity, a day is not included where the reviewing entity is unable to conduct business in the usual manner due to extraordinary circumstances beyond its control such as* natural or other catastrophe, weather conditions, fire, or ***furlough***. In that case, the designated time period resumes when the reviewing entity is again able to conduct business in the usual manner. (emphasis added)

The time to respond to the Providers' EJR was extended for the 16 days during which the Board was unable to conduct business as a result of the furlough.

The decision of the Board is set forth below.

Background

Issue Under Dispute

The Providers are challenging the budget neutrality adjustment to the standardized amounts paid under the inpatient hospital prospective payment system to account for the effects of the "rural floor" on the prospective payment system (PPS) wage index. The Providers allege that the standardized amounts applied to determine their PPS payments were significantly understated due to errors in calculating and applying the

rural floor budget neutrality adjustment. As a result, the Providers contend their PPS payments and related add-on payments were improperly reduced in the contractors' final determinations as to the total amount of program reimbursement due each of the Providers.[3]

Standardized Amount

The statute, 42 U.S.C. § 1395ww(d)(2)(A), required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The base-year cost data were used in the initial development of the standardized amounts for PPS and they were used in computing the Federal rates. The standardized amounts are based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that effects certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994).

Section 1395ww (d)(3)(E) of the Act requires the Secretary from time-to-time to estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor related amount is adjusted by the wage index. Section 1395ww(d)(3)(E) requires that 62% of the standardized amount be adjusted by the wage index unless doing so would result in lower payments to a hospital than would otherwise be made. 71 Fed. Reg. 47870, 48146 (August 18, 2006).

Budget Neutrality

Budget neutrality is determined by comparing aggregate IPPS payments before and after making changes that are required to be budget neutral (i.e., reclassifying and recalibrating diagnostic related groups (DRGs)). Outlier calculations are also included in the simulations. In FFYs 2007 and prior, CMS stated that: [the] budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the [prior years'] budget neutrality adjustments. *Id.* at 48147.

In establishing the PPS rate for FFY 2008 CMS applied the budget neutrality adjustment to the wage index rather than to the standardized amount as it had done in previous years. CMS believes that an adjustment to the wage index would result in substantially similar payments as an adjustment to the standardized amount, as both

[3] Providers' March 11, 2013 Hearing Request, Tab 2, Statement of Group Issue.

involve multipliers to the standardized amount and both would be based upon the same modeling parameters. 72 Fed. Reg. 47130 (August 22, 2007).

Rural Floor

Section 4410 of the Balanced Budget Act of 1997 (BBA of 1997) established the rural floor by requiring that the wage index of a hospital in any urban area cannot be less than the wage index determined for the State's rural area. Since 1998 CMS has implemented the budget neutrality requirement of this provision by adjusting the standardized amounts. 72 Fed. Reg. 24680, 24787 (May 3, 2007). In establishing the PPS standardized amount for FFY 2007, and for prior Federal fiscal years, CMS adjusted the standardized amount to account for the effects of the rural floor. *See e.g.,* 71 Fed. Reg. 48145-48 (August 18, 2006). In FFY 2008 CMS applied the budget neutrality adjustment to the wage index, rather than the standardized amount. [4]

In responding to providers concerns regarding the change to the calculation set forth above and the cumulative effect of the budget neutrality adjustment in the final IPPS rule, CMS stated that

> . . . the rural floor budget neutrality adjustment previously was a cumulative adjustment, similar to the adjustments we currently make for updates to the wage index and DRG [diagnostic related groups] reclassification and recalibration. Beginning in 2008, the rural floor budget neutrality adjustment will be noncumulative.
>
> . . .With regard to alleged errors in FY 1999 through 2007, our calculation of the budget neutrality in past fiscal years is not within the scope of this rulemaking Even if errors were made in prior fiscal years, we would not make an adjustment to make up for those errors when setting rates for FY 2008. It is our longstanding policy that finality is critical to a prospective payment system. Although such errors in rate setting are inevitable, we believe the need to establish final prospective rates outweighs the greater accuracy we might gain if we retroactively recomputed rates whenever an error is discovered.

72 Fed. Reg. at 47330.

[4] 72 Fed. Reg. 47130, 47329 (August 22, 2007).

The Providers' Request for EJR

Basis for EJR

To establish the PPS rate for FFYs 2007 and 2008 and for prior years, CMS used a payment simulation model to determine each year's budget neutrality adjustment to the standardized amount to account for the effect of the rural floor. For FFY 2007 and prior, CMS described the simulation model and its calculation of the resulting budget neutrality adjustment as follows:

> [W]e used the FY 2005 discharge data to simulate payments and compared aggregate payments using the FY 2006 relative weights and wage indexes to aggregate payments using the FY 2007 relative weights and wage indexes. The same methodology was used for the FY 2006 budget neutrality adjustment.
>
> . . . These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the 2006 budget neutrality adjustments.

71 Fed. Reg. at 48147.

In establishing the PPS rate for FFY 2008 CMS applied the budget neutrality adjustment to the wage index rather than to the standardized amount as it had done in previous years. 72 Fed. Reg. at 47330 (August 22, 2007). CMS did not rectify the cumulative impact of its methodology errors from FFY 1999 through 2007, as described above. *Id.* at 47421. Thus, for FFY 2008, the Providers are appealing the understated FFY 2008 standardized amount used in other FFYs.

The Providers are challenging an aspect of CMS' calculation of the final PPS rates published in the Federal Register for FFY 2007 and 2008. The Providers contend that CMS erred in calculating a budget neutrality adjustment to the PPS standardized amount to account for the effect of the rural floor on the wage index. This alleged error results in a systematic understatement of the PPS rates, and this error has been an annually recurring one. Each year's error is permanently built into the standardized amount paid under PPS for each successive year. Consequently, the Providers allege, the final rates established in the final FFY 2007 and 2008 PPS rules are understated both as the result of erroneous methodology used to calculate the budget neutrality adjustment for the effect of the rural floor in FFY 2007 and 2008, as well as the result of the cumulative effect of the same error in prior calculations of the budget neutrality adjustments for the effects of the rural floor in prior fiscal years.

The Providers assert that the Board lacks the authority to change or set aside the budget neutrality adjustment that was published in regulatory form in the Federal Register by the Secretary.

Jurisdiction over the Issue

The Providers contend that the Board has jurisdiction over the appeal because the appeal was timely filed from their Notices of Program Reimbursement implementing the final PPS rates for FFYs 2007 and 2008 and the $50,000 amount in controversy has been met. The Providers assert that the Board has jurisdiction over the RFBNA issue under the decision in *Bethesda Hospital Association v. Bowen*, 485 U.S. 399, (1988) (*Bethesda)*. Under this decision, providers which filed their cost reports in full compliance with the unambiguous dictates of the Secretary's rules and regulations were not barred from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. *Id.* at 404.

The Providers allege that when they filed their cost reports, they had no reason to know of the payment errors CMS made using data within its own control and without transparency. They assert that CMS did not afford hospitals notice that the agency's calculation of the rural floor budget neutrality adjustment was overstated for any year prior to 2008 or that the standardized amount for any year was understated.[6]

Decision of the Board

The Board concludes that it lacks jurisdiction over the appeal because review of budget neutrality adjustments is precluded by the statute and regulations. 42 U.S.C. § 1395ww(d)(7); 42 U.S.C.§1395oo(g)(2); 42 C.F.R. § 405.1804. Because jurisdiction over an appeal is a prerequisite to granting a request for EJR, the Providers' request for EJR is hereby denied.

Payment under the prospective payment system is governed by the statutory provisions of 42 U.S.C. § 1395ww. Subsection (d)(7) states that:

> There shall be no administrative or judicial review under [42 U.S.C. § 1395oo] or otherwise of—
>
> (A) the determination of the requirement, or proportional amount of any adjustment effective pursuant to subsection (e)(1) [budget neutrality] or the determination of the applicable percentage increase under paragraph (12)(A)(iii)

[6] Providers' Request for EJR at 10.

The Board's governing statute, 42 U.S.C. § 1395oo(g)(2), states that:

> The determination and other decisions described in section 1395ww(d)(7) shall not be reviewed by the Board or any court pursuant to action brought under section (f) or otherwise.

CMS' implementing regulation, 42 C.F.R. § 405.1804, entitled "Matters not subject to administrative and judicial review under prospective payment" provides:

> Neither administrative or judicial review is available for controversies about the following matters:
>
> *(a) the determination of the requirement, or the proportional amount, of any budget neutrality adjustment in the prospective payment rates. . . .* (emphasis added)

CMS stated at the time the rule was adopted that the purpose of the rule is:

> to state that the determination and decisions described in section 1886(d)(7) of the Act may not receive Board or judicial review. Section 1186(d)(7) of the Act precludes administrative and judicial review of the following:
>
> A determination of the requirement, or the proportional amount of any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act.

48 Fed. Reg. 39752, 39785 (September 1, 1983).

In addition, section 701(a) of the Administrative Procedure Act (APA) states that the appeal provisions of the APA apply to the administrative actions except where statutes preclude judicial review. *See*, 5 U.S.C. § 701(a). The statutes and the regulations both preclude administrative and judicial review of the budget neutrality adjustment.

In *Amgen, Inc. v. CMS*[7] the D.C. Circuit Court considered whether there is jurisdiction over outpatient PPS (OPPS) payments where the statute precludes administrative or judicial review of the "other adjustments" to OPPS (the classification system, establishment of groups and relative payment weights for

[7] 357 F. 3d 103 (D.C. Cir. 2004)

covered services, or wage adjustment factors). The Court explained that there is a strong presumption that Congress intends judicial review of administrative action which can only be overcome with "clear and convincing evidence" that Congress intended to preclude appeal. The Court concluded that where the statute stipulated that "there should be no administrative or judicial review," that language constituted clear and convincing evidence that appeal was precluded. The Court further noted that payments under PPS are made on a prospective basis and, given the length of time that review of individual appeals could take, the result would be retroactive adjustments to payment rates with the potential of creating havoc with the payment system. The aggregate impact of appeal decisions would undermine the Secretary's ability to ensure budget neutrality.

In an earlier decision, *Universal Health Systems v. Sullivan*,[8] (*UHS*) the D. C. District Court distinguished between an appeal of a Medicare Geographic Classification Review Board (MGCRB) decision (over which judicial review is precluded) and a challenge to the validity of the guidelines utilized by the Board and the Secretary to make reclassification decision. The Court noted that § 701(a) of the APA precludes judicial review where a statute or regulation denies review. In the UHS case, the Court found that it had jurisdiction over the challenge to the guidelines but would not have had jurisdiction over an appeal of an MGCRB decision which was precluded by law.

The Board is not persuaded that preclusion of review of budget neutrality provisions is limited to the fiscal years 1984 and 1985. Even though the rural floor budget neutrality provision was not specifically addressed in the limits on administrative and judicial review, we find the language of the statute itself unambiguous in that there is no indication that the prohibition on administrative or judicial review is limited to the two fiscal periods identified by the Providers. Therefore, no further inquiry into Congressional intent is warranted. Moreover, if any ambiguity were present, it is resolved by the expansive regulatory language, binding on the Board, that prohibits review of "any controversies about [budget neutrality determinations]."

42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permit providers to bypass the Board's hearing procedure and obtain judicial review of an issue involving a question of law or regulation where the Board determines that it is without authority to decide the question. Prior to rendering a decision that it lacks the authority to decide the question before it the Board must determine that it has jurisdiction over the appeal under 42 U.S.C. § 1395oo. 42 C.F.R. § 1842(b)(2). Because both the statutes and regulation preclude administrative and judicial review of the budget neutrality adjustment, the Board finds that it lacks jurisdiction over the appeal.

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

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[8] 770 F. Supp. 704 (D.C. Dist. 1991)

Cape Cod and the Request for EJR

Ordinarily our EJR analysis would end with a determination of no jurisdiction. However, the Board acknowledges that in *Cape Cod HC Wage Index/Rural Floor Group,* PRRB case number 07-0750 *et al.* (*Cape Cod*), the Secretary has taken a contrary position. In *Cape Cod*, the Board concluded that it lacked jurisdiction over the budget neutrality adjustment for the reasons set forth above. The Board's decision was not reversed by the CMS Administrator. On appeal to the Federal district court, however, the Secretary moved for remand on the basis that the Board has jurisdiction over the issue. Neither the D.C. District court remand [9] nor the remand from the Deputy Administrator addresses the Secretary's rationale for its position regarding jurisdiction. Assuming that the Secretary will take the same position with respect to the Board's having jurisdiction over the budget neutrality issue, and in the interest of judicial economy, the Board will also address the question of whether EJR is appropriate.

The Providers in this appeal seek to have the final wage index rates published in the Federal Register modified by applying a different calculation methodology relating to the budget neutrality and rural floor factors. Pursuant to 42 C.F.R. § 412.64, the Secretary calculates the standardized amount on an annual basis. This calculation is published annually in the Federal Register following a complex and lengthy process of data collection and analysis. The methodology for the calculation is described in general terms.

The Board is bound by the Secretary's final rules and has no authority to look behind the rate published unless specifically authorized. Notably the regulations provide for Board review of denials of requests by hospitals for correction of certain wage data that eventually goes into one, hospital-specific, component of the final rate.[10] If the provider appealing the denial is successful, the remedy is limited to the hospital bringing the successful appeal. There is no provision for the Board to adjust the rate itself (as applied to all hospitals) to account for the effect of the error. The Board concludes that the specific grant of authority and establishment of a detailed process for correcting only the rate of the hospital bringing the appeal coupled with the failure to include the effect of that correction on other hospitals or to establish a similar correction process for other components of the wage index are strong indications that the Board does not have authority to change the rate itself.

Even more compelling, however, is the language of the statute and the regulation quoted above that prohibits review of budget neutrality determinations which are at the heart of the question before the Board in this case.

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[9] *Cape Cod Hospital v. Leavitt*, 565 F. Supp. 137 (D.D.C 2008)
[10] 64 Fed. Reg. 41490, 41513 (July 30, 1999).

In *Cape Cod*, the Board originally determined that the language quoted above barred jurisdiction in this appeal. However, on appeal to the Federal district court, the Secretary moved for remand, asserting that the Board jurisdiction decision was erroneous. The provider plaintiffs responded that the remand was unnecessary because the case was properly before the court on EJR. It argued that implicit in the Board's finding it lacked jurisdiction was a determination that it also lacked authority to decide the question, thus, EJR was appropriate. In its remand order, the District Court explained that the two findings are distinct. "Jurisdiction to take any legal action" asks whether the Providers may obtain a hearing at all; "authority to decide the question" asks whether the Board has authority to reach the merits of Providers' claims. The Court concluded that the Secretary's position was correct: the Court lacked subject matter jurisdiction without the Board's first being afforded an opportunity to consider the merits of the Providers' claims, including whether it has authority to decide the question.

While the D.C. District Court accepted the Secretary's position that the Board interpreted the statutory and regulatory prohibitions on review of budget neutrality determinations too broadly to bar jurisdiction, it cannot be ignored altogether. The Court made clear that a second question of authority to reach the merits must also be answered. We conclude that the statute and regulation clearly evidence Congress' and the Secretary's intent that budget neutrality determinations are insulated from the Board's authority to affirm, reverse or modify Otherwise, the strong prohibitions articulated there would be rendered meaningless.

The Board finds that:

1) based upon the Providers' unopposed assertions regarding the challenges to the rural floor/budget neutrality methodology, there are no findings of fact for resolution by the Board;

2) it is bound by the Final Rule in the Federal Register and the regulation; and

3) it is without authority to decide the legal question of whether the calculation methodology for the budget neutrality/rural floor adjustment is valid.

Accordingly, the Board finds that the budget neutrality/rural floor issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and expedited judicial review is

appropriate if the Board has jurisdiction over the issue. Because this is the only issue under appeal in this case, the Board hereby closes the case.

Board Members Participating

Michael W. Harty
John Gary Bowers, CPA
L. Sue Anderson, Esq.

FOR THE BOARD:

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kyle Browning, NGS
Kevin Shanklin, BCBSA

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Refer to: 96-1699G

CERTIFIED MAIL

NOV 01 2013

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Geoff Pike
First Coast Service Options, Inc. – FL
Provider Audit and Reimbursement Dept.
532 Riverside Avenue
Jacksonville, FL 32231-0014

RE: Southeast Region 87 – 93 SSI Calculation Group Appeal
Provider No.: Various
FYE: Various
PRRB Case No.: 96-1699G

Dear Ms. Erde and Mr. Pike,

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced appeal, and on its own motion noted a jurisdictional impediment. The jurisdictional decision of the Board is set forth below.

Background

The hearing request for the establishment of the group appeal was filed with the Board on March 25, 1996. This is a provider group appeal with one issue, the SSI ratio, covered under CMS Ruling 1498-R. The appeal was placed in abeyance on April 22, 2004 in response to the Providers' request which explained that it had requested SSI data from CMS that it had yet to receive. On March 1, 2012, the Board sent a letter to the Providers' representative indicating that the case was being removed from abeyance because *Baystate*[1] had been decided, and requesting the Schedule of Providers.

Board's Decision

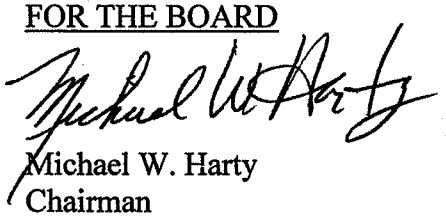
The Board finds that it does not have jurisdiction over DCH Regional Medical Center, Provider No. 01-0092, FYE 9/30/1996, because it did not properly transfer the SSI% issue from its individual appeal into this group appeal, case number 96-1699G. The transfer letter provided for this Provider is a transfer letter for a different Provider, Northport Hospital. As there is no documentation establishing that DCH Regional Medical Center (9/30/1996) was transferred to group number 96-1699G, the Board hereby dismisses the Provider from this appeal. Case number 96-1699G will remain open as there are other Providers that remain in the appeal.

[1] *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008), *amended in part*, 587 F. Supp. 2d 37 (D.D.C. 2008) *judgment entered*, 587 F. Supp. 2d 44 (D.D.C. 2008).

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

Board Members Participating:
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin D. Shanklin, BCBSA

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NOV 04 2013

Hall, Render, Killian, Heath & Lyman
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RE: Ascension 2007–2008 Health 2007-2008 DSH SSI Days Medicare Advantage Days CIRP, PRRB Case No. 10-0280GC

Dear Mr. Barber:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned group appeal in response to your firm's August 22, 2013 letter seeking clarification. The pertinent facts of the case and the Board's jurisdictional determination are set forth below.

Pertinent Facts:

The subject group appeal was filed on December 21, 2009 with the following participants:

Provider No.	Provider Name	FYE
52-0051	Columbia St. Mary's Hospital Milwaukee	6/30/2008
33-0188	Mount St. Mary's Hospital	12/31/2007
33-0011	Our Lady of Lourdes Memorial Hospital	12/31/2007
45-0042	Providence Health Center	6/30/2008
01-0090	Providence Hospital	6/30/2008
10-0025	Sacred Heart Hospital of Pensacola	6/30/2008
13-0003	St. Joseph Regional Medical Center, Inc.	6/30/2008

All participants filed from the June 24, 2009 publication of the SSI percentage.

Subsequently the following providers were added to the group from receipt of Notices of Program Reimbursement.

Provider No.	Provider Name	FYE
03-0010	Carondelet St. Mary Hospital	6/30/2007
03-0100	Carondelet Heart & Vascular Institute	6/30/2008
33-0047	St. Mary's Healthcare	12/31/2007
33-0232	Seton Saint Mary's Hospital	12/31/2007
45-0056	Seton Medical Center	6/30/2007
23-0019	Providence Hospital Southfield	6/30/2007
23-0223	St. John Oakland Hospital	6/30/2007

23-0165	St. John Hospital & Medical Center	6/30/2007
23-0119	St. John Health	6/15/2007
33-0188	Mount Saint Mary's Hospital of Niagra Falls	12/31/2007
23-0197	Genesys Regional Medical Center	6/30/2007
23-0117	Borgess Medical Center	6/30/2007
23-0241	St. John River District Hospital	6/30/2007
01-0090	Providence Hospital	6/30/2007

Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a)(2004) and 42 C.F.R. §§ 405.1835 – 405.1841, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of the NPR.

The Board finds that it lacks jurisdiction over the 7 participants included in the initial appeal request because publication of the SSI Ratios is not a final determination as contemplated by the Board's jurisdictional statute.

Background of the DSH System

In 1986 the DSH payment system was established via statute to act as a percentage add-on to the standard payment per discharge under the Prospective Payment System (PPS). This additional DSH payment is not applied to all hospitals, as the statute both establishes provider eligibility to receive the add-on, and determines the amount to be paid to qualifying providers.[1] Both of these determinations rest heavily upon the calculation of each provider's disproportionate patient percentage (DPP), a figure that incorporates the contested SSI ratios.

The DSH regulations reiterate that not every hospital will receive a DSH adjustment. Under the heading "General considerations," the regulations set forth the factors to be "considered in determining whether a hospital qualifies for a payment adjustment."[2] Subsequent provisions establish that DSH payment is an annual determination whose calculation is keyed to each facility's cost reporting period.[3] The regulation that establishes the payment adjustment factor makes clear that DSH payment is a conditional, as opposed to universal, occurrence; "if a hospital serves a disproportionate number of low-income patients, its [diagnostic related group] revenues for inpatient operating costs are increased by an adjustment factor . . ."[4]

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[1] 42 U.S.C. § 1395ww(d)(5)(F)(v).
[2] 42 C.F.R. § 412.106(a).
[3] *See, e.g.*, 42 C.F.R. § 412.106(b)(1-4).
[4] 42 C.F.R. §412.106(d)(1) (emphasis added).

Federal Register notices published contemporaneous to the implementation of the DSH regulations establish that final, settled cost reports are the true measure of DSH payment. First, in response to a question concerning the process by which a hospital applies for DSH payment, the agency notes that no application is necessary and that fiscal intermediaries "have begun making interim payments (subject to year-end settlement) for those hospitals that they have identified as disproportionate share hospitals."[5]

Additional commentary within this notice makes it explicitly clear that the DSH eligibility and payment determinations are contingent upon a final, settled cost report:

> Since the disproportionate share adjustment is based on a hospital's cost reporting period, final determination of a hospital's eligibility for, and amount of, any disproportionate share adjustment will be made by the fiscal intermediary at the time of the year-end settlement of its cost report.[6]

The commentary also explained that the finality of cost report settlement allowed for the appeal of DSH issues via the already-established Board procedures and no separate appeals mechanism was required for providers who disagreed with their intermediary's finding. To this end, HFCA noted that:

> Since hospitals can appeal the denial of eligibility for the disproportionate share adjustment or the amount of the adjustment they receive under this general appeals mechanism, which is already in place, we do not believe an appeals mechanism specific to the disproportionate share provision is necessary.[7]

The plain language of the DSH statute, the implementing regulations, and agency guidance make clear that DSH adjustments hinge upon the completion and settlement of a provider's cost report. From this settled cost report, the intermediary determines whether a facility is eligible for DSH payment at all, and the amount of any such final payment. This clear endpoint was crafted with an eye toward resolving DSH issues through the standard Board appeal process. It therefore logically follows that a provider may not appeal DSH-related issues prior to the final settlement of its cost report.

The present case seeks to craft an appeal avenue where long-settled agency practice dictates that no such method is required. As noted, the appeal takes issue with the SSI ratios, which are a component of the DPP calculation. The DPP calculation is itself merely an element of the larger DSH determination. As DSH adjustment is keyed to a "final determination" from the "year-end settlement of [a provider's] cost report," it follows that the publication of the SSI percentages is not, in and of itself, an appealable final determination. A provider who is dissatisfied with their SSI percentage can, and must,

---

[5] Medicare Program; Changes to the Inpatient [PPS], 51 Fed. Reg. 31,454, 31,457 (Sept. 3, 1986)(emphasis added).
[6] *Id.* at 31,458 (emphasis added).
[7] *Id.*

finalize its cost report with their intermediary and appeal the issue via the standard Board process.

Since the SSI ratios at issue were not incorporated into settled cost reports (and NPRs) for the initial 7 participants, their applicability to any specific provider cannot be established at this time. For example, while the appealing Providers have projected amount in controversy at issue, it also is possible that a published SSI determination will aid a fiscal intermediary in determining that a provider is not eligible to receive DSH payment. When the DSH adjustment was established, the agency contemplated that eligibility determinations would be appealed through the "general appeals mechanism."

Therefore, the Board hereby dismisses the following participants that appealed from the publication of the SSI Percentage from case number 10-0280GC:

Provider No.	Provider Name	FYE
52-0051	Columbia St. Mary's Hospital Milwaukee	6/30/2008
33-0188	Mount St. Mary's Hospital	12/31/2007
33-0011	Our Lady of Lourdes Memorial Hospital	12/31/2007
45-0042	Providence Health Center	6/30/2008
01-0090	Providence Hospital	6/30/2008
10-0025	Sacred Heart Hospital of Pensacola	6/30/2008
13-0003	St. Joseph Regional Medical Center, Inc.	6/30/2008

The remaining providers in case number 10-0280GC that filed from NPRs (or revised NPRs) for FYE 2007 are hereby transferred to the Ascension NPR based group appeal for the same issue to which the Board assigned case number 13-1659GC, The Ascension 2007 DSH SSI Medicare Advantage Days CIRP.[8] Carondelet Heart & Vascular Institute (03-0100) also appealed FYE 6/30/2008. That participant is being transferred to the Ascension 2008 SSI Fraction Medicare Advantage Days CIRP Group, case number 13-1517GC. After the transfer of NPR based providers, there are no providers remaining in this group. Therefore, the Board hereby closes case number 10-0280GC.

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

Board Members Participating:
John Gary Bowers, CPA
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

For the Board:

Michael W. Harty
Chairman

[8] The issue statement filed in the initial request for a group appeal (10-0280GC) is specific to the Medicare Proxy. Therefore, these Providers are not also being transferred to the bifurcated Medicaid Fraction Medicare Advantage Days CIRP group, 13-3671GC.

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and .1877

cc: Kevin D. Shanklin, Executive Director, BCBSA
James Ward, Noridian Administrative Services
Lauren Hulls, Hall Render Killian Heath & Lyman

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NOV 04 2013

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RE: Ascension 2000-9/30/2004 DSH Medicare Advantage Days CIRP, Case No. 13-1658GC

Dear Mr. Barber:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned group appeal in response to your firm's May 30, 2013 and August 22, 2013 letters seeking clarification. The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

The subject group appeal was created as the result of a bifurcation of case number 09-0667GC, the Ascension DSH Medicare Advantage Days Group for FYEs 12/31/2000 through 12/31/2007. Because of the different legal issues and to comply with Board rules regarding the number of FYEs handled in a group, the Medicare Advantage Days issue in case number 09-0667GC was restructured by FYEs as follows:

- 2000 thru 9/30/04 were put in case number 13-1658GC
- 2005 through 2006 remained in case number 09-0667GC
- 2007 was put in case number 13-1659GC

In letters dated May 30, 2013 and August 22, 2013, your firm advised the Board that the Board's trifurcation of the groups by FYE did not recognize the Medicaid Fraction aspect of the original Medicare Advantage Days appeal. Therefore, your firm requested that the Board create three corresponding group appeals to handle the Medicaid Fraction Medicare Advantage Days issue for the same timeframes. [1]

[1] Your letter also indicated that the Board had created a duplicate appeal of case number 10-0280GC when it created case number 13-1659GC because case number 10-0280GC was already established for the 2007 SSI Medicare Advantage Days issue for Ascension. In a separate letter, the Board found that case number 13-1659GC is not duplicative of case number 10-0280GC as the initial group was filed from publication of the SSI ratio while case number 13-1659GC is an NPR based group appeal.

Board Determination:

After review, the Board determined that, based on the documentation submitted by the Providers in case numbers 09-0667GC and 13-1659GC, it was appropriate to create a Medicaid Fraction Medicare Advantage Days CIRP for the corresponding timeframes. The Board modified the titles of case numbers 09-0667GC and 13-1659GC to include "SSI" and two new Medicaid Fraction Medicare Advantage Days groups were established as follows:

- 2005 through 2006 were placed in case number 13-3666GC and
- 2007 was put in case number 13-3671GC

With regard to group case number 13-1658GC, the Board notes that there is only one participating provider - St. Vincent's Medical Center appealing the FYEs 2000 thru 2004. St. Vincent's Medical Center was originally transferred to the initial group, case number 09-0667GC, on January 20, 2009 from the following individual appeals:

FYE	Original Case No.	Closed Date
2000	04-1736	10/6/2009
2001	06-0163	03/10/2009
2002	06-2218	12/2/2010
2003	07-2073	2/18/2011
2004	08-0771	9/25/2009

After reviewing these individual appeals, we have determined that only the Medicaid Fraction Medicare Advantage Days issue was appealed or added to the cases.

For each of the subject FYEs, the issue is described as:

> Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, the Medicaid days proxy, set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations.
>
> The Provider contends that the Intermediary failed to include patient days applicable to Medicare Managed Care Part C patients who were also eligible for Medicaid in the Medicaid fraction for Medicare DSH payment adjustment calculation purposes.

Based on this issue statement, the Board finds that the SSI Fraction Medicare Advantage Days was not included as part of the issue. Although the Provider attempted to clarify the Medicare Advantage Days issue when it requested to be transferred to the group on January 20, 2009, this clarification letter was submitted beyond the time limit for adding issues to an appeal which expired October 20, 2008. Any clarifications of issues in pending appeals was also due by October 20, 2008, in accordance with the Board's Rules issued on August 21, 2008 and in 42 C.F.R. §405.1835(c).

Based on this review, the request to form a Medicare (SSI) Fraction Medicare Advantage Days companion group for FYEs 2000 through 9/30/2004 is denied.

Further, since there is only one participant in the group, the Board is hereby creating the following new individual appeals for St. Vincent's Medical Center:

FYE	Case No.
9/30/2000	13-3948
9/30/2001	13-3949
9/30/2002	13-3950
9/30/2003	13-3951
9/30/2004	13-3952

Enclosed, please find Acknowledgement and Critical Due Dates Letters for these new individual appeals for which the sole issue in each case is the SSI Fraction Medicare Advantage Days issue.

Since there are no other participants in case number 13-1658GC, the Board is hereby closing that case.

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

Board Members Participating:
John Gary Bowers, CPA
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

For the Board:

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and .1877
Acknowledgement and Critical Due Dates Letters

cc: Kevin D. Shanklin, Executive Director, BCBSA (w/enclosures)
Kyle Browning, Appeals Lead, National Government Services (w/enclosures)
Maureen O'Brien Griffin, Hall, Render, Killian, Heath & Lyman (w/enclosures)

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CERTIFIED MAIL

NOV 05 2013

Isaac Blumberg
Blumberg Ribner, Inc.
315 South Beverly Drive, Suite 505
Beverly Hills, CA 90212

RE: Provider: Saint Luke's- Roosevelt Hospital Center as a participant in "Continuum Health Partners 1986-1998 SSI Percentage CIRP Group"
Provider No: 33-0046
FYE: 12/31/1995
PRRB Case No.: 09-1832GC

Dear Mr. Blumberg:

The Provider Reimbursement Review Board (Board) has reviewed the Schedule of Providers and the associated jurisdictional documents incident to its own motion review of the group appeal. The jurisdictional decision of the Board with respect to Saint Luke's-Roosevelt Hospital Center (Provider No. 33-0046, FYE 12/31/95), included on the Schedule of Providers, is set forth below.

Background

On September 16, 2005, a revised Notice of Program Reimbursement (RNPR) was issued to the Provider, Saint Luke's-Roosevelt Hospital Center, provider number 33-0046, for cost reporting period ending December 31, 1995. The RNPR indicated that the cost report was reopened to revise the Provider's disproportionate share (DSH) calculation to incorporate revisions to the Provider's unpaid Medicaid eligible days, partially paid eligible days and baby days with Medicaid eligible mothers.

On February 24, 2006, the Provider filed an appeal of the RNPR challenging Medicare/Medicaid dual eligible days. The Board assigned case number 06-0779 to the case. On March 28, 2006, the Provider requested to add the SSI percentage issue to case number 06-0779 and to transfer the SSI percentage issue to case number 95-2120G. The Provider further requested that the dual eligible days issue be transferred from case number 06-0779 to case number 06-0092G and that case number 06-0779 be closed. On January 6, 2011, the Provider requested to transfer the SSI percentage issue from case number 95-2120G to case number 09-1832GC.

Decision of the Board

The Board finds that it does not have jurisdiction over Saint Luke's-Roosevelt Hospital Center, (Provider No. 33-0046, FYE 12/31/95) because this Provider is appealing from a RNPR which did not specifically adjust the SSI ratio issue. The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2005) provides in relevant part:

> (a) A determination of an intermediary, a decision by a hearing officer or panel of hearing officers, a decision by the Board, or a decision by the Secretary may be reopened with respect to findings on matters at issue in such determination or decision, by such intermediary officer or panel of hearing officers, Board, or Secretary.

42 C.F.R. 405.1889 (2005) explains the effect of a cost report revision:

> Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in §405.1885, such revision shall be considered a separate and distinct determination or decision to which the provisions of §§405.1811[right to intermediary hearing], 405.1835 [right to Board hearing], 405.1875 [CMS Administrator's review] and 405.1877 [judicial review] are applicable.

The regulation has also been addressed and explained in the decision *HCA Health Services of Oklahoma v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994). In this case, the Court held that when a fiscal intermediary reopens its original determination regarding the amount of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening.

In this appeal, the Intermediary reopened the Provider's cost report to incorporate revisions to the Provider's unpaid Medicaid eligible days, partially paid eligible days and baby days with Medicaid eligible mothers. None of the submitted work papers or audit adjustments referenced any revision to the SSI percentage. As the Provider appealed from a RNPR and there was no specific adjustment to the SSI percentage, the Board finds that it lacks jurisdiction over this Provider, Saint Luke's Roosevelt Hospital Center (Provider No. 33-0046, FYE 12/31/95), and therefore dismisses the Provider from 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 and 405.1877 upon final disposition of the appeal.

Board Members Participating:
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

For the Board:
Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin D. Shanklin
Executive Director

Senior Government Initiatives
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National Government Services
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Refer to:

CERTIFIED MAIL NOV 12 2013

Quality Reimbursement Services
J. C. Ravindran, President
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: HMA/QRS 1999-2003 DSH/Medicaid Eligible Labor Days CIRP Group
Provider Nos. Various (see attached Schedule of Providers)
FYEs 9/30/2000 – 9/30/2003
PRRB Case No.: 08-2965GC

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced group appeal, and on its own motion noted a jurisdictional impediment. The jurisdictional determination of the Board is set forth below.

Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a)(2004) and 42 C.F.R. §§ 405.1835 – 405.1841, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of the NPR.

The Board finds that the participants listed on the Schedule of Providers did not appeal the Labor Delivery Room Days issue in their individual appeal requests, nor is there evidence that the Providers separately added the issue to their individual appeals prior to the request to transfer to/form the subject group appeal.

The Board issued Rules which went into effect on August 21, 2008, limiting the ability to add issues. After this date, the Providers must have specifically added the issue to their individual appeals prior to requesting a transfer to the group appeal.

Because the subject group appeal was filed on September 5, 2008, after the issuance of the August 2008 Rules, and because there is no evidence demonstrating the issues were part of the individual appeals before the request to transfer into/form the subject group, the Board denies jurisdiction over all participants in the group appeal and hereby dismisses case number 08-2965GC.[1]

[1] Riverview Regional Medical Center (Participant #9) was withdrawn from the group by letter dated September 10, 2013.

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

Board Members Participating:
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.

FOR THE BOARD

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin D. Shanklin, Executive Director, BCBSA

Wisconsin Physicians Service
Byron Lamprecht
Cost Report Appeals
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Refer to: 13-3433 **Certified Mail**

NOV 14 2013

Community Health Systems, Inc.
Larry M. Carlton, CPA
Senior Vice President
4000 Meridian Boulevard
Franklin, TN 37067

Re: Porter Memorial Hospital, Provider No. 15-0035, FYE 12/31/07,
PRRB No. Case No. 13-3433

Dear Mr. Carlton:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's appeal request dated August 26, 2013 and received (filed) in our office September 4, 2013.[1] The Board's determination is set forth below.

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 - 405.1840, 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 $10,000 or more and the request for hearing is received by the Board within 180 days of the date of receipt of the final determination by the provider.[2]

The Board received the Provider's request for hearing on September 4, 2013. Pursuant to 42 C.F.R. § 405.1801(a)(1)(iii), the Notice of Program Reimbursement ("NPR") is presumed to have been received 5 days after the date of issuance by the intermediary. This presumption, which is otherwise conclusive, may be overcome if it is established by a preponderance of the evidence that such materials were actually received on a later date. In this case, the NPR is dated February 27, 2013 and stamped "Received" on March 4th (5 days after issuance). The appeal request was not received by the Board within 180 days of the date of receipt of the NPR, which would have been August 31, 2013.

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[1] See, 42 C.F.R. § 405.1801(a)(2) (2010) (The date of receipt of documents by a reviewing entity is presumed to be the date of delivery or stamped "Received" by the reviewing entity on the document or other submitted material.)

[2] See, 42 C.F.R. § 405.1835(a)(3) (2010) (A provider has a right to a hearing before the Board if, among other things, the Board receives the provider's hearing request within 180 days of the date of receipt of the intermediary's [final] determination by the provider.)

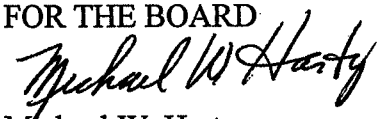
Since August 31, 2013 was a Saturday, the Federal Rules of Civil Procedure allow the receipt date to be considered the next day following the period that ends on a Saturday, Sunday or other legal holiday. Since September 2, 2013, was a federal holiday, the request should have been received by September 3, 2013.

The appeal request was not received by the Board within 180 days of the date of receipt, as required by 42 C.F.R. § 405.1835. Therefore, it was not timely filed. The Board lacks jurisdiction to grant a hearing on the matters at issue in the appeal. Consequently, 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 and 405.1877.

Board Members Participating
John Gary Bowers, CPA
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

Cc: Wisconsin Physicians Service
Byron Lamprecht
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Refer to: 13-1036

CERTIFIED MAIL

NOV 20 2013

Corinna Goron
President
Healthcare Reimbursement Services
17101 Preston Road, Suite 220
Dallas, TX 75248-1372

Re: Lafayette General Medical Center
Provider No. 19-0002
FYE 9/30/2008
PRRB Case No. 13-1036

Dear Ms. Goron:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's October 29, 2013 request for expedited judicial review (EJR) (received October 31, 2013). This request is unopposed. The issue under dispute involves whether the Centers for Medicare & Medicaid Services (CMS) erred in calculating a budget neutrality adjustment to the prospective payment system (PPS) standardized amount to account for the effects of the rural floor on the wage index. The Board's jurisdictional determination over the rural floor budget neutrality issue and determination with respect to the request for EJR are set forth below.

Medicare Statutory and Regulatory Background

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

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

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the PPS. The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors. *See* 42 U.S.C. § 1395ww(d)(5). This case involves the annual changes to the PPS rates for hospital inpatient operating costs (IPPS) and the methodology for determining those rates.

Standardized Amount

The statute, 42 U.S.C. § 1395ww(d)(2)(A), required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The base-year cost data were used in the initial development of the standardized amounts for PPS which were then used to compute the Federal rates. The standardized amounts are based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Section 1395ww(d)(2)(C) requires that updated base-year per discharge costs be standardized in order to adjust data which might cause variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments (for Alaska and Hawaii), indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994).

Section 1395ww(d)(3)(E) requires the Secretary from time to time to adjust the proportion of the hospitals' costs that are attributable to wages and wage-related costs of the DRG prospective payment rates for area differences in hospital wage levels. The adjustment factors (wage index) should reflect the relative hospital wage level in the geographic area of the hospital being compared to the national average hospital wage level. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor related amount is adjusted by the wage index. Section 1395ww(d)(3)(E)(ii) requires that 62% of the standardized amount be adjusted by the wage index unless doing so would result in lower payments to a hospital than would otherwise be made. 71 Fed. Reg. 47870, 48146 (August 18, 2006).

Budget Neutrality

Budget neutrality is determined by comparing aggregate IPPS payments before and after making changes that are required to be budget neutral (e.g., reclassifying and recalibrating the diagnostic related groups (DRGs)). Outlier payments are also included in the simulations. *Id.* at 48147. In FFYs 2007 and prior, CMS stated that: [the] budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the [prior years'] budget neutrality adjustments. *Id.* at 48147.

In establishing the PPS rate for FFY 2008 CMS applied the budget neutrality adjustment to the wage index rather than to the standardized amount as it had done in previous years. CMS believes that an adjustment to the wage index would result in substantially similar payments as an adjustment to the standardized amount, as both involve multipliers to the standardized amount and both would be based upon the same modeling parameters. 72 Fed. Reg. 47130 (August 22, 2007).

Rural Floor

Section 4410 of the Balanced Budget Act of 1997 (BBA of 1997) established the rural floor by requiring that the wage index of a hospital in any urban area cannot be less than the wage index determined for the state's rural area. Since Federal fiscal year (FFY) 1998, CMS has implemented the budget neutrality requirement of this provision by adjusting the standardized amounts. 72 Fed. Reg. 24680, 24787 (May 3, 2007). In establishing the PPS standardized

amount for FFY 2007 and for prior Federal fiscal years, CMS adjusted the standardized amount downward to account for the effects of the rural floor. *See e.g.* 71 Fed. Reg. at 48145-48148 (August 18, 2006). In FFY 2008 CMS applied the budget neutrality adjustment to the wage index, rather than the standardized amount. [1]

In responding to providers concerns regarding the change to the calculation set forth above and the cumulative effect of the budget neutrality adjustment in the final IPPS rule, CMS stated that:

> [T]he rural floor budget neutrality adjustment previously was a cumulative adjustment, similar to the adjustments we currently make for updates to the wage index and DRG [diagnostic related groups] reclassification and recalibration. Beginning in 2008, the rural floor budget neutrality adjustment will be noncumulative.
>
> ****
>
> With regard to alleged errors in FY 1999 through 2007, our calculation of the budget neutrality in past fiscal years is not within the scope of this rulemaking. Even if errors were made in prior fiscal years, we would not make an adjustment to make up for those errors when setting rates for FY 2008. It is our longstanding policy that finality is critical to a prospective payment system. Although such errors in rate setting are inevitable, we believe the need to establish final prospective rates outweighs the greater accuracy we might gain if we retroactively recomputed rates whenever an error is discovered.

72 Fed. Reg. 47130, 47330 (August 22, 2007).

Wage Index

The statute, 42 U.S.C. § 1395ww(d)(3)(E) and (d)(9)(C)(iv), requires that CMS make an adjustment to the labor-related portion of the national and Puerto Rico PPS rates to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. *Id.* at 48153. The wage index must be updated annually. *Id.* at 48005.

Procedural History

This appeal was timely filed on March 11, 2013 from an original NPR. The Provider contends that the rural floor budget neutrality adjustments as implemented by CMS violate the law's requirement of budget neutrality. The Provider argues that rather than adjusting area wage indexes to achieve budget neutrality, the Secretary adjusted the standardized amount and carried that forward from year to year. The Provider continues that CMS duplicated prior adjustments

[1] 72 Fed. Reg. 47130, 47329 (August 22, 2007).

by each year calculating the full amount of the adjustment necessary to counteract the effect of the rural floor and then applying that adjustment to a figure that includes adjustments carried over from previous years. CMS then reduced the standardized amount to account for the full difference between these two figures. The Provider concludes that the cumulative effect of the improperly duplicative budget neutrality adjustments was to reduce the payment levels below what they otherwise should have been.

Basis for EJR

To establish the PPS rate for FFY 2008 and for prior years, CMS used a payment simulation model to determine each year's budget neutrality adjustment to the standardized amount to account for the effect of the rural floor. In the FFY 2007 rule, CMS described the simulation model and its calculation of the resulting budget neutrality adjustment as follows:

> [W]e used FY 2005 discharge data to simulate payments and compared aggregate payments using the FY 2006 relative weights and wage indexes to aggregate payments using the FY 2007 relative weights and wage indexes. The same methodology was used for the FY 2006 budget neutrality adjustment.
>
> . . . These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2006 budget neutrality adjustments.

71 Fed. Reg. 47870, 48147 (August 18, 2006).

In establishing the PPS rate for FFY 2008 CMS applied the budget neutrality adjustment to the wage index rather than to the standardized amount as it had done in previous years. 72 Fed. Reg. 47130, 47330 (August 22, 2007). CMS did not rectify the cumulative impact of its methodology errors from FFY 1999 through 2007, as described above. *Id.* at 47421. Thus, for FFY 2008, the Provider is appealing the understated FFY 2008 standardized amount used in other FFYs.

The Provider is challenging an aspect of CMS' calculation of the final PPS rates published in the Federal Register for FFY 2008. The Provider contends that CMS erred in calculating a budget neutrality adjustment to the PPS standardized amount to account for the effects of the rural floor on the wage index. This alleged error results in a systematic understatement of the PPS rates, and this error has been an annual and recurring one. Each year's error is permanently incorporated into the standardized amount paid under PPS for each successive year.

Jurisdiction over the Issue

The Provider contends that the Board has jurisdiction over these appeals because the appeals were timely filed from NPRs and the amount in controversy threshold has been met. The Provider points out that review of the PPS payment determination is subject only to the exceptions set forth at 42 U.S.C. § 1395oo(g)(2). This section provides, in relevant part, that determinations described in 42 U.S.C. § 1395ww(d)(7) shall not be reviewed by the Board or any

court. Among the matters not subject to review is the determination of the requirement, or the proportional amount, of any budget neutrality adjustment. The Provider contends that this preclusion of review provision is limited to certain budget neutrality adjustments for fiscal years 1984 and 1985 to ensure that the total amounts paid under PPS, then a new system, were the same as the total amounts that would have been spent under the Medicare law (as modified by the Tax Equity & Fiscal Responsibility Act of 1982 (TEFRA)). 42 U.S.C. § 1395ww(e)(1)(A)-(B).

The Intermediary did not provide comment to the Board in this matter.

Decision of the Board

The Board concludes that it lacks jurisdiction over the appeal because review of budget neutrality adjustments is expressly prohibited by the statute and regulations. *See* 42 U.S.C. §1395ww(d)(7); 42 U.S.C. § 1395oo(g)(2); 42 C.F.R. §§ 405.1804 and 405.1840(b)(2). Because jurisdiction over an issue is a prerequisite to granting a request for EJR, the Board finds that EJR is not appropriate.

Payment under the prospective payment system is governed by the statutory provisions of 42 U.S.C. § 1395ww. Subsection (d)(7) states that:

> There shall be no administrative or judicial review under [42 U.S.C. §1395oo] or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount of any adjustment effected pursuant to subsection (e)(1) [budget neutrality] or the determination of the applicable percentage increase under paragraph (12)(A)(ii) . . .

The Board's governing statute, 42 U.S.C. § 1395oo(g)(2), states that:

> The determinations and other decisions described in section 1395ww(d)(7) shall not be reviewed by the Board or by any court pursuant to action brought under subsection (f) or otherwise.

CMS' implementing regulation, 42 C.F.R. § 405.1804, entitled "Matters not subject to administrative and judicial review under prospective payment" provides:

> Neither administrative or judicial review is available for controversies about the following matters:
>
> (a) The determination of the requirement, or the proportional amount, of any budget neutrality adjustment in the prospective payment rates. . . . (emphasis added)

CMS stated at the time the rule was adopted that the purpose of the rule is:

> to state that the determinations and decisions described in section 1886(d)(7) of the Act may not receive Board or judicial review. Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
>
> > A determination of the requirement, or the proportional amounts of, any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act . . .

48 Fed. Reg. 39752, 39785 (September 1, 1983).

In addition, section 701(a) of the Administrative Procedure Act (APA) states that the appeal provisions of the APA apply to the administrative actions except where statutes preclude judicial review. *See* 5 U.S.C. § 701(a). The statutes and the regulations both preclude administrative and judicial review of the budget neutrality adjustment.

In *Amgen, Inc. v. Smith*,[2] the D.C. Circuit Court considered whether there is jurisdiction over outpatient PPS (OPPS) payments where the statute precludes administrative or judicial review of the "other adjustments" to OPPS (the classification system, establishment of groups and relative payment weights for covered services, of wage adjustment factors). The Court explained that there is a strong presumption that Congress intends judicial review of administrative action which can only be overcome with "clear and convincing evidence" that Congress intended to preclude appeal. The Court concluded that where the statute stipulated that "there should be no administrative or judicial review," that language constituted clear and convincing evidence that the appeal was precluded. The Court further noted that payments under PPS are made on a prospective basis and, given the length of time that review of individual appeals could take, the result would be retroactive adjustments to payment rates with the potential of creating havoc with the payment system. The aggregate impact of appeal decisions would undermine the Secretary's ability to ensure budget neutrality.

In an earlier decision, *Universal Health Services of McAllen, Inc. v. Sullivan*,[3] (*UHS*) the D. C. District Court distinguished between an appeal of a Medicare Geographic Classification Review Board (MGCRB) decision (over which judicial review is precluded) and a challenge to the validity of the guidelines utilized by the MGCRB and the Secretary to make reclassification decisions. The Court noted that § 701(a) of the APA precludes judicial review where a statute or regulation denies review. In *UHS*, the Court found that it had jurisdiction over the challenge to the guidelines but would not have had jurisdiction over an appeal of an MGCRB decision which was precluded by law.

The Board is not persuaded that preclusion of review of budget neutrality provisions is limited to the fiscal years 1984 and 1985. Even though the rural floor budget neutrality provision was not specifically addressed in the limits on administrative and judicial review, we find the language of the statute itself unambiguous in that there is no indication that the prohibition on administrative

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[2] 357 F.3d 103 (D.C. Cir. 2004).
[3] 770 F. Supp. 704 (D.C. Dist. 1991).

or judicial review is limited to the two fiscal periods identified by the Providers. Therefore, no further inquiry into Congressional intent is warranted. Moreover, if any ambiguity were present, it is resolved by the expansive regulatory language, binding on the Board, that prohibits review of "any controversies about [budget neutrality determinations]."

42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permit providers to bypass the Board's hearing procedure and obtain judicial review of a specific matter at issue involving a question of law or regulation where the Board determines that it is without authority to decide the legal question. Prior to rendering a decision that it lacks the authority to decide the legal question before it, the Board must determine that it has jurisdiction over the matter at issue in the appeal under 42 U.S.C. § 1395oo. 42 C.F.R. § 405.1842(a)(2008). We conclude that both the statute and regulation preclude administrative review of the budget neutrality adjustment; therefore, the Board lacks jurisdiction over the issue.

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

Cape Cod and the Request for EJR

Ordinarily our EJR analysis would end with a determination of no jurisdiction. However, in *Cape Cod HC 2007 Wage Index/Rural Floor Group*, PRRB case number 07-0705G et al, (*Cape Cod*), the Secretary has taken a contrary position. In *Cape Cod*, the Board concluded that it lacked jurisdiction over the budget neutrality adjustment based on the authorities set forth above. The Board's decision was not reversed by the CMS Administrator. On appeal to the Federal district court, however, the Secretary moved for remand on the basis that the Board had jurisdiction over the issue. The provider plaintiffs responded that the remand was unnecessary because the case was properly before the court on EJR. It argued that implicit in the Board's finding it lacked jurisdiction was a determination that it also lacked authority to decide the question, thus, EJR was appropriate. In its remand order, the District Court explained that the two findings are distinct. "Jurisdiction to take any legal action" asks whether the Providers may obtain a hearing at all; "authority to decide the question" asks whether the Board has authority to reach the merits of Providers' claims. The Court concluded that the Secretary's position was correct: the Court lacked subject matter jurisdiction without the Board's first being afforded an opportunity to consider the merits of the Providers' claims, including whether it has authority to decide the question. Neither the D.C. District court remand[4] nor the remand from the Deputy Administrator addresses the Secretary's rationale for his position regarding jurisdiction. Assuming, however, that the Secretary will take the same position in this case with respect to the Board's having jurisdiction over the budget neutrality issue, and in the interest of judicial economy, the Board will also address the question of whether EJR is appropriate.[5]

The Provider in this appeal seeks to have its final wage index rate modified by applying a

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[4] *Cape Cod Hospital v. Leavitt*, (D.D.C. July 21, 2008) (2008 WL 2791683).

[5] After the above remand based on the Secretary's position regarding jurisdiction, the Board found the Provider was entitled to expedited judicial review. In December of 2009, the District Court for the District of Columbia granted the defendant's (government's) motion for summary judgment for the budget neutrality adjustment. *Cape Cod Hospital et al. v. Sebelius*, 2009 WL 4981330 (D.D.C. December 22, 2009) at pp. 9-16.

different calculation methodology relating to the budget neutrality and rural floor factors. Pursuant to 42 C.F.R. § 412.64, the Secretary calculates the standardized amount on an annual basis. This calculation is published annually in the Federal Register following a complex and lengthy process of data collection and analysis. The methodology for the calculation is described in general terms.

The Board is bound by the Secretary's final rules and has no authority to review the data underlying the rate published unless specifically authorized. Notably the Final Rule only provides for Board review of denials of requests by hospitals for correction of certain wage data that eventually goes into one hospital-specific component of the final rate.[6] If the provider appealing the denial is successful, the remedy is limited to the hospital bringing the successful appeal. There is no provision for the Board to adjust the rate itself (as applied to all hospitals) to account for the effect of the error. The Board concludes that the specific grant of authority and establishment of a detailed process for correcting the rate of only the hospital bringing the appeal, coupled with the failure to include the effect of that correction on other hospitals or to establish a similar correction process for other components of the wage index, are strong indications that the Board does not have authority to change the rate itself.

Even more compelling, however, is the language of the statute and the regulation quoted above that prohibits review of budget neutrality determinations which are at the heart of the question before the Board in this case. Even if the Board interpreted the statutory and regulatory prohibitions on review of budget neutrality determinations too broadly to bar jurisdiction, those prohibitions cannot be ignored altogether. We conclude that the statute and regulation evidence Congress' and the Secretary's intent that budget neutrality determinations are insulated from the Board's authority to affirm, reverse or modify a reimbursement determination. Otherwise, the specific prohibitions articulated there would be rendered meaningless.

Assuming, arguendo, that the Secretary takes the same position in these cases that the Board has jurisdiction, then the Board finds that:

1) based upon the Provider's unopposed assertions regarding the challenges to the rural floor/budget neutrality methodology, there are no findings of fact for resolution by the Board;

2) it is bound by the Final Rule in the Federal Register and the regulation; and

3) it is without authority to decide the legal question of whether the calculation methodology for the budget neutrality/rural floor adjustment is valid.

The Board finds that it does not have jurisdiction over the RFBNA issue, therefore the request for expedited judicial review is denied. If, however, the Secretary finds that the Board does have jurisdiction over the RFBNA issue, then expedited judicial review would be appropriate. As the Rural Floor Budget Neutrality Adjustment issue is the sole remaining issue in the appeal, the Board hereby closes case number 13-1036.

---

[6] 64 Fed. Reg. 41490, 41513 (July 30, 1999). This authority has never been codified in the code of Federal Regulations.

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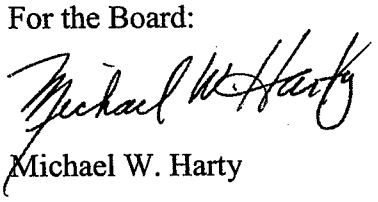
For the Board:



Michael W. Harty

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

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Refer to: 13-3736

CERTIFIED MAIL

NOV 20 2013

Corinna Goron
President
Healthcare Reimbursement Services
17101 Preston Road, Suite 220
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Re: Baton Rouge General Medical Center
Provider No. 19-0065
FYE 9/30/2008
PRRB Case No. 13-3736

Dear Ms. Goron:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's October 31, 2013 request for expedited judicial review (EJR) (received November 1, 2013). This request is unopposed. The issue under dispute involves whether the Centers for Medicare & Medicaid Services (CMS) erred in calculating a budget neutrality adjustment to the prospective payment system (PPS) standardized amount to account for the effects of the rural floor on the wage index. The Board's jurisdictional determination over the rural floor budget neutrality issue and determination with respect to the request for EJR are set forth below.

Medicare Statutory and Regulatory Background

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

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

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the PPS. The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors. *See* 42 U.S.C. § 1395ww(d)(5). This case involves the annual changes to the PPS rates for hospital inpatient operating costs (IPPS) and the methodology for determining those rates.

Standardized Amount

The statute, 42 U.S.C. § 1395ww(d)(2)(A), required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The base-year cost data were used in the initial development of the standardized amounts for PPS which were then used to compute the Federal rates. The standardized amounts are based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Section 1395ww(d)(2)(C) requires that updated base-year per discharge costs be standardized in order to adjust data which might cause variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments (for Alaska and Hawaii), indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994).

Section 1395ww(d)(3)(E) requires the Secretary from time to time to adjust the proportion of the hospitals' costs that are attributable to wages and wage-related costs of the DRG prospective payment rates for area differences in hospital wage levels. The adjustment factors (wage index) should reflect the relative hospital wage level in the geographic area of the hospital being compared to the national average hospital wage level. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor related amount is adjusted by the wage index. Section 1395ww(d)(3)(E)(ii) requires that 62% of the standardized amount be adjusted by the wage index unless doing so would result in lower payments to a hospital than would otherwise be made. 71 Fed. Reg. 47870, 48146 (August 18, 2006).

Budget Neutrality

Budget neutrality is determined by comparing aggregate IPPS payments before and after making changes that are required to be budget neutral (e.g., reclassifying and recalibrating the diagnostic related groups (DRGs)). Outlier payments are also included in the simulations. *Id.* at 48147. In FFYs 2007 and prior, CMS stated that: [the] budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the [prior years'] budget neutrality adjustments. *Id.* at 48147.

In establishing the PPS rate for FFY 2008 CMS applied the budget neutrality adjustment to the wage index rather than to the standardized amount as it had done in previous years. CMS believes that an adjustment to the wage index would result in substantially similar payments as an adjustment to the standardized amount, as both involve multipliers to the standardized amount and both would be based upon the same modeling parameters. 72 Fed. Reg. 47130 (August 22, 2007).

Rural Floor

Section 4410 of the Balanced Budget Act of 1997 (BBA of 1997) established the rural floor by requiring that the wage index of a hospital in any urban area cannot be less than the wage index determined for the state's rural area. Since Federal fiscal year (FFY) 1998, CMS has implemented the budget neutrality requirement of this provision by adjusting the standardized amounts. 72 Fed. Reg. 24680, 24787 (May 3, 2007). In establishing the PPS standardized

amount for FFY 2007 and for prior Federal fiscal years, CMS adjusted the standardized amount downward to account for the effects of the rural floor. *See e.g.* 71 Fed. Reg. at 48145-48148 (August 18, 2006). In FFY 2008 CMS applied the budget neutrality adjustment to the wage index, rather than the standardized amount. [1]

In responding to providers concerns regarding the change to the calculation set forth above and the cumulative effect of the budget neutrality adjustment in the final IPPS rule, CMS stated that:

> [T]he rural floor budget neutrality adjustment previously was a cumulative adjustment, similar to the adjustments we currently make for updates to the wage index and DRG [diagnostic related groups] reclassification and recalibration. Beginning in 2008, the rural floor budget neutrality adjustment will be noncumulative.
>
> ****
>
> With regard to alleged errors in FY 1999 through 2007, our calculation of the budget neutrality in past fiscal years is not within the scope of this rulemaking. Even if errors were made in prior fiscal years, we would not make an adjustment to make up for those errors when setting rates for FY 2008. It is our longstanding policy that finality is critical to a prospective payment system. Although such errors in rate setting are inevitable, we believe the need to establish final prospective rates outweighs the greater accuracy we might gain if we retroactively recomputed rates whenever an error is discovered.

72 Fed. Reg. 47130, 47330 (August 22, 2007).

Wage Index

The statute, 42 U.S.C. § 1395ww(d)(3)(E) and (d)(9)(C)(iv), requires that CMS make an adjustment to the labor-related portion of the national and Puerto Rico PPS rates to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. *Id.* at 48153. The wage index must be updated annually. *Id.* at 48005.

Procedural History

This appeal was timely filed on September 20, 2013 from an original NPR. The Provider contends that the rural floor budget neutrality adjustments as implemented by CMS violate the law's requirement of budget neutrality. The Provider argues that rather than adjusting area wage indexes to achieve budget neutrality, the Secretary adjusted the standardized amount and carried that forward from year to year. The Provider continues that CMS duplicated prior adjustments

[1] 72 Fed. Reg. 47130, 47329 (August 22, 2007).

by each year calculating the full amount of the adjustment necessary to counteract the effect of the rural floor and then applying that adjustment to a figure that includes adjustments carried over from previous years. CMS then reduced the standardized amount to account for the full difference between these two figures. The Provider concludes that the cumulative effect of the improperly duplicative budget neutrality adjustments was to reduce the payment levels below what they otherwise should have been.

Basis for EJR

To establish the PPS rate for FFY 2008 and for prior years, CMS used a payment simulation model to determine each year's budget neutrality adjustment to the standardized amount to account for the effect of the rural floor. In the FFY 2007 rule, CMS described the simulation model and its calculation of the resulting budget neutrality adjustment as follows:

> [W]e used FY 2005 discharge data to simulate payments and compared aggregate payments using the FY 2006 relative weights and wage indexes to aggregate payments using the FY 2007 relative weights and wage indexes. The same methodology was used for the FY 2006 budget neutrality adjustment.
>
> . . . These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2006 budget neutrality adjustments.

71 Fed. Reg. 47870, 48147 (August 18, 2006).

In establishing the PPS rate for FFY 2008 CMS applied the budget neutrality adjustment to the wage index rather than to the standardized amount as it had done in previous years. 72 Fed. Reg. 47130, 47330 (August 22, 2007). CMS did not rectify the cumulative impact of its methodology errors from FFY 1999 through 2007, as described above. *Id.* at 47421. Thus, for FFY 2008, the Provider is appealing the understated FFY 2008 standardized amount used in other FFYs.

The Provider is challenging an aspect of CMS' calculation of the final PPS rates published in the Federal Register for FFY 2008. The Provider contends that CMS erred in calculating a budget neutrality adjustment to the PPS standardized amount to account for the effects of the rural floor on the wage index. This alleged error results in a systematic understatement of the PPS rates, and this error has been an annual and recurring one. Each year's error is permanently incorporated into the standardized amount paid under PPS for each successive year.

Jurisdiction over the Issue

The Provider contends that the Board has jurisdiction over these appeals because the appeals were timely filed from NPRs and the amount in controversy threshold has been met. The Provider points out that review of the PPS payment determination is subject only to the exceptions set forth at 42 U.S.C. § 1395oo(g)(2). This section provides, in relevant part, that determinations described in 42 U.S.C. § 1395ww(d)(7) shall not be reviewed by the Board or any

court. Among the matters not subject to review is the determination of the requirement, or the proportional amount, of any budget neutrality adjustment. The Provider contends that this preclusion of review provision is limited to certain budget neutrality adjustments for fiscal years 1984 and 1985 to ensure that the total amounts paid under PPS, then a new system, were the same as the total amounts that would have been spent under the Medicare law (as modified by the Tax Equity & Fiscal Responsibility Act of 1982 (TEFRA)). 42 U.S.C. § 1395ww(e)(1)(A)-(B).

The Intermediary did not provide comment to the Board in this matter.

Decision of the Board

The Board concludes that it lacks jurisdiction over the appeal because review of budget neutrality adjustments is expressly prohibited by the statute and regulations. *See* 42 U.S.C. §1395ww(d)(7); 42 U.S.C. § 1395oo(g)(2); 42 C.F.R. §§ 405.1804 and 405.1840(b)(2). Because jurisdiction over an issue is a prerequisite to granting a request for EJR, the Board finds that EJR is not appropriate.

Payment under the prospective payment system is governed by the statutory provisions of 42 U.S.C. § 1395ww. Subsection (d)(7) states that:

> There shall be no administrative or judicial review under [42 U.S.C. §1395oo] or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount of any adjustment effected pursuant to subsection (e)(1) [budget neutrality] or the determination of the applicable percentage increase under paragraph (12)(A)(ii) . . .

The Board's governing statute, 42 U.S.C. § 1395oo(g)(2), states that:

> The determinations and other decisions described in section 1395ww(d)(7) shall not be reviewed by the Board or by any court pursuant to action brought under subsection (f) or otherwise.

CMS' implementing regulation, 42 C.F.R. § 405.1804, entitled "Matters not subject to administrative and judicial review under prospective payment" provides:

> Neither administrative or judicial review is available for controversies about the following matters:
>
> (a) The determination of the requirement, or the proportional amount, of any budget neutrality adjustment in the prospective payment rates. . . . (emphasis added)

CMS stated at the time the rule was adopted that the purpose of the rule is:

> to state that the determinations and decisions described in section 1886(d)(7) of the Act may not receive Board or judicial review. Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
>
> > A determination of the requirement, or the proportional amounts of, any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act . . .

48 Fed. Reg. 39752, 39785 (September 1, 1983).

In addition, section 701(a) of the Administrative Procedure Act (APA) states that the appeal provisions of the APA apply to the administrative actions except where statutes preclude judicial review. *See* 5 U.S.C. § 701(a). The statutes and the regulations both preclude administrative and judicial review of the budget neutrality adjustment.

In *Amgen, Inc. v. Smith*,[2] the D.C. Circuit Court considered whether there is jurisdiction over outpatient PPS (OPPS) payments where the statute precludes administrative or judicial review of the "other adjustments" to OPPS (the classification system, establishment of groups and relative payment weights for covered services, of wage adjustment factors). The Court explained that there is a strong presumption that Congress intends judicial review of administrative action which can only be overcome with "clear and convincing evidence" that Congress intended to preclude appeal. The Court concluded that where the statute stipulated that "there should be no administrative or judicial review," that language constituted clear and convincing evidence that the appeal was precluded. The Court further noted that payments under PPS are made on a prospective basis and, given the length of time that review of individual appeals could take, the result would be retroactive adjustments to payment rates with the potential of creating havoc with the payment system. The aggregate impact of appeal decisions would undermine the Secretary's ability to ensure budget neutrality.

In an earlier decision, *Universal Health Services of McAllen, Inc. v. Sullivan*,[3] (*UHS*) the D. C. District Court distinguished between an appeal of a Medicare Geographic Classification Review Board (MGCRB) decision (over which judicial review is precluded) and a challenge to the validity of the guidelines utilized by the MGCRB and the Secretary to make reclassification decisions. The Court noted that § 701(a) of the APA precludes judicial review where a statute or regulation denies review. In *UHS*, the Court found that it had jurisdiction over the challenge to the guidelines but would not have had jurisdiction over an appeal of an MGCRB decision which was precluded by law.

The Board is not persuaded that preclusion of review of budget neutrality provisions is limited to the fiscal years 1984 and 1985. Even though the rural floor budget neutrality provision was not specifically addressed in the limits on administrative and judicial review, we find the language of the statute itself unambiguous in that there is no indication that the prohibition on administrative

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[2] 357 F.3d 103 (D.C. Cir. 2004).
[3] 770 F. Supp. 704 (D.C. Dist. 1991).

or judicial review is limited to the two fiscal periods identified by the Providers. Therefore, no further inquiry into Congressional intent is warranted. Moreover, if any ambiguity were present, it is resolved by the expansive regulatory language, binding on the Board, that prohibits review of "any controversies about [budget neutrality determinations]."

42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permit providers to bypass the Board's hearing procedure and obtain judicial review of a specific matter at issue involving a question of law or regulation where the Board determines that it is without authority to decide the legal question. Prior to rendering a decision that it lacks the authority to decide the legal question before it, the Board must determine that it has jurisdiction over the matter at issue in the appeal under 42 U.S.C. § 1395oo. 42 C.F.R. § 405.1842(a)(2008). We conclude that both the statute and regulation preclude administrative review of the budget neutrality adjustment; therefore, the Board lacks jurisdiction over the issue.

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

Cape Cod and the Request for EJR

Ordinarily our EJR analysis would end with a determination of no jurisdiction. However, in *Cape Cod HC 2007 Wage Index/Rural Floor Group*, PRRB case number 07-0705G et al, (*Cape Cod*), the Secretary has taken a contrary position. In *Cape Cod*, the Board concluded that it lacked jurisdiction over the budget neutrality adjustment based on the authorities set forth above. The Board's decision was not reversed by the CMS Administrator. On appeal to the Federal district court, however, the Secretary moved for remand on the basis that the Board had jurisdiction over the issue. The provider plaintiffs responded that the remand was unnecessary because the case was properly before the court on EJR. It argued that implicit in the Board's finding it lacked jurisdiction was a determination that it also lacked authority to decide the question, thus, EJR was appropriate. In its remand order, the District Court explained that the two findings are distinct. "Jurisdiction to take any legal action" asks whether the Providers may obtain a hearing at all; "authority to decide the question" asks whether the Board has authority to reach the merits of Providers' claims. The Court concluded that the Secretary's position was correct: the Court lacked subject matter jurisdiction without the Board's first being afforded an opportunity to consider the merits of the Providers' claims, including whether it has authority to decide the question. Neither the D.C. District court remand[4] nor the remand from the Deputy Administrator addresses the Secretary's rationale for his position regarding jurisdiction. Assuming, however, that the Secretary will take the same position in this case with respect to the Board's having jurisdiction over the budget neutrality issue, and in the interest of judicial economy, the Board will also address the question of whether EJR is appropriate.[5]

The Provider in this appeal seeks to have its final wage index rate modified by applying a

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[4] *Cape Cod Hospital v. Leavitt*, (D.D.C. July 21, 2008) (2008 WL 2791683).

[5] After the above remand based on the Secretary's position regarding jurisdiction, the Board found the Provider was entitled to expedited judicial review. In December of 2009, the District Court for the District of Columbia granted the defendant's (government's) motion for summary judgment for the budget neutrality adjustment. *Cape Cod Hospital et al. v. Sebelius*, 2009 WL 4981330 (D.D.C. December 22, 2009) at pp. 9-16.

different calculation methodology relating to the budget neutrality and rural floor factors. Pursuant to 42 C.F.R. § 412.64, the Secretary calculates the standardized amount on an annual basis. This calculation is published annually in the Federal Register following a complex and lengthy process of data collection and analysis. The methodology for the calculation is described in general terms.

The Board is bound by the Secretary's final rules and has no authority to review the data underlying the rate published unless specifically authorized. Notably the Final Rule only provides for Board review of denials of requests by hospitals for correction of certain wage data that eventually goes into one hospital-specific component of the final rate.[6] If the provider appealing the denial is successful, the remedy is limited to the hospital bringing the successful appeal. There is no provision for the Board to adjust the rate itself (as applied to all hospitals) to account for the effect of the error. The Board concludes that the specific grant of authority and establishment of a detailed process for correcting the rate of only the hospital bringing the appeal, coupled with the failure to include the effect of that correction on other hospitals or to establish a similar correction process for other components of the wage index, are strong indications that the Board does not have authority to change the rate itself.

Even more compelling, however, is the language of the statute and the regulation quoted above that prohibits review of budget neutrality determinations which are at the heart of the question before the Board in this case. Even if the Board interpreted the statutory and regulatory prohibitions on review of budget neutrality determinations too broadly to bar jurisdiction, those prohibitions cannot be ignored altogether. We conclude that the statute and regulation evidence Congress' and the Secretary's intent that budget neutrality determinations are insulated from the Board's authority to affirm, reverse or modify a reimbursement determination. Otherwise, the specific prohibitions articulated there would be rendered meaningless.

Assuming, arguendo, that the Secretary takes the same position in these cases that the Board has jurisdiction, then the Board finds that:

1) based upon the Provider's unopposed assertions regarding the challenges to the rural floor/budget neutrality methodology, there are no findings of fact for resolution by the Board;

2) it is bound by the Final Rule in the Federal Register and the regulation; and

3) it is without authority to decide the legal question of whether the calculation methodology for the budget neutrality/rural floor adjustment is valid.

The Board finds that it does not have jurisdiction over the RFBNA issue, therefore the request for expedited judicial review is denied. If, however, the Secretary finds that the Board does have jurisdiction over the RFBNA issue, then expedited judicial review would be appropriate. As the RFBNA issue is the sole issue in the appeal, the Board hereby closes case number 13-3736.

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[6] 64 Fed. Reg. 41490, 41513 (July 30, 1999). This authority has never been codified in the code of Federal Regulations.

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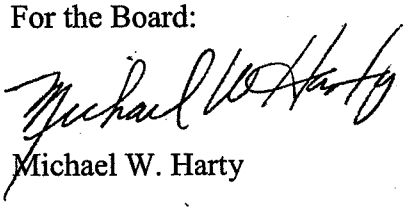

Michael W. Harty

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

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Refer to: 06-0386G

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NOV 21 2013

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RE: Puerto Rico 2000 DSH Group Appeal I
PN: Various
FYE: 12/31/2000
PRRB Case No.: 06-0386G

Dear Mr. Roth and Mr. Pike,

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced appeal. The jurisdictional decision of the Board is set forth below.

Background

The Providers filed a group appeal request with the Board on December 15, 2005. The Board assigned case number 06-0386G to the appeal. This group appeal is one of about 76 individual appeals and 8 group appeals for 27 hospitals in Puerto Rico that are currently before the Board on two common issues: the SSI% issue and the Medicare + Choice days issue. As this is a group appeal, the only issue is the SSI% issue.

On August 21, 2007, the Board sent a letter to the various Providers requesting additional documentation related to the revised NPR appeals in order to determine whether it has jurisdiction over the issues. In the same letter, the Board explained that it was considering on its own motion an EJR because it was unsure whether it had the authority to decide the question before it (referring to the SSI% issue). The Board stated that the replacement of cash assistance under Titles I, X, and XIV of the Social Security Act by Title XVI (SSI) in 1974 does not apply to Puerto Rico. The Provider, on the other hand, argued that anyone eligible for cash assistance under Titles I, X, and XIV would qualify for benefits under Title XVI. The Board requested that both parties submit comments regarding a potential EJR, in addition to the requested jurisdictional documents.

On February 7, 2008, the Board issued a decision finding that it has jurisdiction to determine whether eligibility under Title I, X, and XIV also satisfies eligibility under Title XVI, therefore an EJR was not granted. On that same date, the Board sent another letter to the Provider requesting additional documentation related to the appeal from a revised NPR. The Board

specified what information it was requesting, including workpapers related to the SSI% issue. On May 19, 2008, the Providers submitted the Schedule of Providers and "Documents Confirming Board Jurisdiction over RNPR Appeals." One of the Providers in case number 06-0386G, Hospital San Pablo Bayamon (provider number 40-0109, FYE 12/31/2000), has appealed from a revised NPR.[1]

Providers' Position

The Providers' representative argues in its May 19, 2008 jurisdictional submission that the Board has jurisdiction over Hospital San Pablo's appeal from a revised NPR because the "DSH calculation was reopened and changed." The representative also references a jurisdictional decision, PRRB Case No. 98-0443, in which the Board found that it had jurisdiction over the SSI% issue although it was not specifically adjusted because the entire DSH calculation was reopened and changed.

Board's Decision

The Board finds that it does not have jurisdiction over Hospital San Pablo Bayamon (provider number 40-0109) because the revised NPR did not specifically adjust the SSI%.

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 1885 provides in relevant part:

> (a) General. (1) A Secretary determination, an intermediary determination, or a decision by a reviewing entity (as described in § 405.1801(a) of this subpart) may be reopened, for findings on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the intermediary (with respect to intermediary determinations) or by the reviewing entity that made the decision (as described in § 405.1885(c) of this subpart).

42 C.F.R. § 405.1889 explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.

[1] This Provider also included the date of its original NPR on the Schedule of Providers and included the original NPR in the documents supporting the Schedule of Providers, however that NPR is not part of this appeal. The Provider appealed the original NPR on July 22, 2004, and the Board established case number 04-1917. Case number 04-1917 was dismissed on September 3, 2004 because the appeal was not timely filed.

> (b)(2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

This regulation has also been addressed and explained in the decision *HCA Health Services of Oklahoma v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994). In this case, the Court held that when a fiscal intermediary reopens its original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening.

The Provider's reliance on a jurisdictional decision issued in 1998 is misplaced. Since that time, the Board, in conformity with the regulations and case law discussed above, has required that a Provider demonstrate that there was a specific adjustment to an issue appealed from a revised NPR in order to find jurisdiction, which Hospital San Pablo was not able to do here.

The Board finds that it does not have jurisdiction over Hospital San Pablo Bayamon and hereby dismisses this Provider from case number 06-0386G because the Provider appealed from a revised NPR that did not specifically adjusted the SSI%.

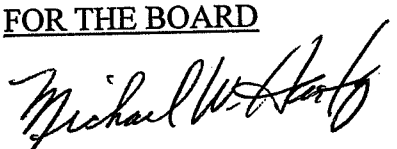
The dismissal of Hospital San Pablo Bayamon leaves only one Provider in case number 06-0386G, Hospital San Pablo del Este Fajardo (provider number 40-0125, FYE 12/31/2002). The Board hereby transfers San Pablo del Este Fajardo to case number 06-0389G, Puerto Rico 2000 DSH Group Appeal II. Although this Provider is commonly owned, the Board will allow this Provider to be transferred back to the pending optional group 06-0389G as it is the only participant in remaining in the chain with the SSI% issue for the 2000 FYE.

Since there are no remaining participants in the Puerto Rico 2000 DSH Group Appeal I, case number 06-0386G is hereby closed.

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

Board Members Participating:
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin D. Shanklin, BCBSA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
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CERTIFIED MAIL

NOV 22 2013

David S. Kornblum, CPA
Healthcare Advisory Services
14050 Broadway Terrace
Oakland, CA 94611-1249

RE: Jurisdictional Challenge
Provider: DSK 82-83 RCL Group Appeal
Provider No: Various
FYE: Various
PRRB Case No.: 04-0227G

Dear Mr. Kornblum:

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional briefs of the parties in the above-referenced appeal. The Board's decision regarding jurisdiction is set forth below.

Background

On December 02, 2003, the Providers filed a request for an optional group appeal challenging the routine cost limit (RCL). The Providers each appealed from denials of reopenings to amend their RCL in their individual appeals. [1] The Board assigned case number 04-0227G to the case.

On May 21, 2004, the Intermediary filed a jurisdictional challenge regarding all four Providers in the group. The Intermediary contended that the appeals were not timely filed and that the appeals were based on denials of reopenings. On September 13, 2004, the Providers submitted their response to the Intermediary's jurisdictional challenge and their final Position Paper. The Providers requested that the Board incorporate the entire record of case number 90-1415G with the record of case number 04-0227G. On June 28, 2005, the Intermediary submitted its final Position Paper.

Intermediary's Position

The Intermediary contends that the Providers are not within the jurisdictional parameters for either a reopening or an appeal. The Providers did not file their appeal within the required timeframe as established under 42 C.F.R. § 405.1841.[2] The RCL issue could have been appealed by the Providers within 180 days from the notice of program reimbursements (NPRs). The RCL

[1] The Providers filed their appeal requests on the following dates: 02/14/95, 12/08/97, 05/03/95 and 01/13/95. NPRs were mailed to the Providers on the following dates: 05/15/84, 04/27/84, 01/20/84 and 09/04/84.
[2] Intermediary's jurisdictional challenge at 2.

issue existed during that period and the finalized cost report did reflect a limit. The Intermediary asserts the Providers failed to avail themselves of this avenue and waited over 10 years to file a reopening request.[3] This prompted the Intermediary to deny the reopening requests; therefore, prompting the Providers filing for appeals based on the denial of reopening dates.[4] The Intermediary maintains the appeals were filed almost 11 years after the NPRs were issued.[5]

Provider's Position

The Providers maintain that they are entitled to an exception for good cause for the late filing of their appeals under the doctrine of equitable tolling[6] and 42 C.F.R. § 405.1885(d). The Providers argue that there is nothing in the Medicare statute to restrict the application of equitable tolling principles to the 180 day limitation period placed on cost appeals under Section 1395oo(a). The Providers contend rather 42 C.F.R. § 405.1841(b), which permits the PRRB "for good cause shown" to entertain an appeal filed after the 180 day time limit has expired, suggests the contrary.

The Providers maintain the HCFA Administrator's decision in *St. Mary's Hosp.*[7], also suggests that equitable considerations should be applied to determine whether an appeal after the 180 day limit may be entertained. The Providers argue the admonition from the HCFA Administrator to temper the rules with the laches principle amounts to nothing more than the position the Providers assert: equitable tolling principles may be applied to extend its time to appeal from the RCL.

The Providers maintain even before the Supreme Court announced the general rule of equitable tolling in *Irwin*[8], the Court employed equitable tolling principles against administrative agencies that made determinations based on undisclosed rules or criteria. The Providers cite to *Bowen v. City of New York*, 476 U.S. 467 (1986), where the Court found that the equities in favor of tolling are compelling where the Social Security Administration employed internal guidelines, never published in the Federal Register, to deny respondent's disability claims.

The Providers contend like the respondents in the Bowen case the Providers did not know when they received their original NPRs that the routine cost limits applied therein were statistically invalid. The Providers argue the NPRs were made on the basis of a systematic procedural irregularity and thus, they are entitled to a substantive review of these irregularities under the principle of equitable tolling.[9]

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[3] Intermediary's Position Paper at 6.
[4] Intermediary's jurisdictional challenge at 2.
[5] Intermediary's Position Paper at 6-7.
[6] The Providers contend equitable tolling principles extends the limitations period on an action when the plaintiffs are prevented from asserting their claims by some kind of wrongful conduct on the part of the defendant, *Seattle Audubon Soc'y*, 931 F.2d at 595, or where the complainant has been induced or tricked by his adversary's misconduct into allowing the filing deadline to pass, *Irwin*, 111 S. Ct. at 458; second, where extraordinary circumstances beyond the plaintiff's control made it impossible to file the claims on time, *Seattle Audubon Soc'y*, 931 F.2d at 595; and third, where the claimant has actively pursued his judicial remedies by filing a defective pleading during the statutory period, *Irwin*, 111 S.Ct. at 458.
[7] HCFA Admn'r Dec. No. 82-71 (June 28, 1983), p. 4.
[8] *Irwin v. Department of Veterans Affairs*, 498 U.S. 89; 111 S.Ct. 453 (1990).
[9] Providers Position Paper at 9-11.

The Providers maintain that the Secretary knowingly hid from the Providers and similar providers known defects in the RCL formula.[10] The Providers contend in light of the four publications in the Federal Register which proclaimed the sufficiency of the covered days adjustment, they would never had reason to believe that the covered days adjustment really had been established and applied without legitimate foundation and that the lack of foundation and inadequacy of the adjustment was known to CMS/HCFA at all times since 1981.

The Providers contend that the error and concealment was gleamed from documents produced by the Secretary to the Providers from the files of PRRB case number 90-1415G. The Providers argue that the declarations from that file make clear, aside from a small group of lawyers and their clients, that no one outside of CMS/HCFA knew about the errors in the routine cost limit and the efforts to conceal those errors.

The Providers argue that the Secretary's wrongful concealment of obvious errors in the routine cost limit, coupled with the Secretary's continued public assurance that the limits were sound and adequate, prevented the Providers from asserting their challenge to the routine cost limit within 180 days of the issuance of the original NPR. Thus, the Providers maintain equitable principles dictate that it be afforded a hearing on these issues.[11]

The Providers argue that CMS/HCFA's conduct in not correcting its covered days of care adjustment factors, in light of the evidence, to prevent any further disadvantage to hospital and/or not advising hospitals of the inadequacy of the adjustments so that they could have been aware of the need to file proper and timely exception requests constitutes "fraud or similar fault" under 42 C.F.R. § 405.1885(d) and is a basis for reopening the Providers' cost report beyond the three year period.[12]

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) (2003) and 42 C.F.R. § 405.1841(a)(1) (2003), 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 $10,000 or more ($50,000 for a group) and the request for hearing is received by the Board within 180 days of the date the notice of the intermediary's determination was mailed to the provider.

Jurisdiction for reopening a determination or decision rests exclusively with the administrative body that rendered the last determination or decision.[13] The intermediary's refusal to reopen the cost report is not reviewable. *Your Home Visiting Nurse Services, Inc. v. Shalala*, 525 U.S. 449, 454 (1999). In addressing the issue of whether the Board has jurisdiction to review an Intermediary's refusal to reopen a reimbursement determination, the Supreme Court in *Your Home* addressed the interpretation of the "final determination . . . as to the amount of total

[10] *Id.* at 11.
[11] *Id.* at 22-23.
[12] *Id.* at 24.
[13] 42 C.F.R. § 405.1885(c) (2003)

program reimbursement due the provider" from 42 U.S.C. § 1395*oo*(a)(1)(A)(i).[14] The Court adopted the Secretary of Health and Human Services' (HHS) interpretation of that phrase that, "this phrase does not include a refusal to reopen, which is not a 'final determination . . . as to the amount,' but rather the *refusal* to make a new determination."[15] The Court found that the Board does not have jurisdiction over providers' appeals from the intermediary's refusal to reopen the cost reports.[16]

In the instant case, the Providers requested that the Intermediary reopen their cost reports on various dates in 1994 and 1997.[17] The Intermediary denied the Providers' requests to reopen[18] because the requests were made beyond the 3 year filing requirement period.[19] As jurisdiction to reopen a determination rests exclusively with the administrative body that rendered the determination (in this case, the Intermediary) and a refusal by the intermediary to reopen a cost report is not reviewable, the Board finds that it lacks jurisdiction over the Providers.

The Providers argue that the Board should take jurisdiction over the late filed appeals pursuant to 42 C.F.R. § 1885(d) as the intermediary's determination was procured by "fraud or similar fault" on the part of CMS. However, as stated previously, a determination to reopen or not to reopen a determination is "not a final determination" and thus is not subject to review by the Board.

Additionally, the Providers did not timely appeal from their final determinations, all of which were issued on various dates in 1984.[20] The Providers filed their appeal requests on various dates in 1995 and 1997,[21] almost 11 years after their NPRs were issued, which is well beyond the 180 day time limit for filing appeals.

The Providers argue that they are entitled to an exception for good cause for the late filing of their appeals under the doctrine of equitable tolling. However, the Supreme Court recently addressed the question of whether the Board can consider equitable tolling and found that equitable tolling does not apply to appeals pending before the Board. *See Sebelius v. Auburn Regional Medical Center*, 133 S.Ct. 817, 822 (2013). The Court held that the Board cannot consider equitable tolling to extend the time for filing.[22]

The Board finds that it does not have jurisdiction over any of the Providers in case number 04-0227G because they are appealing from the Intermediary's refusal to reopen cost reports, which is not a determination over which the Board has jurisdiction. Additionally, even if the Providers appealed from their final determinations, those appeals are untimely and the Providers lack good

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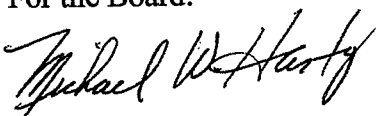
[14] 525 U.S. at 453.
[15] *Id.* Emphasis in original.
[16] *Id.* at 458.
[17] The requests to reopen were dated: 12/22/94, 10/03/97, 03/16/94 and 11/16/94.
[18] The Intermediary denied the requests to reopen on the following dates: 02/06/95, 10/29/97, 03/14/95 and 12/08/94.
[19] 42 C.F.R. § 405.1885(a) (2003) provides: "[a]ny such requests to reopen must be made within 3 years of the date of the notice of the intermediary or Board hearing decision."
[20] The NPRs were mailed on the following dates: 05/15/84, 04/27/84, 01/30/84 and 09/04/84.
[21] The Providers filed their appeal requests on the following dates: 02/14/95, 12/08/97, 05/03/95 and 01/13/95.
[22] *Id.*

cause for the late filings. The Board dismisses the Providers from case number 04-0227G and closes 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 and 405.1877.

Board Members Participating:
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Anderson, Esq.

For the Board:



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin D. Shanklin
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Refer to: 13-2429

CERTIFIED MAIL

NOV 22 2013

Corinna Goron
President
Healthcare Reimbursement Services
17101 Preston Road, Suite 220
Dallas, TX 75248-1372

Re: North Oaks Medical Center
Provider No. 19-0015
FYE 6/30/2008
PRRB Case No. 13-2429

Dear Ms. Goron:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's October 31, 2013 request for expedited judicial review (EJR) (received November 1, 2013). This request is unopposed. The issue under dispute involves whether the Centers for Medicare & Medicaid Services (CMS) erred in calculating a budget neutrality adjustment to the Prospective Payment System (PPS) standardized amount to account for the effects of the rural floor on the wage index. The Board's jurisdictional determination over the rural floor budget neutrality issue and determination with respect to the request for EJR are set forth below.[1]

Medicare Statutory and Regulatory Background

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

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

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the PPS. The PPS statute contains a number of provisions that adjust reimbursement based on

[1] The federal fiscal years (FFYs) under appeal in these cases comprise two FFYs. The period from 7/1/2007 – 9/30/2007, comprises FFY 2007, and the period from 10/1/2007 – 6/30/2008, comprises FFY 2008. This letter will address both of these FFYs.

hospital-specific factors. *See* 42 U.S.C. § 1395ww(d)(5). This case involves the annual changes to the PPS rates for hospital inpatient operating costs (IPPS) and the methodology for determining those rates.

Standardized Amount

The statute, 42 U.S.C. § 1395ww(d)(2)(A), required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The base-year cost data were used in the initial development of the standardized amounts for PPS which were then used to compute the Federal rates. The standardized amounts are based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Section 1395ww(d)(2)(C) requires that updated base-year per discharge costs be standardized in order to adjust data which might cause variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments (for Alaska and Hawaii), indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994).

Section 1395ww(d)(3)(E) requires the Secretary from time to time to adjust the proportion of the hospitals' costs that are attributable to wages and wage-related costs of the DRG prospective payment rates for area differences in hospital wage levels. The adjustment factors (wage index) should reflect the relative hospital wage level in the geographic area of the hospital being compared to the national average hospital wage level. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor related amount is adjusted by the wage index. Section 1395ww(d)(3)(E)(ii) requires that 62% of the standardized amount be adjusted by the wage index unless doing so would result in lower payments to a hospital than would otherwise be made. 71 Fed. Reg. 47870, 48146 (August 18, 2006).

Budget Neutrality

Budget neutrality is determined by comparing aggregate IPPS payments before and after making changes that are required to be budget neutral (e.g., reclassifying and recalibrating the diagnostic related groups (DRGs)). Outlier payments are also included in the simulations. *Id.* at 48147. In FFYs 2007 and prior, CMS stated that: [the] budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the [prior years'] budget neutrality adjustments. *Id.* at 48147.

In establishing the PPS rate for FFY 2008 CMS applied the budget neutrality adjustment to the wage index rather than to the standardized amount as it had done in previous years. CMS believes that an adjustment to the wage index would result in substantially similar payments as an adjustment to the standardized amount, as both involve multipliers to the standardized amount and both would be based upon the same modeling parameters. 72 Fed. Reg. 47130 (August 22, 2007).

Rural Floor

Section 4410 of the Balanced Budget Act of 1997 (BBA of 1997) established the rural floor by requiring that the wage index of a hospital in any urban area cannot be less than the wage index

determined for the state's rural area. Since Federal fiscal year (FFY) 1998, CMS has implemented the budget neutrality requirement of this provision by adjusting the standardized amounts. 72 Fed. Reg. 24680, 24787 (May 3, 2007). In establishing the PPS standardized amount for FFY 2007 and for prior Federal fiscal years, CMS adjusted the standardized amount downward to account for the effects of the rural floor. *See e.g.* 71 Fed. Reg. at 48145-48148 (August 18, 2006). In FFY 2008 CMS applied the budget neutrality adjustment to the wage index, rather than the standardized amount. [2]

In responding to providers concerns regarding the change to the calculation set forth above and the cumulative effect of the budget neutrality adjustment in the final IPPS rule, CMS stated that:

> [T]he rural floor budget neutrality adjustment previously was a cumulative adjustment, similar to the adjustments we currently make for updates to the wage index and DRG [diagnostic related groups] reclassification and recalibration. Beginning in 2008, the rural floor budget neutrality adjustment will be noncumulative.
>
> ****
>
> With regard to alleged errors in FY 1999 through 2007, our calculation of the budget neutrality in past fiscal years is not within the scope of this rulemaking. Even if errors were made in prior fiscal years, we would not make an adjustment to make up for those errors when setting rates for FY 2008. It is our longstanding policy that finality is critical to a prospective payment system. Although such errors in rate setting are inevitable, we believe the need to establish final prospective rates outweighs the greater accuracy we might gain if we retroactively recomputed rates whenever an error is discovered.

72 Fed. Reg. 47130, 47330 (August 22, 2007).

Wage Index

The statute, 42 U.S.C. § 1395ww(d)(3)(E) and (d)(9)(C)(iv), requires that CMS make an adjustment to the labor-related portion of the national and Puerto Rico PPS rates to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. *Id.* at 48153. The wage index must be updated annually. *Id.* at 48005.

Procedural History

This appeal was timely filed on July 10, 2013 from an original NPR. The Provider contends that the rural floor budget neutrality adjustments as implemented by CMS violate the law's

[2] 72 Fed. Reg. 47130, 47329 (August 22, 2007).

requirement of budget neutrality. The Provider argues that rather than adjusting area wage indexes to achieve budget neutrality, the Secretary adjusted the standardized amount and carried that forward from year to year. The Provider continues that CMS duplicated prior adjustments by each year calculating the full amount of the adjustment necessary to counteract the effect of the rural floor and then applying that adjustment to a figure that includes adjustments carried over from previous years. CMS then reduced the standardized amount to account for the full difference between these two figures. The Provider concludes that the cumulative effect of the improperly duplicative budget neutrality adjustments was to reduce the payment levels below what they otherwise should have been.

Basis for EJR

To establish the PPS rate for FFYs 2007 and 2008 and for prior years, CMS used a payment simulation model to determine each year's budget neutrality adjustment to the standardized amount to account for the effect of the rural floor. In the FFY 2007 rule, CMS described the simulation model and its calculation of the resulting budget neutrality adjustment as follows:

> [W]e used FY 2005 discharge data to simulate payments and compared aggregate payments using the FY 2006 relative weights and wage indexes to aggregate payments using the FY 2007 relative weights and wage indexes. The same methodology was used for the FY 2006 budget neutrality adjustment.
>
> . . . These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2006 budget neutrality adjustments.

71 Fed. Reg. 47870, 48147 (August 18, 2006).

In establishing the PPS rate for FFY 2008 CMS applied the budget neutrality adjustment to the wage index rather than to the standardized amount as it had done in previous years. 72 Fed. Reg. 47130, 47330 (August 22, 2007). CMS did not rectify the cumulative impact of its methodology errors from FFY 1999 through 2007, as described above. *Id.* at 47421. Thus, for FFY 2008, the Provider is appealing the understated FFY 2008 standardized amount used in other FFYs.
The Provider is challenging an aspect of CMS' calculation of the final PPS rates published in the Federal Register for FFYs 2007[3] and 2008. The Provider contends that CMS erred in calculating a budget neutrality adjustment to the PPS standardized amount to account for the effects of the rural floor on the wage index. This alleged error results in a systematic understatement of the PPS rates, and this error has been an annual and recurring one. Each year's error is permanently incorporated into the standardized amount paid under PPS for each successive year.

[3] The final PPS rates for FFY 2007 were published in the Federal Register on October 11, 2006. 71 Fed. Reg. 59886, 59889 (October 11, 2006). The August 18, 2006 Federal Register cited above noted that the standardized amount was tentative because factors such as the outlier offset and budget neutrality adjustment for the wage index and reclassification that are applied to the standardized amount had not been determined pending the calculation of the occupational mix adjustment. 71 Fed. Reg. 47870, 48146.

Jurisdiction over the Issue

The Provider contends that the Board has jurisdiction over these appeals because the appeals were timely filed from NPRs and the amount in controversy threshold has been met. The Provider points out that review of the PPS payment determination is subject only to the exceptions set forth at 42 U.S.C. § 1395oo(g)(2). This section provides, in relevant part, that determinations described in 42 U.S.C. § 1395ww(d)(7) shall not be reviewed by the Board or any court. Among the matters not subject to review is the determination of the requirement, or the proportional amount, of any budget neutrality adjustment. The Provider contends that this preclusion of review provision is limited to certain budget neutrality adjustments for fiscal years 1984 and 1985 to ensure that the total amounts paid under PPS, then a new system, were the same as the total amounts that would have been spent under the Medicare law (as modified by the Tax Equity & Fiscal Responsibility Act of 1982 (TEFRA)). 42 U.S.C. § 1395ww(e)(1)(A)-(B).

The Intermediary did not provide comment to the Board in this matter.

Decision of the Board

The Board concludes that it lacks jurisdiction over the appeal because review of budget neutrality adjustments is expressly prohibited by the statute and regulations. *See* 42 U.S.C. §1395ww(d)(7); 42 U.S.C. § 1395oo(g)(2); 42 C.F.R. §§ 405.1804 and 405.1840(b)(2). Because jurisdiction over an issue is a prerequisite to granting a request for EJR, the Board finds that EJR is not appropriate.

Payment under the prospective payment system is governed by the statutory provisions of 42 U.S.C. § 1395ww. Subsection (d)(7) states that:

> There shall be no administrative or judicial review under [42 U.S.C. §1395oo] or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount of any adjustment effected pursuant to subsection (e)(1) [budget neutrality] or the determination of the applicable percentage increase under paragraph (12)(A)(ii) . . .

The Board's governing statute, 42 U.S.C. § 1395oo(g)(2), states that:

> The determinations and other decisions described in section 1395ww(d)(7) shall not be reviewed by the Board or by any court pursuant to action brought under subsection (f) or otherwise.

CMS' implementing regulation, 42 C.F.R. § 405.1804, entitled "Matters not subject to administrative and judicial review under prospective payment" provides:

> Neither administrative or judicial review is available for controversies

about the following matters:

(a) The determination of the requirement, or the proportional amount, of any budget neutrality adjustment in the prospective payment rates. . . . (emphasis added)

CMS stated at the time the rule was adopted that the purpose of the rule is:

to state that the determinations and decisions described in section 1886(d)(7) of the Act may not receive Board or judicial review. Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:

A determination of the requirement, or the proportional amounts of, any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act . . .

48 Fed. Reg. 39752, 39785 (September 1, 1983).

In addition, section 701(a) of the Administrative Procedure Act (APA) states that the appeal provisions of the APA apply to the administrative actions except where statutes preclude judicial review. *See* 5 U.S.C. § 701(a). The statutes and the regulations both preclude administrative and judicial review of the budget neutrality adjustment.

In *Amgen, Inc. v. Smith*,[4] the D.C. Circuit Court considered whether there is jurisdiction over outpatient PPS (OPPS) payments where the statute precludes administrative or judicial review of the "other adjustments" to OPPS (the classification system, establishment of groups and relative payment weights for covered services, of wage adjustment factors). The Court explained that there is a strong presumption that Congress intends judicial review of administrative action which can only be overcome with "clear and convincing evidence" that Congress intended to preclude appeal. The Court concluded that where the statute stipulated that "there should be no administrative or judicial review," that language constituted clear and convincing evidence that the appeal was precluded. The Court further noted that payments under PPS are made on a prospective basis and, given the length of time that review of individual appeals could take, the result would be retroactive adjustments to payment rates with the potential of creating havoc with the payment system. The aggregate impact of appeal decisions would undermine the Secretary's ability to ensure budget neutrality.

In an earlier decision, *Universal Health Services of McAllen, Inc. v. Sullivan*,[5] (*UHS*) the D. C. District Court distinguished between an appeal of a Medicare Geographic Classification Review Board (MGCRB) decision (over which judicial review is precluded) and a challenge to the validity of the guidelines utilized by the MGCRB and the Secretary to make reclassification decisions. The Court noted that § 701(a) of the APA precludes judicial review where a statute or regulation denies review. In *UHS*, the Court found that it had jurisdiction over the challenge to

[4] 357 F. 3d 103 (D.C. Cir. 2004).
[5] 770 F. Supp. 704 (D.C. Dist. 1991).

the guidelines but would not have had jurisdiction over an appeal of an MGCRB decision which was precluded by law.

The Board is not persuaded that preclusion of review of budget neutrality provisions is limited to the fiscal years 1984 and 1985. Even though the rural floor budget neutrality provision was not specifically addressed in the limits on administrative and judicial review, we find the language of the statute itself unambiguous in that there is no indication that the prohibition on administrative or judicial review is limited to the two fiscal periods identified by the Providers. Therefore, no further inquiry into Congressional intent is warranted. Moreover, if any ambiguity were present, it is resolved by the expansive regulatory language, binding on the Board, that prohibits review of "any controversies about [budget neutrality determinations]."

42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permit providers to bypass the Board's hearing procedure and obtain judicial review of a specific matter at issue involving a question of law or regulation where the Board determines that it is without authority to decide the legal question. Prior to rendering a decision that it lacks the authority to decide the legal question before it, the Board must determine that it has jurisdiction over the matter at issue in the appeal under 42 U.S.C. § 1395oo. 42 C.F.R. § 405.1842(a)(2008). We conclude that both the statute and regulation preclude administrative review of the budget neutrality adjustment; therefore, the Board lacks jurisdiction over the issue.

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

Cape Cod and the Request for EJR

Ordinarily our EJR analysis would end with a determination of no jurisdiction. However, in *Cape Cod HC 2007 Wage Index/Rural Floor Group*, PRRB case number 07-0705G et al, (*Cape Cod*), the Secretary has taken a contrary position. In *Cape Cod*, the Board concluded that it lacked jurisdiction over the budget neutrality adjustment based on the authorities set forth above. The Board's decision was not reversed by the CMS Administrator. On appeal to the Federal district court, however, the Secretary moved for remand on the basis that the Board had jurisdiction over the issue. The provider plaintiffs responded that the remand was unnecessary because the case was properly before the court on EJR. It argued that implicit in the Board's finding it lacked jurisdiction was a determination that it also lacked authority to decide the question, thus, EJR was appropriate. In its remand order, the District Court explained that the two findings are distinct. "Jurisdiction to take any legal action" asks whether the Providers may obtain a hearing at all; "authority to decide the question" asks whether the Board has authority to reach the merits of Providers' claims. The Court concluded that the Secretary's position was correct: the Court lacked subject matter jurisdiction without the Board's first being afforded an opportunity to consider the merits of the Providers' claims, including whether it has authority to decide the question. Neither the D.C. District court remand[6] nor the remand from the Deputy Administrator addresses the Secretary's rationale for his position regarding jurisdiction. Assuming, however, that the Secretary will take the same position in this case with respect to the Board's having jurisdiction over the budget neutrality issue, and in the interest of judicial

[6] *Cape Cod Hospital v. Leavitt*, (D.D.C. July 21, 2008) (2008 WL 2791683).

economy, the Board will also address the question of whether EJR is appropriate.[7]

The Provider in this appeal seeks to have its final wage index rate modified by applying a different calculation methodology relating to the budget neutrality and rural floor factors. Pursuant to 42 C.F.R. § 412.64, the Secretary calculates the standardized amount on an annual basis. This calculation is published annually in the Federal Register following a complex and lengthy process of data collection and analysis. The methodology for the calculation is described in general terms.

The Board is bound by the Secretary's final rules and has no authority to review the data underlying the rate published unless specifically authorized. Notably the Final Rule only provides for Board review of denials of requests by hospitals for correction of certain wage data that eventually goes into one hospital-specific component of the final rate.[8] If the provider appealing the denial is successful, the remedy is limited to the hospital bringing the successful appeal. There is no provision for the Board to adjust the rate itself (as applied to all hospitals) to account for the effect of the error. The Board concludes that the specific grant of authority and establishment of a detailed process for correcting the rate of only the hospital bringing the appeal, coupled with the failure to include the effect of that correction on other hospitals or to establish a similar correction process for other components of the wage index, are strong indications that the Board does not have authority to change the rate itself.

Even more compelling, however, is the language of the statute and the regulation quoted above that prohibits review of budget neutrality determinations which are at the heart of the question before the Board in this case. Even if the Board interpreted the statutory and regulatory prohibitions on review of budget neutrality determinations too broadly to bar jurisdiction, those prohibitions cannot be ignored altogether. We conclude that the statute and regulation evidence Congress' and the Secretary's intent that budget neutrality determinations are insulated from the Board's authority to affirm, reverse or modify a reimbursement determination. Otherwise, the specific prohibitions articulated there would be rendered meaningless.

Assuming, arguendo, that the Secretary takes the same position in these cases that the Board has jurisdiction, then the Board finds that:

1) based upon the Provider's unopposed assertions regarding the challenges to the rural floor/budget neutrality methodology, there are no findings of fact for resolution by the Board;

2) it is bound by the Final Rule in the Federal Register and the regulation; and

3) it is without authority to decide the legal question of whether the calculation

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[7] After the above remand based on the Secretary's position regarding jurisdiction, the Board found the Provider was entitled to expedited judicial review. In December of 2009, the District Court for the District of Columbia granted the defendant's (government's) motion for summary judgment for the budget neutrality adjustment. *Cape Cod Hospital et al. v. Sebelius*, 2009 WL 4981330 (D.D.C. December 22, 2009) at pp. 9-16.

[8] 64 Fed. Reg. 41490, 41513 (July 30, 1999). This authority has never been codified in the code of Federal Regulations.

methodology for the budget neutrality/rural floor adjustment is valid.

The Board finds that it does not have jurisdiction over the RFBNA issue, therefore the request for expedited judicial review is denied. If, however, the Secretary finds that the Board does have jurisdiction over the RFBNA issue, then expedited judicial review would be appropriate. As the Rural Floor Budget Neutrality Adjustment issue is the sole issue in the appeal, the Board hereby closes case number 13-2429.

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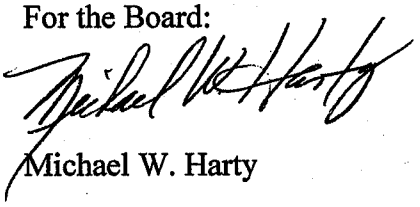
For the Board:



Michael W. Harty

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

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Refer to: 13-3221

NOV 22 2013

J.C. Ravindran
President
Quality Reimbursement Services
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

Re: Hospital San Lucas II
Provider No. 40-0044
FYE 12/31/2006
PRRB Case No. 13-3221

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's request for expedited judicial review (EJR) dated November 1, 2013 (received November 4, 2013). The request is unopposed. The issue under dispute involves whether the Centers for Medicare & Medicaid Services (CMS) erred in calculating a budget neutrality adjustment to the Prospective Payment System (PPS) standardized amount to account for the effects of the rural floor on the wage index. The Board's jurisdictional determination over the rural floor budget neutrality issue and determination with respect to the request for EJR are set forth below.[1]

Medicare Statutory and Regulatory Background

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

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

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the PPS. The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors. *See* 42 U.S.C. § 1395ww(d)(5). This case involves the annual changes

[1] The federal fiscal years (FFYs) under appeal in this case comprise two FFYs. The period from 1/1/2006 – 9/30/2006, comprises FFY 2006, and the period from 10/1/2006 – 12/31/2006, comprises FFY 2007. This letter will address both of these FFYs.

to the PPS rates for hospital inpatient operating costs (IPPS) and the methodology for determining those rates.

Standardized Amount

The statute, 42 U.S.C. § 1395ww(d)(2)(A), required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The base-year cost data were used in the initial development of the standardized amounts for PPS which were then used to compute the Federal rates. The standardized amounts are based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Section 1395ww(d)(2)(C) requires that updated base-year per discharge costs be standardized in order to adjust data which might cause variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments (for Alaska and Hawaii), indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994).

Section 1395ww(d)(3)(E) requires the Secretary from time to time to adjust the proportion of the hospitals' costs that are attributable to wages and wage-related costs of the DRG prospective payment rates for area differences in hospital wage levels. The adjustment factors (wage index) should reflect the relative hospital wage level in the geographic area of the hospital being compared to the national average hospital wage level. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor related amount is adjusted by the wage index. Section 1395ww(d)(3)(E)(ii) requires that 62% of the standardized amount be adjusted by the wage index unless doing so would result in lower payments to a hospital than would otherwise be made. 71 Fed. Reg. 47870, 48146 (August 18, 2006).

Budget Neutrality

Budget neutrality is determined by comparing aggregate IPPS payments before and after making changes that are required to be budget neutral (e.g., reclassifying and recalibrating the diagnostic related groups (DRGs)). Outlier payments are also included in the simulations. Id. at 48147. In FFYs 2007 and prior, CMS stated that: [the] budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the [prior years'] budget neutrality adjustments. Id. at 48147.

In establishing the PPS rate for FFY 2008 CMS applied the budget neutrality adjustment to the wage index rather than to the standardized amount as it had done in previous years. CMS believes that an adjustment to the wage index would result in substantially similar payments as an adjustment to the standardized amount, as both involve multipliers to the standardized amount and both would be based upon the same modeling parameters. 72 Fed. Reg. 47130 (August 22, 2007).

Rural Floor

Section 4410 of the Balanced Budget Act of 1997 (BBA of 1997) established the rural floor by requiring that the wage index of a hospital in any urban area cannot be less than the wage index determined for the state's rural area. Since Federal fiscal year (FFY) 1998, CMS has

implemented the budget neutrality requirement of this provision by adjusting the standardized amounts. 72 Fed. Reg. 24680, 24787 (May 3, 2007). In establishing the PPS standardized amount for FFYs 2006 and 2007 and for prior Federal fiscal years, CMS adjusted the standardized amount downward to account for the effects of the rural floor. *See e.g.* 71 Fed. Reg. at 48145-48148 (August 18, 2006).

Wage Index

The statute, 42 U.S.C. § 1395ww(d)(3)(E) and (d)(9)(C)(iv), requires that CMS make an adjustment to the labor-related portion of the national and Puerto Rico PPS rates to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. *Id.* at 48153. The wage index must be updated annually. *Id.* at 48005.

Procedural History

This appeal was timely filed on August 30, 2013, from an original NPR. The Provider contends that the rural floor budget neutrality adjustments as implemented by CMS violate the law's requirement of budget neutrality. The Provider argues that rather than adjusting area wage indexes to achieve budget neutrality, the Secretary adjusted the standardized amount and carried that forward from year to year. The Provider continues that CMS duplicated prior adjustments by each year calculating the full amount of the adjustment necessary to counteract the effect of the rural floor and then applying that adjustment to a figure that includes adjustments carried over from previous years. CMS then reduced the standardized amount to account for the full difference between these two figures. The Provider concludes that the cumulative effect of the improperly duplicative budget neutrality adjustments was to reduce the payment levels below what they otherwise should have been.

Basis for EJR

To establish the PPS rate for FFYs 2006 and 2007 and for prior years, CMS used a payment simulation model to determine each year's budget neutrality adjustment to the standardized amount to account for the effect of the rural floor. In the FFY 2006 rule, CMS described the simulation model and its calculation of the resulting budget neutrality adjustment as follows:

> [W]e used FY 2004 discharge data to simulate payment and compared aggregate payments using the FY 2005 relative weights and wage index to aggregate payments using the FY 2006 relative weights and wage index. The same methodology was used for the FY 2005 budget neutrality adjustment.
>
> . . . These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2005 budget neutrality adjustments.

70 Fed. Reg. 47278, 47493 (August 12, 2005).

In the FFY 2007 rule, CMS described the simulation model and its calculation of the resulting budget neutrality adjustment as follows:

> [W]e used FY 2005 discharge data to simulate payments and compared aggregate payments using the FY 2006 relative weights and wage indexes to aggregate payments using the FY 2007 relative weights and wage indexes. The same methodology was used for the FY 2006 budget neutrality adjustment.
>
> . . . These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2006 budget neutrality adjustments.

71 Fed. Reg. 47870, 48147 (August 18, 2006).

The Provider is challenging an aspect of CMS' calculation of the final PPS rates published in the Federal Register for FFYs 2006 and 2007.[2] The Provider contends that CMS erred in calculating a budget neutrality adjustment to the PPS standardized amount to account for the effects of the rural floor on the wage index. This alleged error results in a systematic understatement of the PPS rates, and this error has been an annual and recurring one. Each year's error is permanently incorporated into the standardized amount paid under PPS for each successive year.

Jurisdiction over the Issue

The Provider contends that the Board has jurisdiction over this appeal because the appeal was timely filed from its NPR and the amount in controversy threshold has been met. The Provider points out that review of the PPS payment determination is subject only to the exceptions set forth at 42 U.S.C. § 1395oo(g)(2). This section provides, in relevant part, that determinations described in 42 U.S.C. § 1395ww(d)(7) shall not be reviewed by the Board or any court. Among the matters not subject to review is the determination of the requirement, or the proportional amount, of any budget neutrality adjustment. The Provider contends that this preclusion of review provision is limited to certain budget neutrality adjustments for fiscal years 1984 and 1985 to ensure that the total amounts paid under PPS, then a new system, were the same as the total amounts that would have been spent under the Medicare law (as modified by the Tax Equity & Fiscal Responsibility Act of 1982 (TEFRA)). 42 U.S.C. § 1395ww(e)(1)(A)-(B).

The Intermediary did not provide comment to the Board in this matter.

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[2] The final PPS rates for FFY 2007 were published in the Federal Register on October 11, 2006. 71 Fed. Reg. 59886, 59889 (October 11, 2006). The August 18, 2006 Federal Register cited above noted that the standardized amount was tentative because factors such as the outlier offset and budget neutrality adjustment for the wage index and reclassification that are applied to the standardized amount had not been determined pending the calculation of the occupational mix adjustment. 71 Fed. Reg. 47870, 48146.

Decision of the Board

The Board concludes that it lacks jurisdiction over the appeal because review of budget neutrality adjustments is expressly prohibited by the statute and regulations. *See* 42 U.S.C. §1395ww(d)(7); 42 U.S.C. § 1395oo(g)(2); 42 C.F.R. §§ 405.1804 and 405.1840(b)(2). Because jurisdiction over an issue is a prerequisite to granting a request for EJR, the Board finds that EJR is not appropriate.

Payment under the prospective payment system is governed by the statutory provisions of 42 U.S.C. § 1395ww. Subsection (d)(7) states that:

> There shall be no administrative or judicial review under [42 U.S.C. §1395oo] or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount of any adjustment effected pursuant to subsection (e)(1) [budget neutrality] or the determination of the applicable percentage increase under paragraph (12)(A)(ii) . . .

The Board's governing statute, 42 U.S.C. § 1395oo(g)(2), states that:

> The determinations and other decisions described in section 1395ww(d)(7) shall not be reviewed by the Board or by any court pursuant to action brought under subsection (f) or otherwise.

CMS' implementing regulation, 42 C.F.R. § 405.1804, entitled "Matters not subject to administrative and judicial review under prospective payment" provides:

> Neither administrative or judicial review is available for controversies about the following matters:
>
> (a) The determination of the requirement, or the proportional amount, of any budget neutrality adjustment in the prospective payment rates. . . . (emphasis added)

CMS stated at the time the rule was adopted that the purpose of the rule is:

> to state that the determinations and decisions described in section 1886(d)(7) of the Act may not receive Board or judicial review. Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
>
> A determination of the requirement, or the proportional amounts of, any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act . . .

48 Fed. Reg. 39752, 39785 (September 1, 1983).

In addition, section 701(a) of the Administrative Procedure Act (APA) states that the appeal provisions of the APA apply to the administrative actions except where statutes preclude judicial review. *See* 5 U.S.C. § 701(a). The statutes and the regulations both preclude administrative and judicial review of the budget neutrality adjustment.

In *Amgen, Inc. v. Smith,*[3] the D.C. Circuit Court considered whether there is jurisdiction over outpatient PPS (OPPS) payments where the statute precludes administrative or judicial review of the "other adjustments" to OPPS (the classification system, establishment of groups and relative payment weights for covered services, of wage adjustment factors). The Court explained that there is a strong presumption that Congress intends judicial review of administrative action which can only be overcome with "clear and convincing evidence" that Congress intended to preclude appeal. The Court concluded that where the statute stipulated that "there should be no administrative or judicial review," that language constituted clear and convincing evidence that the appeal was precluded. The Court further noted that payments under PPS are made on a prospective basis and, given the length of time that review of individual appeals could take, the result would be retroactive adjustments to payment rates with the potential of creating havoc with the payment system. The aggregate impact of appeal decisions would undermine the Secretary's ability to ensure budget neutrality.

In an earlier decision, *Universal Health Services of McAllen, Inc. v. Sullivan,*[4] (*UHS*) the D. C. District Court distinguished between an appeal of a Medicare Geographic Classification Review Board (MGCRB) decision (over which judicial review is precluded) and a challenge to the validity of the guidelines utilized by the MGCRB and the Secretary to make reclassification decisions. The Court noted that § 701(a) of the APA precludes judicial review where a statute or regulation denies review. In *UHS*, the Court found that it had jurisdiction over the challenge to the guidelines but would not have had jurisdiction over an appeal of an MGCRB decision which was precluded by law.

The Board is not persuaded that preclusion of review of budget neutrality provisions is limited to the fiscal years 1984 and 1985. Even though the rural floor budget neutrality provision was not specifically addressed in the limits on administrative and judicial review, we find the language of the statute itself unambiguous in that there is no indication that the prohibition on administrative or judicial review is limited to the two fiscal periods identified by the Providers. Therefore, no further inquiry into Congressional intent is warranted. Moreover, if any ambiguity were present, it is resolved by the expansive regulatory language, binding on the Board, that prohibits review of "any controversies about [budget neutrality determinations]."

42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permit providers to bypass the Board's hearing procedure and obtain judicial review of a specific matter at issue involving a question of law or regulation where the Board determines that it is without authority to decide the legal question. Prior to rendering a decision that it lacks the authority to decide the legal question before it, the Board must determine that it has jurisdiction over the matter at issue in the appeal under 42 U.S.C. § 1395oo. 42 C.F.R. § 405.1842(a)(2008). We conclude that both the statute

[3] 357 F. 3d 103 (D.C. Cir. 2004).
[4] 770 F. Supp. 704 (D.C. Dist. 1991).

and regulation preclude administrative review of the budget neutrality adjustment; therefore, the Board lacks jurisdiction over the issue.

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

Application of *Cape Cod* case on the Request for EJR

Ordinarily our EJR analysis would end with a determination of no jurisdiction. However, in *Cape Cod HC 2007 Wage Index/Rural Floor Group*, PRRB case number 07-0705G et al, (*Cape Cod*), the Secretary has taken a contrary position. In *Cape Cod*, the Board concluded that it lacked jurisdiction over the budget neutrality adjustment based on the authorities set forth above. The Board's decision was not reversed by the CMS Administrator. On appeal to the Federal district court, however, the Secretary moved for remand on the basis that the Board had jurisdiction over the issue. The provider plaintiffs responded that the remand was unnecessary because the case was properly before the court on EJR. It argued that implicit in the Board's finding it lacked jurisdiction was a determination that it also lacked authority to decide the question, thus, EJR was appropriate. In its remand order, the District Court explained that the two findings are distinct. "Jurisdiction to take any legal action" asks whether the Providers may obtain a hearing at all; "authority to decide the question" asks whether the Board has authority to reach the merits of Providers' claims. The Court concluded that the Secretary's position was correct: the Court lacked subject matter jurisdiction without the Board's first being afforded an opportunity to consider the merits of the Providers' claims, including whether it has authority to decide the question. Neither the D.C. District court remand[5] nor the remand from the Deputy Administrator addresses the Secretary's rationale for his position regarding jurisdiction. Assuming, however, that the Secretary will take the same position in this case with respect to the Board's having jurisdiction over the budget neutrality issue, and in the interest of judicial economy, the Board will also address the question of whether EJR is appropriate.[6]

The Provider in this appeal seeks to have its final wage index rate modified by applying a different calculation methodology relating to the budget neutrality and rural floor factors. Pursuant to 42 C.F.R. § 412.64, the Secretary calculates the standardized amount on an annual basis. This calculation is published annually in the Federal Register following a complex and lengthy process of data collection and analysis. The methodology for the calculation is described in general terms.

The Board is bound by the Secretary's final rules and has no authority to review the data underlying the rate published unless specifically authorized. Notably the Final Rule only provides for Board review of denials of requests by hospitals for correction of certain wage data that eventually goes into one hospital-specific component of the final rate.[7] If the provider

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[5] *Cape Cod Hospital v. Leavitt*, (D.D.C. July 21, 2008) (2008 WL 2791683).

[6] After the above remand based on the Secretary's position regarding jurisdiction, the Board found the Provider was entitled to expedited judicial review. In December of 2009, the District Court for the District of Columbia granted the defendant's (government's) motion for summary judgment for the budget neutrality adjustment. *Cape Cod Hospital et al. v. Sebelius*, 2009 WL 4981330 (D.D.C. December 22, 2009) at pp. 9-16.

[7] 64 Fed. Reg. 41490, 41513 (July 30, 1999). This authority has never been codified in the code of Federal Regulations.

appealing the denial is successful, the remedy is limited to the hospital bringing the successful appeal. There is no provision for the Board to adjust the rate itself (as applied to all hospitals) to account for the effect of the error. The Board concludes that the specific grant of authority and establishment of a detailed process for correcting the rate of only the hospital bringing the appeal, coupled with the failure to include the effect of that correction on other hospitals or to establish a similar correction process for other components of the wage index, are strong indications that the Board does not have authority to change the rate itself.

Even more compelling, however, is the language of the statute and the regulation quoted above that prohibits review of budget neutrality determinations which are at the heart of the question before the Board in this case. Even if the Board interpreted the statutory and regulatory prohibitions on review of budget neutrality determinations too broadly to bar jurisdiction, those prohibitions cannot be ignored altogether. We conclude that the statute and regulation evidence Congress' and the Secretary's intent that budget neutrality determinations are insulated from the Board's authority to affirm, reverse or modify a reimbursement determination. Otherwise, the specific prohibitions articulated there would be rendered meaningless.

Assuming, arguendo, that the Secretary takes the same position in these cases that the Board has jurisdiction, then the Board finds that:

1) based upon the Provider's unopposed assertions regarding the challenges to the rural floor/budget neutrality methodology, there are no findings of fact for resolution by the Board;

2) it is bound by the Final Rule in the Federal Register and the regulation; and

3) it is without authority to decide the legal question of whether the calculation methodology for the budget neutrality/rural floor adjustment is valid.

The Board finds that it does not have jurisdiction over the RFBNA issue, therefore the request for expedited judicial review is denied. If, however, the Secretary finds that the Board does have jurisdiction over the RFBNA issue, then expedited judicial review would be appropriate. As the Rural Floor Budget Neutrality Adjustment issue is the sole issue in the appeal, the Board hereby closes case number 13-3221.

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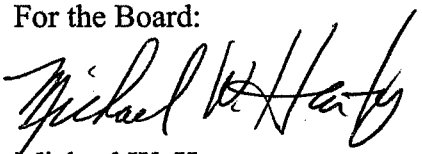
For the Board:



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

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Refer to: 13-1737

CERTIFIED MAIL

NOV 22 2013

Corinna Goron
President
Healthcare Reimbursement Services
17101 Preston Road, Suite 220
Dallas, TX 75248-1372

Re: Hi-Desert Medical Center
Provider No. 05-0279
FYE 6/30/2008
PRRB Case No. 13-1737

Dear Ms. Goron:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's October 31, 2013 request for expedited judicial review (EJR) (received November 1, 2013). This request is unopposed. The issue under dispute involves whether the Centers for Medicare & Medicaid Services (CMS) erred in calculating a budget neutrality adjustment to the Prospective Payment System (PPS) standardized amount to account for the effects of the rural floor on the wage index. The Board's jurisdictional determination over the rural floor budget neutrality issue and determination with respect to the request for EJR are set forth below.[1]

Medicare Statutory and Regulatory Background

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

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

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the PPS. The PPS statute contains a number of provisions that adjust reimbursement based on

[1] The federal fiscal years (FFYs) under appeal in these cases comprise two FFYs. The period from 7/1/2007 – 9/30/2007, comprises FFY 2007, and the period from 10/1/2007 – 6/30/2008, comprises FFY 2008. This letter will address both of these FFYs.

hospital-specific factors. *See* 42 U.S.C. § 1395ww(d)(5). This case involves the annual changes to the PPS rates for hospital inpatient operating costs (IPPS) and the methodology for determining those rates.

Standardized Amount

The statute, 42 U.S.C. § 1395ww(d)(2)(A), required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The base-year cost data were used in the initial development of the standardized amounts for PPS which were then used to compute the Federal rates. The standardized amounts are based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Section 1395ww(d)(2)(C) requires that updated base-year per discharge costs be standardized in order to adjust data which might cause variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments (for Alaska and Hawaii), indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994).

Section 1395ww(d)(3)(E) requires the Secretary from time to time to adjust the proportion of the hospitals' costs that are attributable to wages and wage-related costs of the DRG prospective payment rates for area differences in hospital wage levels. The adjustment factors (wage index) should reflect the relative hospital wage level in the geographic area of the hospital being compared to the national average hospital wage level. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor related amount is adjusted by the wage index. Section 1395ww(d)(3)(E)(ii) requires that 62% of the standardized amount be adjusted by the wage index unless doing so would result in lower payments to a hospital than would otherwise be made. 71 Fed. Reg. 47870, 48146 (August 18, 2006).

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Budget neutrality is determined by comparing aggregate IPPS payments before and after making changes that are required to be budget neutral (e.g., reclassifying and recalibrating the diagnostic related groups (DRGs)). Outlier payments are also included in the simulations. *Id.* at 48147. In FFYs 2007 and prior, CMS stated that: [the] budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the [prior years'] budget neutrality adjustments. *Id.* at 48147.

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determined for the state's rural area. Since Federal fiscal year (FFY) 1998, CMS has implemented the budget neutrality requirement of this provision by adjusting the standardized amounts. 72 Fed. Reg. 24680, 24787 (May 3, 2007). In establishing the PPS standardized amount for FFY 2007 and for prior Federal fiscal years, CMS adjusted the standardized amount downward to account for the effects of the rural floor. *See e.g.* 71 Fed. Reg. at 48145-48148 (August 18, 2006). In FFY 2008 CMS applied the budget neutrality adjustment to the wage index, rather than the standardized amount. [2]

In responding to providers concerns regarding the change to the calculation set forth above and the cumulative effect of the budget neutrality adjustment in the final IPPS rule, CMS stated that:

> [T]he rural floor budget neutrality adjustment previously was a cumulative adjustment, similar to the adjustments we currently make for updates to the wage index and DRG [diagnostic related groups] reclassification and recalibration. Beginning in 2008, the rural floor budget neutrality adjustment will be noncumulative.
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> With regard to alleged errors in FY 1999 through 2007, our calculation of the budget neutrality in past fiscal years is not within the scope of this rulemaking. Even if errors were made in prior fiscal years, we would not make an adjustment to make up for those errors when setting rates for FY 2008. It is our longstanding policy that finality is critical to a prospective payment system. Although such errors in rate setting are inevitable, we believe the need to establish final prospective rates outweighs the greater accuracy we might gain if we retroactively recomputed rates whenever an error is discovered.

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Wage Index

The statute, 42 U.S.C. § 1395ww(d)(3)(E) and (d)(9)(C)(iv), requires that CMS make an adjustment to the labor-related portion of the national and Puerto Rico PPS rates to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. *Id.* at 48153. The wage index must be updated annually. *Id.* at 48005.

Procedural History

This appeal was timely filed on April 24, 2013, from an original NPR. The Provider contends that the rural floor budget neutrality adjustments as implemented by CMS violate the law's

[2] 72 Fed. Reg. 47130, 47329 (August 22, 2007).

requirement of budget neutrality. The Provider argues that rather than adjusting area wage indexes to achieve budget neutrality, the Secretary adjusted the standardized amount and carried that forward from year to year. The Provider continues that CMS duplicated prior adjustments by each year calculating the full amount of the adjustment necessary to counteract the effect of the rural floor and then applying that adjustment to a figure that includes adjustments carried over from previous years. CMS then reduced the standardized amount to account for the full difference between these two figures. The Provider concludes that the cumulative effect of the improperly duplicative budget neutrality adjustments was to reduce the payment levels below what they otherwise should have been.

Basis for EJR

To establish the PPS rate for FFYs 2007 and 2008 and for prior years, CMS used a payment simulation model to determine each year's budget neutrality adjustment to the standardized amount to account for the effect of the rural floor. In the FFY 2007 rule, CMS described the simulation model and its calculation of the resulting budget neutrality adjustment as follows:

> [W]e used FY 2005 discharge data to simulate payments and compared aggregate payments using the FY 2006 relative weights and wage indexes to aggregate payments using the FY 2007 relative weights and wage indexes. The same methodology was used for the FY 2006 budget neutrality adjustment.
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> . . . These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2006 budget neutrality adjustments.

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The Provider is challenging an aspect of CMS' calculation of the final PPS rates published in the Federal Register for FFYs 2007[3] and 2008. The Provider contends that CMS erred in calculating a budget neutrality adjustment to the PPS standardized amount to account for the effects of the rural floor on the wage index. This alleged error results in a systematic understatement of the PPS rates, and this error has been an annual and recurring one. Each year's error is permanently incorporated into the standardized amount paid under PPS for each successive year.

Jurisdiction over the Issue

[3] The final PPS rates for FFY 2007 were published in the Federal Register on October 11, 2006. 71 Fed. Reg. 59886, 59889 (October 11, 2006). The August 18, 2006 Federal Register cited above noted that the standardized amount was tentative because factors such as the outlier offset and budget neutrality adjustment for the wage index and reclassification that are applied to the standardized amount had not been determined pending the calculation of the occupational mix adjustment. 71 Fed. Reg. 47870, 48146.

The Provider contends that the Board has jurisdiction over these appeals because the appeals were timely filed from NPRs and the amount in controversy threshold has been met. The Provider points out that review of the PPS payment determination is subject only to the exceptions set forth at 42 U.S.C. § 1395oo(g)(2). This section provides, in relevant part, that determinations described in 42 U.S.C. § 1395ww(d)(7) shall not be reviewed by the Board or any court. Among the matters not subject to review is the determination of the requirement, or the proportional amount, of any budget neutrality adjustment. The Provider contends that this preclusion of review provision is limited to certain budget neutrality adjustments for fiscal years 1984 and 1985 to ensure that the total amounts paid under PPS, then a new system, were the same as the total amounts that would have been spent under the Medicare law (as modified by the Tax Equity & Fiscal Responsibility Act of 1982 (TEFRA)). 42 U.S.C. § 1395ww(e)(1)(A)-(B).

The Intermediary did not provide comment to the Board in this matter.

Decision of the Board

The Board concludes that it lacks jurisdiction over the appeal because review of budget neutrality adjustments is expressly prohibited by the statute and regulations. *See* 42 U.S.C. §1395ww(d)(7); 42 U.S.C. § 1395oo(g)(2); 42 C.F.R. §§ 405.1804 and 405.1840(b)(2). Because jurisdiction over an issue is a prerequisite to granting a request for EJR, the Board finds that EJR is not appropriate.

Payment under the prospective payment system is governed by the statutory provisions of 42 U.S.C. § 1395ww. Subsection (d)(7) states that:

> There shall be no administrative or judicial review under [42 U.S.C. §1395oo] or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount of any adjustment effected pursuant to subsection (e)(1) [budget neutrality] or the determination of the applicable percentage increase under paragraph (12)(A)(ii) . . .

The Board's governing statute, 42 U.S.C. § 1395oo(g)(2), states that:

> The determinations and other decisions described in section 1395ww(d)(7) shall not be reviewed by the Board or by any court pursuant to action brought under subsection (f) or otherwise.

CMS' implementing regulation, 42 C.F.R. § 405.1804, entitled "Matters not subject to administrative and judicial review under prospective payment" provides:

> Neither administrative or judicial review is available for controversies about the following matters:

> (a) The determination of the requirement, or the proportional amount, of any budget neutrality adjustment in the prospective payment rates. . . . (emphasis added)

CMS stated at the time the rule was adopted that the purpose of the rule is:

> to state that the determinations and decisions described in section 1886(d)(7) of the Act may not receive Board or judicial review. Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
>
> > A determination of the requirement, or the proportional amounts of, any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act . . .

48 Fed. Reg. 39752, 39785 (September 1, 1983).

In addition, section 701(a) of the Administrative Procedure Act (APA) states that the appeal provisions of the APA apply to the administrative actions except where statutes preclude judicial review. *See* 5 U.S.C. § 701(a). The statutes and the regulations both preclude administrative and judicial review of the budget neutrality adjustment.

In *Amgen, Inc. v. Smith*,[4] the D.C. Circuit Court considered whether there is jurisdiction over outpatient PPS (OPPS) payments where the statute precludes administrative or judicial review of the "other adjustments" to OPPS (the classification system, establishment of groups and relative payment weights for covered services, of wage adjustment factors). The Court explained that there is a strong presumption that Congress intends judicial review of administrative action which can only be overcome with "clear and convincing evidence" that Congress intended to preclude appeal. The Court concluded that where the statute stipulated that "there should be no administrative or judicial review," that language constituted clear and convincing evidence that the appeal was precluded. The Court further noted that payments under PPS are made on a prospective basis and, given the length of time that review of individual appeals could take, the result would be retroactive adjustments to payment rates with the potential of creating havoc with the payment system. The aggregate impact of appeal decisions would undermine the Secretary's ability to ensure budget neutrality.

In an earlier decision, *Universal Health Services of McAllen, Inc. v. Sullivan*,[5] (*UHS*) the D. C. District Court distinguished between an appeal of a Medicare Geographic Classification Review Board (MGCRB) decision (over which judicial review is precluded) and a challenge to the validity of the guidelines utilized by the MGCRB and the Secretary to make reclassification decisions. The Court noted that § 701(a) of the APA precludes judicial review where a statute or regulation denies review. In *UHS*, the Court found that it had jurisdiction over the challenge to the guidelines but would not have had jurisdiction over an appeal of an MGCRB decision which

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[4] 357 F. 3d 103 (D.C. Cir. 2004).
[5] 770 F. Supp. 704 (D.C. Dist. 1991).

was precluded by law.

The Board is not persuaded that preclusion of review of budget neutrality provisions is limited to the fiscal years 1984 and 1985. Even though the rural floor budget neutrality provision was not specifically addressed in the limits on administrative and judicial review, we find the language of the statute itself unambiguous in that there is no indication that the prohibition on administrative or judicial review is limited to the two fiscal periods identified by the Providers. Therefore, no further inquiry into Congressional intent is warranted. Moreover, if any ambiguity were present, it is resolved by the expansive regulatory language, binding on the Board, that prohibits review of "any controversies about [budget neutrality determinations]."

42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permit providers to bypass the Board's hearing procedure and obtain judicial review of a specific matter at issue involving a question of law or regulation where the Board determines that it is without authority to decide the legal question. Prior to rendering a decision that it lacks the authority to decide the legal question before it, the Board must determine that it has jurisdiction over the matter at issue in the appeal under 42 U.S.C. § 1395oo. 42 C.F.R. § 405.1842(a)(2008). We conclude that both the statute and regulation preclude administrative review of the budget neutrality adjustment; therefore, the Board lacks jurisdiction over the issue.

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

Cape Cod and the Request for EJR

Ordinarily our EJR analysis would end with a determination of no jurisdiction. However, in *Cape Cod HC 2007 Wage Index/Rural Floor Group*, PRRB case number 07-0705G et al, (*Cape Cod*), the Secretary has taken a contrary position. In *Cape Cod*, the Board concluded that it lacked jurisdiction over the budget neutrality adjustment based on the authorities set forth above. The Board's decision was not reversed by the CMS Administrator. On appeal to the Federal district court, however, the Secretary moved for remand on the basis that the Board had jurisdiction over the issue. The provider plaintiffs responded that the remand was unnecessary because the case was properly before the court on EJR. It argued that implicit in the Board's finding it lacked jurisdiction was a determination that it also lacked authority to decide the question, thus, EJR was appropriate. In its remand order, the District Court explained that the two findings are distinct. "Jurisdiction to take any legal action" asks whether the Providers may obtain a hearing at all; "authority to decide the question" asks whether the Board has authority to reach the merits of Providers' claims. The Court concluded that the Secretary's position was correct: the Court lacked subject matter jurisdiction without the Board's first being afforded an opportunity to consider the merits of the Providers' claims, including whether it has authority to decide the question. Neither the D.C. District court remand[6] nor the remand from the Deputy Administrator addresses the Secretary's rationale for his position regarding jurisdiction. Assuming, however, that the Secretary will take the same position in this case with respect to the Board's having jurisdiction over the budget neutrality issue, and in the interest of judicial

[6] *Cape Cod Hospital v. Leavitt*, (D.D.C. July 21, 2008) (2008 WL 2791683).

economy, the Board will also address the question of whether EJR is appropriate.[7]

The Provider in this appeal seeks to have its final wage index rate modified by applying a different calculation methodology relating to the budget neutrality and rural floor factors. Pursuant to 42 C.F.R. § 412.64, the Secretary calculates the standardized amount on an annual basis. This calculation is published annually in the Federal Register following a complex and lengthy process of data collection and analysis. The methodology for the calculation is described in general terms.

The Board is bound by the Secretary's final rules and has no authority to review the data underlying the rate published unless specifically authorized. Notably the Final Rule only provides for Board review of denials of requests by hospitals for correction of certain wage data that eventually goes into one hospital-specific component of the final rate.[8] If the provider appealing the denial is successful, the remedy is limited to the hospital bringing the successful appeal. There is no provision for the Board to adjust the rate itself (as applied to all hospitals) to account for the effect of the error. The Board concludes that the specific grant of authority and establishment of a detailed process for correcting the rate of only the hospital bringing the appeal, coupled with the failure to include the effect of that correction on other hospitals or to establish a similar correction process for other components of the wage index, are strong indications that the Board does not have authority to change the rate itself.

Even more compelling, however, is the language of the statute and the regulation quoted above that prohibits review of budget neutrality determinations which are at the heart of the question before the Board in this case. Even if the Board interpreted the statutory and regulatory prohibitions on review of budget neutrality determinations too broadly to bar jurisdiction, those prohibitions cannot be ignored altogether. We conclude that the statute and regulation evidence Congress' and the Secretary's intent that budget neutrality determinations are insulated from the Board's authority to affirm, reverse or modify a reimbursement determination. Otherwise, the specific prohibitions articulated there would be rendered meaningless.

Assuming, arguendo, that the Secretary takes the same position in these cases that the Board has jurisdiction, then the Board finds that:

1) based upon the Provider's unopposed assertions regarding the challenges to the rural floor/budget neutrality methodology, there are no findings of fact for resolution by the Board;

2) it is bound by the Final Rule in the Federal Register and the regulation; and

3) it is without authority to decide the legal question of whether the calculation

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[7] After the above remand based on the Secretary's position regarding jurisdiction, the Board found the Provider was entitled to expedited judicial review. In December of 2009, the District Court for the District of Columbia granted the defendant's (government's) motion for summary judgment for the budget neutrality adjustment. *Cape Cod Hospital et al. v. Sebelius*, 2009 WL 4981330 (D.D.C. December 22, 2009) at pp. 9-16.

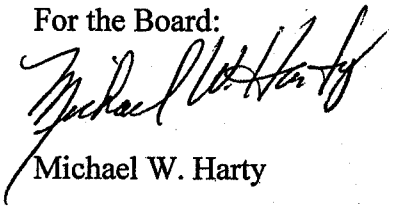
[8] 64 Fed. Reg. 41490, 41513 (July 30, 1999). This authority has never been codified in the code of Federal Regulations.

methodology for the budget neutrality/rural floor adjustment is valid.

The Board finds that it does not have jurisdiction over the RFBNA issue, therefore the request for expedited judicial review is denied. If, however, the Secretary finds that the Board does have jurisdiction over the RFBNA issue, then expedited judicial review would be appropriate. As the Rural Floor Budget Neutrality Adjustment issue is the sole issue in the appeal, the Board hereby closes case number 13-1737.

BOARD MEMBERS PARTICIPATING:
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

For the Board:



Michael W. Harty

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

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CERTIFIED MAIL

NOV 26 2013

J.C. Ravindran
Quality Reimbursement Services
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

Re: Request for EJR for the FYE 12/31/07, FFYs 2007 and 2008 Wage Index/Rural Floor individual cases:

PRRB Case No. 13-3127, Hospital Metropolitano Dr. Susoni, Provider No. 40-0117;
PRRB Case No. 13-3335, Smith Northview Hospital, Provider No. 11-0212;
PRRB Case No. 13-0250, Pemiscot County Memorial Hospital, Provider No. 26-0070;
PRRB Case No. 13-1389, Montrose Memorial Hospital, Provider No. 06-0006; and
PRRB Case No. 13-1130, Ira Davenport Memorial Hospital, Provider No. 33-0144.

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' requests for expedited judicial review (EJR) dated October 31, 2013 (received November 4, 2013), for the individual cases listed above. These requests are unopposed. The issue under dispute involves whether the Centers for Medicare & Medicaid Services (CMS) erred in calculating a budget neutrality adjustment to the prospective payment system (PPS) standardized amount to account for the effects of the rural floor on the wage index. The Board's jurisdictional determination over the rural floor budget neutrality issue and determination with respect to the requests for EJR are set forth below.[1]

Medicare Statutory and Regulatory Background

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

The Medicare program was established to provide health insurance to the aged and disabled. *See* 42 U.S.C. §§ 1395-1395cc. CMS, formerly the Health Care Financing Administration, is the operating component of the Department of Health and Human Services charged with administering the Medicare program. CMS' payment and audit functions under the Medicare

[1] The federal fiscal years (FFYs) under appeal in these cases comprise two FFYs. The period from 01/01/07-09/30/07, comprises FFY 2007, and the period from 10/1/07-12/31/07, comprises FFY 2008. This letter will address both of these FFYs.

program are contracted to organizations known as fiscal intermediaries and Medicare Administrative Contractors (hereinafter referred to as intermediaries). Intermediaries determine the payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. *See* 42 U.S.C. § 1395h, 42 C.F.R. §§ 413.20 and 413.24.

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the PPS. The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors. *See* 42 U.S.C. § 1395ww(d)(5). This case involves the annual changes to the PPS rates for hospital inpatient operating costs (IPPS) and the methodology for determining those rates.

Standardized Amount

The statute, 42 U.S.C. § 1395ww(d)(2)(A), required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The base-year cost data were used in the initial development of the standardized amounts for PPS which were then used to compute the Federal rates. The standardized amounts are based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Section 1395ww(d)(2)(C) requires that updated base-year per discharge costs be standardized in order to adjust data which might cause variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments (for Alaska and Hawaii), indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994).

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Wage Index

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area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. *Id.* at 48153. The wage index must be updated annually. *Id.* at 48005.

Procedural History

These appeals were timely from original NPRs.[3] The Providers contend that the rural floor budget neutrality adjustments as implemented by CMS violate the law's requirement of budget neutrality. The Providers challenge CMS' calculation and application of the budget neutrality adjustment to the PPS standardized amount to account for annual adjustments to the PPS wage index. The Providers assert that CMS implemented the "rural floor" provisions on a budget "negative" basis as opposed to a budget "neutral" basis as required. The budget neutrality adjustments made by CMS have been compounding over the years rather than having been applied and removed on a yearly basis. The Providers maintain there have been errors in the application of these factors over the years that have resulted in understated PPS payments.

The Providers contend that CMS has erred in the computation of the annual budget neutrality adjustment factors, including the adjustment factor applied to the standardized amounts to account for changes in the wage index and rural floor. CMS has been applying non-reversing rural floor budget neutrality adjustments to the national standardized amounts (which impacts PPS payments) each year since 1998 to reduce payments to hospitals; wherein CMS should have used a reversing type of adjustment. The alleged error results in a systematic understatement of the PPS standardized amount because it overstates the budget neutrality factor for annual updates to the wage index. The Providers believe the error is annual and recurring.

Basis for EJR

To establish the PPS rate for FFYs 2007 and 2008 and for prior years, CMS used a payment simulation model to determine each year's budget neutrality adjustment to the standardized amount to account for the effect of the rural floor. For FFY 2007 and prior, CMS described the simulation model and its calculation of the resulting budget neutrality adjustment as follows:

> [W]e used FY 2005 discharge data to simulate payments and compared aggregate payments using the FY 2006 relative weights and wage indexes to aggregate payments using the FY 2007 relative weights and wage indexes. The same methodology was used for the FY 2006 budget neutrality adjustment.

[3] The appeal for case number 13-3127 was filed on August 21, 2013; the appeal for case number 13-3335 was filed on September 6, 2013; the appeal for case number 13-0250 was filed on December 18, 2012; the appeal for case number 13-1389 was filed on April 05, 2013; and the appeal for case number 13-1130 was filed on March 20, 2013.

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The Intermediary did not provide comment to the Board in this matter.

Decision of the Board

The Board concludes that it lacks jurisdiction over the appeals because review of budget neutrality adjustments is expressly prohibited by the statute and regulations. *See* 42 U.S.C.

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§1395ww(d)(7); 42 U.S.C. § 1395oo(g)(2); 42 C.F.R. §§ 405.1804 and 405.1840(b)(2). Because jurisdiction over an issue is a prerequisite to granting a request for EJR, the Board finds that EJR is not appropriate.

Payment under the prospective payment system is governed by the statutory provisions of 42 U.S.C. § 1395ww. Subsection (d)(7) states that:

> There shall be no administrative or judicial review under [42 U.S.C. §1395oo] or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount of any adjustment effected pursuant to subsection (e)(1) [budget neutrality] or the determination of the applicable percentage increase under paragraph (12)(A)(ii) . . .

The Board's governing statute, 42 U.S.C. § 1395oo(g)(2), states that:

> The determinations and other decisions described in section 1395ww(d)(7) shall not be reviewed by the Board or by any court pursuant to action brought under subsection (f) or otherwise.

CMS' implementing regulation, 42 C.F.R. § 405.1804, entitled "Matters not subject to administrative and judicial review under prospective payment" provides:

> Neither administrative or judicial review is available for controversies about the following matters:
>
> (a) The determination of the requirement, or the proportional amount, of any budget neutrality adjustment in the prospective payment rates. . . . (emphasis added)

CMS stated at the time the rule was adopted that the purpose of the rule is:

> to state that the determinations and decisions described in section 1886(d)(7) of the Act may not receive Board or judicial review. Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
>
> A determination of the requirement, or the proportional amounts of, any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act . . .

48 Fed. Reg. 39752, 39785 (September 1, 1983).

In addition, section 701(a) of the Administrative Procedure Act (APA) states that the appeal provisions of the APA apply to the administrative actions except where statutes preclude judicial

review. *See* 5 U.S.C. § 701(a). The statutes and the regulations both preclude administrative and judicial review of the budget neutrality adjustment.

In *Amgen, Inc. v. Smith*,[5] the D.C. Circuit Court considered whether there is jurisdiction over outpatient PPS (OPPS) payments where the statute precludes administrative or judicial review of the "other adjustments" to OPPS (the classification system, establishment of groups and relative payment weights for covered services, of wage adjustment factors). The Court explained that there is a strong presumption that Congress intends judicial review of administrative action which can only be overcome with "clear and convincing evidence" that Congress intended to preclude appeal. The Court concluded that where the statute stipulated that "there should be no administrative or judicial review," that language constituted clear and convincing evidence that the appeal was precluded. The Court further noted that payments under PPS are made on a prospective basis and, given the length of time that review of individual appeals could take, the result would be retroactive adjustments to payment rates with the potential of creating havoc with the payment system. The aggregate impact of appeal decisions would undermine the Secretary's ability to ensure budget neutrality.

In an earlier decision, *Universal Health Services of McAllen, Inc. v. Sullivan*,[6] (*UHS*) the D. C. District Court distinguished between an appeal of a Medicare Geographic Classification Review Board (MGCRB) decision (over which judicial review is precluded) and a challenge to the validity of the guidelines utilized by the MGCRB and the Secretary to make reclassification decisions. The Court noted that § 701(a) of the APA precludes judicial review where a statute or regulation denies review. In *UHS*, the Court found that it had jurisdiction over the challenge to the guidelines but would not have had jurisdiction over an appeal of an MGCRB decision which was precluded by law.

The Board is not persuaded that preclusion of review of budget neutrality provisions is limited to the fiscal years 1984 and 1985. Even though the rural floor budget neutrality provision was not specifically addressed in the limits on administrative and judicial review, we find the language of the statute itself unambiguous in that there is no indication that the prohibition on administrative or judicial review is limited to the two fiscal periods identified by the Providers. Therefore, no further inquiry into Congressional intent is warranted. Moreover, if any ambiguity were present, it is resolved by the expansive regulatory language, binding on the Board, that prohibits review of "any controversies about [budget neutrality determinations]."

42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permit providers to bypass the Board's hearing procedure and obtain judicial review of a specific matter at issue involving a question of law or regulation where the Board determines that it is without authority to decide the legal question. Prior to rendering a decision that it lacks the authority to decide the legal question before it, the Board must determine that it has jurisdiction over the matter at issue in the appeal under 42 U.S.C. § 1395oo. 42 C.F.R. § 405.1842(a)(2008). We conclude that both the statute and regulation preclude administrative review of the budget neutrality adjustment; therefore, the Board lacks jurisdiction over the issue.

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[5] 357 F.3d 103 (D.C. Cir. 2004).
[6] 770 F. Supp. 704 (D.C. Dist. 1991).

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

Cape Cod and the Request for EJR

Ordinarily our EJR analysis would end with a determination of no jurisdiction. However, in *Cape Cod HC 2007 Wage Index/Rural Floor Group*, PRRB case number 07-0705G et al, (*Cape Cod*), the Secretary has taken a contrary position. In *Cape Cod*, the Board concluded that it lacked jurisdiction over the budget neutrality adjustment based on the authorities set forth above. The Board's decision was not reversed by the CMS Administrator. On appeal to the Federal district court, however, the Secretary moved for remand on the basis that the Board had jurisdiction over the issue. The provider plaintiffs responded that the remand was unnecessary because the case was properly before the court on EJR. It argued that implicit in the Board's finding it lacked jurisdiction was a determination that it also lacked authority to decide the question, thus, EJR was appropriate. In its remand order, the District Court explained that the two findings are distinct. "Jurisdiction to take any legal action" asks whether the Providers may obtain a hearing at all; "authority to decide the question" asks whether the Board has authority to reach the merits of Providers' claims. The Court concluded that the Secretary's position was correct: the Court lacked subject matter jurisdiction without the Board's first being afforded an opportunity to consider the merits of the Providers' claims, including whether it has authority to decide the question. Neither the D.C. District court remand[7] nor the remand from the Deputy Administrator addresses the Secretary's rationale for his position regarding jurisdiction. Assuming, however, that the Secretary will take the same position in this case with respect to the Board's having jurisdiction over the budget neutrality issue, and in the interest of judicial economy, the Board will also address the question of whether EJR is appropriate.[8]

The Providers in this appeal seek to have its final wage index rate modified by applying a different calculation methodology relating to the budget neutrality and rural floor factors. Pursuant to 42 C.F.R. § 412.64, the Secretary calculates the standardized amount on an annual basis. This calculation is published annually in the Federal Register following a complex and lengthy process of data collection and analysis. The methodology for the calculation is described in general terms.

The Board is bound by the Secretary's final rules and has no authority to review the data underlying the rate published unless specifically authorized. Notably the Final Rule only provides for Board review of denials of requests by hospitals for correction of certain wage data that eventually goes into one hospital-specific component of the final rate.[9] If the provider appealing the denial is successful, the remedy is limited to the hospital bringing the successful appeal. There is no provision for the Board to adjust the rate itself (as applied to all hospitals) to

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[7] *Cape Cod Hospital v. Leavitt*, (D.D.C. July 21, 2008) (2008 WL 2791683).

[8] After the above remand based on the Secretary's position regarding jurisdiction, the Board found the Provider was entitled to expedited judicial review. In December of 2009, the District Court for the District of Columbia granted the defendant's (government's) motion for summary judgment for the budget neutrality adjustment. *Cape Cod Hospital et al. v. Sebelius*, 2009 WL 4981330 (D.D.C. December 22, 2009) at pp. 9-16.

[9] 64 Fed. Reg. 41490, 41513 (July 30, 1999). This authority has never been codified in the code of Federal Regulations.

account for the effect of the error. The Board concludes that the specific grant of authority and establishment of a detailed process for correcting the rate of only the hospital bringing the appeal, coupled with the failure to include the effect of that correction on other hospitals or to establish a similar correction process for other components of the wage index, are strong indications that the Board does not have authority to change the rate itself.

Even more compelling, however, is the language of the statute and the regulation quoted above that prohibits review of budget neutrality determinations which are at the heart of the question before the Board in this case. Even if the Board interpreted the statutory and regulatory prohibitions on review of budget neutrality determinations too broadly to bar jurisdiction, those prohibitions cannot be ignored altogether. We conclude that the statute and regulation evidence Congress' and the Secretary's intent that budget neutrality determinations are insulated from the Board's authority to affirm, reverse or modify a reimbursement determination. Otherwise, the specific prohibitions articulated there would be rendered meaningless.

Assuming, arguendo, that the Secretary takes the same position in these cases that the Board has jurisdiction, then the Board finds that:

1) based upon the Providers' unopposed assertions regarding the challenges to the rural floor/budget neutrality methodology, there are no findings of fact for resolution by the Board;

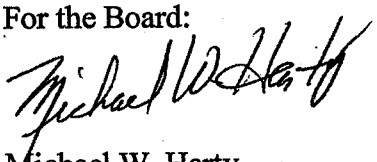
2) it is bound by the Final Rule in the Federal Register and the regulation; and

3) it is without authority to decide the legal question of whether the calculation methodology for the budget neutrality/rural floor adjustment is valid.

The Board finds that it does not have jurisdiction over the RFBNA issue, therefore the request for expedited judicial review is denied. If, however, the Secretary finds that the Board does have jurisdiction over the RFBNA issue, then expedited judicial review would be appropriate. As the Rural Floor Budget Neutrality Adjustment issue is the sole issue under appeal in these cases, the Board hereby closes the cases.

BOARD MEMBERS PARTICIPATING:
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

For the Board:



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin D. Shanklin, Blue Cross Blue Shield Association
Renee Rhone, Cahaba Government Benefit Administrators
Geoff Pike, First Coast Service Options, Inc.
Donna Silvio, Novitas Solutions, Inc.

Byron Lamprecht, Wisconsin Physician Service
Kyle Browning, National Government Services

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CERTIFIED MAIL

NOV 26 2013

Al Gancman
Eastpoint Healthcare
1800 Century Park East, 6th Floor
Century City, CA 90067

Re: Pecos County Memorial Hospital
Provider No. 45-0178
FYE 12/31/07
PRRB Case No. 13-1656

Dear Mr. Gancman:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's request for expedited judicial review (EJR) dated September 20, 2013 (received November 4, 2013). The request is unopposed. The issue under dispute involves whether the Centers for Medicare & Medicaid Services (CMS) erred in calculating a budget neutrality adjustment to the prospective payment system (PPS) standardized amount to account for the effects of the rural floor on the wage index. The Board's jurisdictional determination over the rural floor budget neutrality issue and determination with respect to the request for EJR are set forth below.[1]

Medicare Statutory and Regulatory Background

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

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

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the PPS. The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors. *See* 42 U.S.C. § 1395ww(d)(5). This case involves the annual changes

[1] The federal fiscal years (FFYs) under appeal in this case comprises two FFYs. The period from 01/01/07-09/30/07, comprises FFY 2007, and the period from 10/1/07-12/31/07, comprises FFY 2008. This letter will address both of these FFYs.

to the PPS rates for hospital inpatient operating costs (IPPS) and the methodology for determining those rates.

Standardized Amount

The statute, 42 U.S.C. § 1395ww(d)(2)(A), required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The base-year cost data were used in the initial development of the standardized amounts for PPS which were then used to compute the Federal rates. The standardized amounts are based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Section 1395ww(d)(2)(C) requires that updated base-year per discharge costs be standardized in order to adjust data which might cause variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments (for Alaska and Hawaii), indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994).

Section 1395ww(d)(3)(E) requires the Secretary from time to time to adjust the proportion of the hospitals' costs that are attributable to wages and wage-related costs of the DRG prospective payment rates for area differences in hospital wage levels. The adjustment factors (wage index) should reflect the relative hospital wage level in the geographic area of the hospital being compared to the national average hospital wage level. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor related amount is adjusted by the wage index. Section 1395ww(d)(3)(E)(ii) requires that 62% of the standardized amount be adjusted by the wage index unless doing so would result in lower payments to a hospital than would otherwise be made. 71 Fed. Reg. 47870, 48146 (August 18, 2006).

Budget Neutrality

Budget neutrality is determined by comparing aggregate IPPS payments before and after making changes that are required to be budget neutral (e.g., reclassifying and recalibrating the diagnostic related groups (DRGs)). Outlier payments are also included in the simulations. *Id.* at 48147. In FFYs 2007 and prior, CMS stated that: [the] budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the [prior years'] budget neutrality adjustments. *Id.* at 48147.

In establishing the PPS rate for FFY 2008 CMS applied the budget neutrality adjustment to the wage index rather than to the standardized amount as it had done in previous years. CMS believes that an adjustment to the wage index would result in substantially similar payments as an adjustment to the standardized amount, as both involve multipliers to the standardized amount and both would be based upon the same modeling parameters. 72 Fed. Reg. 47130 (August 22, 2007).

Rural Floor

Section 4410 of the Balanced Budget Act of 1997 (BBA of 1997) established the rural floor by requiring that the wage index of a hospital in any urban area cannot be less than

the wage index determined for the state's rural area. Since Federal fiscal year (FFY) 1998, CMS has implemented the budget neutrality requirement of this provision by adjusting the standardized amounts. 72 Fed. Reg. 24680, 24787 (May 3, 2007). In establishing the PPS standardized amount for FFY 2007 and for prior Federal fiscal years, CMS adjusted the standardized amount downward to account for the effects of the rural floor. *See e.g.* 71 Fed. Reg. at 48145-48148 (August 18, 2006). In FFY 2008 CMS applied the budget neutrality adjustment to the wage index, rather than the standardized amount. [2]

In responding to providers concerns regarding the change to the calculation set forth above and the cumulative effect of the budget neutrality adjustment in the final IPPS rule, CMS stated that:

> [T]he rural floor budget neutrality adjustment previously was a cumulative adjustment, similar to the adjustments we currently make for updates to the wage index and DRG [diagnostic related groups] reclassification and recalibration. Beginning in 2008, the rural floor budget neutrality adjustment will be noncumulative.
>
> ****
>
> With regard to alleged errors in FY 1999 through 2007, our calculation of the budget neutrality in past fiscal years is not within the scope of this rulemaking. Even if errors were made in prior fiscal years, we would not make an adjustment to make up for those errors when setting rates for FY 2008. It is our longstanding policy that finality is critical to a prospective payment system. Although such errors in rate setting are inevitable, we believe the need to establish final prospective rates outweighs the greater accuracy we might gain if we retroactively recomputed rates whenever an error is discovered.

72 Fed. Reg. 47130, 47330 (August 22, 2007).

Wage Index

The statute, 42 U.S.C. § 1395ww(d)(3)(E) and (d)(9)(C)(iv), requires that CMS make an adjustment to the labor-related portion of the national and Puerto Rico PPS rates to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. *Id.* at 48153. The wage index must be updated annually. *Id.* at 48005.

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[2] 72 Fed. Reg. 47130, 47329 (August 22, 2007).

Procedural History

This appeal was timely filed on April 12, 2013, from an original NPR. The Provider contends that the rural floor budget neutrality adjustments as implemented by CMS violate the law's requirement of budget neutrality. The Provider challenges CMS' calculation and application of the budget neutrality adjustment to the PPS standardized amount to account for annual adjustments to the PPS wage index. The Provider asserts that CMS implemented the "rural floor" provisions on a budget "negative" basis as opposed to a budget "neutral" basis as required. The budget neutrality adjustments made by CMS have been compounding over the years rather than having been applied and removed on a yearly basis. The Provider maintains there have been errors in the application of these factors over the years that have resulted in understated PPS payments.

The Provider contends that CMS has erred in the computation of the annual budget neutrality adjustment factors, including the adjustment factor applied to the standardized amounts to account for changes in the wage index and rural floor. CMS has been applying non-reversing rural floor budget neutrality adjustments to the national standardized amounts (which impacts PPS payments) each year since 1998 to reduce payments to hospitals; wherein CMS should have used a reversing type of adjustment. The alleged error results in a systematic understatement of the PPS standardized amount because it overstates the budget neutrality factor for annual updates to the wage index. The Provider believes the error is annual and recurring.

Basis for EJR

To establish the PPS rate for FFYs 2007 and 2008 and for prior years, CMS used a payment simulation model to determine each year's budget neutrality adjustment to the standardized amount to account for the effect of the rural floor. For FFY 2007 and prior, CMS described the simulation model and its calculation of the resulting budget neutrality adjustment as follows:

> [W]e used FY 2005 discharge data to simulate payments and compared aggregate payments using the FY 2006 relative weights and wage indexes to aggregate payments using the FY 2007 relative weights and wage indexes. The same methodology was used for the FY 2006 budget neutrality adjustment.
>
> . . . These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2006 budget neutrality adjustments.

71 Fed. Reg. 47870, 48147 (August 18, 2006).

In establishing the PPS rate for FFY 2008, CMS applied the budget neutrality adjustment to the wage index rather than to the standardized amount as it had done in previous years. 72 Fed. Reg. 47130, 47330 (August 22, 2007). CMS did not rectify the cumulative impact of its methodology errors from FFY 1999 through 2007, as described above. *Id.* at 47421. Thus, for FFY 2008, the Provider is appealing the understated FFY 2008 standardized amount used in other FFYs.

The Provider is challenging an aspect of CMS' calculation of the final PPS rates published in the Federal Register for FFYs 2007[3] and 2008. The Provider contends that CMS erred in calculating a budget neutrality adjustment to the PPS standardized amount to account for the effects of the rural floor on the wage index. This alleged error results in a systematic understatement of the PPS rates, and this error has been an annual and recurring one. Each year's error is permanently incorporated into the standardized amount paid under PPS for each successive year.

Jurisdiction over the Issue

The Provider contends that the Board has jurisdiction over this appeal because the appeal was timely filed from an NPR and the amount in controversy threshold has been met. The Provider points out that review of the PPS payment determination is subject only to the exceptions set forth at 42 U.S.C. § 1395oo(g)(2). This section provides, in relevant part, that determinations described in 42 U.S.C. § 1395ww(d)(7) shall not be reviewed by the Board or any court. Among the matters not subject to review is the determination of the requirement, or the proportional amount, of any budget neutrality adjustment. The Provider contends that this preclusion of review provision is limited to certain budget neutrality adjustments for fiscal years 1984 and 1985 to ensure that the total amounts paid under PPS, then a new system, were the same as the total amounts that would have been spent under the Medicare law (as modified by the Tax Equity & Fiscal Responsibility Act of 1982 (TEFRA)). 42 U.S.C. § 1395ww(e)(1)(A)-(B).

The Intermediary did not provide comment to the Board in this matter.

Decision of the Board

The Board concludes that it lacks jurisdiction over the appeal because review of budget neutrality adjustments is expressly prohibited by the statute and regulations. *See* 42 U.S.C. §1395ww(d)(7); 42 U.S.C. § 1395oo(g)(2); 42 C.F.R. §§ 405.1804 and 405.1840(b)(2). Because jurisdiction over an issue is a prerequisite to granting a request for EJR, the Board finds that EJR is not appropriate.

Payment under the prospective payment system is governed by the statutory provisions of 42 U.S.C. § 1395ww. Subsection (d)(7) states that:

> There shall be no administrative or judicial review under [42 U.S.C. §1395oo] or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount of any adjustment effected pursuant to subsection (e)(1) [budget

[3] The final PPS rates for FFY 2007 were published in the Federal Register on October 11, 2006. 71 Fed. Reg. 59886, 59889 (October 11, 2006). The August 18, 2006 Federal Register cited above noted that the standardized amount was tentative because factors such as the outlier offset and budget neutrality adjustment for the wage index and reclassification that are applied to the standardized amount had not been determined pending the calculation of the occupational mix adjustment. 71 Fed. Reg. 47870, 48146.

> neutrality] or the determination of the applicable percentage increase under paragraph (12)(A)(ii) . . .

The Board's governing statute, 42 U.S.C. § 1395oo(g)(2), states that:

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CMS' implementing regulation, 42 C.F.R. § 405.1804, entitled "Matters not subject to administrative and judicial review under prospective payment" provides:

> Neither administrative or judicial review is available for controversies about the following matters:
>
> (a) The determination of the requirement, or the proportional amount, of any budget neutrality adjustment in the prospective payment rates. . . . (emphasis added)

CMS stated at the time the rule was adopted that the purpose of the rule is:

> to state that the determinations and decisions described in section 1886(d)(7) of the Act may not receive Board or judicial review. Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
>
> > A determination of the requirement, or the proportional amounts of, any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act . . .

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In addition, section 701(a) of the Administrative Procedure Act (APA) states that the appeal provisions of the APA apply to the administrative actions except where statutes preclude judicial review. *See* 5 U.S.C. § 701(a). The statutes and the regulations both preclude administrative and judicial review of the budget neutrality adjustment.

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[4] 357 F.3d 103 (D.C. Cir. 2004).

preclude appeal. The Court concluded that where the statute stipulated that "there should be no administrative or judicial review," that language constituted clear and convincing evidence that the appeal was precluded. The Court further noted that payments under PPS are made on a prospective basis and, given the length of time that review of individual appeals could take, the result would be retroactive adjustments to payment rates with the potential of creating havoc with the payment system. The aggregate impact of appeal decisions would undermine the Secretary's ability to ensure budget neutrality.

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The Board is not persuaded that preclusion of review of budget neutrality provisions is limited to the fiscal years 1984 and 1985. Even though the rural floor budget neutrality provision was not specifically addressed in the limits on administrative and judicial review, we find the language of the statute itself unambiguous in that there is no indication that the prohibition on administrative or judicial review is limited to the two fiscal periods identified by the Providers. Therefore, no further inquiry into Congressional intent is warranted. Moreover, if any ambiguity were present, it is resolved by the expansive regulatory language, binding on the Board, that prohibits review of "any controversies about [budget neutrality determinations]."

42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permit providers to bypass the Board's hearing procedure and obtain judicial review of a specific matter at issue involving a question of law or regulation where the Board determines that it is without authority to decide the legal question. Prior to rendering a decision that it lacks the authority to decide the legal question before it, the Board must determine that it has jurisdiction over the matter at issue in the appeal under 42 U.S.C. § 1395oo. 42 C.F.R. § 405.1842(a)(2008). We conclude that both the statute and regulation preclude administrative review of the budget neutrality adjustment; therefore, the Board lacks jurisdiction over the issue.

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

Cape Cod and the Request for EJR

Ordinarily our EJR analysis would end with a determination of no jurisdiction. However, in *Cape Cod HC 2007 Wage Index/Rural Floor Group*, PRRB case number 07-0705G et al, (*Cape Cod*), the Secretary has taken a contrary position. In *Cape Cod*, the Board concluded that it

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lacked jurisdiction over the budget neutrality adjustment based on the authorities set forth above. The Board's decision was not reversed by the CMS Administrator. On appeal to the Federal district court, however, the Secretary moved for remand on the basis that the Board had jurisdiction over the issue. The provider plaintiffs responded that the remand was unnecessary because the case was properly before the court on EJR. It argued that implicit in the Board's finding it lacked jurisdiction was a determination that it also lacked authority to decide the question, thus, EJR was appropriate. In its remand order, the District Court explained that the two findings are distinct. "Jurisdiction to take any legal action" asks whether the Providers may obtain a hearing at all; "authority to decide the question" asks whether the Board has authority to reach the merits of Providers' claims. The Court concluded that the Secretary's position was correct: the Court lacked subject matter jurisdiction without the Board's first being afforded an opportunity to consider the merits of the Providers' claims, including whether it has authority to decide the question. Neither the D.C. District court remand[6] nor the remand from the Deputy Administrator addresses the Secretary's rationale for his position regarding jurisdiction. Assuming, however, that the Secretary will take the same position in this case with respect to the Board's having jurisdiction over the budget neutrality issue, and in the interest of judicial economy, the Board will also address the question of whether EJR is appropriate.[7]

The Provider in this appeal seeks to have its final wage index rate modified by applying a different calculation methodology relating to the budget neutrality and rural floor factors. Pursuant to 42 C.F.R. § 412.64, the Secretary calculates the standardized amount on an annual basis. This calculation is published annually in the Federal Register following a complex and lengthy process of data collection and analysis. The methodology for the calculation is described in general terms.

The Board is bound by the Secretary's final rules and has no authority to review the data underlying the rate published unless specifically authorized. Notably the Final Rule only provides for Board review of denials of requests by hospitals for correction of certain wage data that eventually goes into one hospital-specific component of the final rate.[8] If the provider appealing the denial is successful, the remedy is limited to the hospital bringing the successful appeal. There is no provision for the Board to adjust the rate itself (as applied to all hospitals) to account for the effect of the error. The Board concludes that the specific grant of authority and establishment of a detailed process for correcting the rate of only the hospital bringing the appeal, coupled with the failure to include the effect of that correction on other hospitals or to establish a similar correction process for other components of the wage index, are strong indications that the Board does not have authority to change the rate itself.

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[6] *Cape Cod Hospital v. Leavitt*, (D.D.C. July 21, 2008) (2008 WL 2791683).

[7] After the above remand based on the Secretary's position regarding jurisdiction, the Board found the Provider was entitled to expedited judicial review. In December of 2009, the District Court for the District of Columbia granted the defendant's (government's) motion for summary judgment for the budget neutrality adjustment. *Cape Cod Hospital et al. v. Sebelius*, 2009 WL 4981330 (D.D.C. December 22, 2009) at pp. 9-16.

[8] 64 Fed. Reg. 41490, 41513 (July 30, 1999). This authority has never been codified in the code of Federal Regulations.

Even more compelling, however, is the language of the statute and the regulation quoted above that prohibits review of budget neutrality determinations which are at the heart of the question before the Board in this case. Even if the Board interpreted the statutory and regulatory prohibitions on review of budget neutrality determinations too broadly to bar jurisdiction, those prohibitions cannot be ignored altogether. We conclude that the statute and regulation evidence Congress' and the Secretary's intent that budget neutrality determinations are insulated from the Board's authority to affirm, reverse or modify a reimbursement determination. Otherwise, the specific prohibitions articulated there would be rendered meaningless.

Assuming, arguendo, that the Secretary takes the same position in these cases that the Board has jurisdiction, then the Board finds that:

1) based upon the Provider's unopposed assertion regarding the challenges to the rural floor/budget neutrality methodology, there are no findings of fact for resolution by the Board;

2) it is bound by the Final Rule in the Federal Register and the regulation; and

3) it is without authority to decide the legal question of whether the calculation methodology for the budget neutrality/rural floor adjustment is valid.

The Board finds that it does not have jurisdiction over the RFBNA issue, therefore the request for expedited judicial review is denied. If, however, the Secretary finds that the Board does have jurisdiction over the RFBNA issue, then expedited judicial review would be appropriate. As the Rural Floor Budget Neutrality Adjustment issue is the sole issue in the appeal, the Board hereby closes case number 13-1656.

BOARD MEMBERS PARTICIPATING:
Michael W. Harty
John Gary Bowers, CPA
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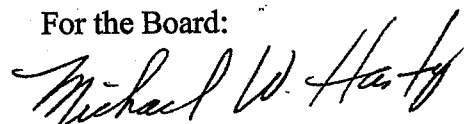
L. Sue Andersen, Esq.

For the Board:



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin D. Shanklin, Blue Cross Blue Shield Association
Donna Silvio, Novitas Solutions, Inc.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
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Baltimore MD 21244-2670

Phone: 410-786-2671
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CERTIFIED MAIL

NOV 26 2013

11-0110GC

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Kenneth R. Marcus
2290 First National Building
660 Woodward Avenue
Detroit, MI 48226

Cahaba Government Benefit Administrators
Renee Rhone
Senior Auditor/Appeals Specialist
1206 Pointe Centre Drive, Ste 240
Chattanooga, TN 37421

RE: BMHCC 2004-2005 DSH L&D Days CIRP Group
PRRB Case No.: 11-0110G
FYEs: 2004-2005

Dear Mr. Marcus and Ms. Rhone,

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced appeal and noted jurisdictional impediments. The jurisdictional decision of the Board is set forth below.

Background:

The Common Issue Related Party (CIRP) group appeal was filed with the Board on November 19, 2010. At issue is the group appeal is the exclusion of Medicare DSH Labor and Delivery Room (L&D) Days from the Medicaid proxy. There are eight provider/FYE's as participants in this appeal that cover both 9/30/04 and 9/30/05. In response to the Board's April 25, 2013 request, the Providers timely submitted a final schedule of providers on May 15th, 2013. From review of that schedule, it was identified that each of the Providers appealed from a revised Notice of Program Reimbursement (RNPR). New Board rule 21, which went into effect March 1, 2013, required additional documentation for each provider appealing from a RNPR to be included in the final schedule, to support that the issue under appeal was revised in each RNPR pursuant to 42 C.F.R. § 405.1889. Although the providers May 15, 2013 submission was after the effective date of the new requirement, the group schedule did not contain the required documentation to support the L&D issue was adjusted in each of the appealed RNPRs. The Board, providing a second opportunity to properly document the record, issued a subsequent request on May 23, 2013 for the Provider to supply the missing pertinent information. The Provider responded with an updated schedule on June 17, 2013, which it purports accurately and timely responded to the Board's request.

Board Determination:

The Board finds that it does not have jurisdiction over any of the Providers in this group, as the Providers have failed to document that L&D days were revised in the RNPRs from which they are appealing. Each of the Providers submitted adjustment reports under Tab D that document an adjustment to increase Medicaid Days on W/S S-3, as well as a corresponding adjustment to increase the DSH% on

W/S E Part A. While the record remains unclear as to the bases of all of RNPRs, two of the adjustment reports specifically reference that the RNPR's were issued to adjust Medicaid Eligible days to the amount determined per administrative resolution of PRRB Case 07-0690G.

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 provides in relevant part:

> (a) General. (1) A Secretary determination, an intermediary determination, or a decision by a reviewing entity (as described in § 405.1801(a) of this subpart) may be reopened, for findings on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the intermediary (with respect to intermediary determinations) or by the reviewing entity that made the decision (as described in § 405.1885(c) of this subpart).

42 C.F.R. § 405.1889 (2008) explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (b)(2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

Neither the original schedule of providers, nor the June 17, 2013 updated schedule which were both required to include the required documentation to support the issue in dispute was adjusted on the RNPRs, reference the issue Labor and Delivery Days. The specific issue in dispute, labor and delivery days, was not referenced on any reopening notices, the accompanying workpapers, nor the audit adjustments. The only information in the record that did document what issue(s) were specifically revised in the RNPRs, was the references on the adjustment reports for Providers #3 and #4 which specifically stated that the RNPRs were issued to implement the Administrative Resolution for PRRB Case # 07-0690G. As each of the RNPRs under appeal were issued within the same relative time frame as those issued for Provider 3 and 4, the Board will presume that each of the RNPRs (which are all for related parties as this is CIRP group) were issued subsequent to the implementation of that specific A/R. The issue in PRRB Case 07-0690G, was not labor and delivery days, but of the separate and distinct legal issue of paid vs. , unpaid Medicaid days, and therefore labor and delivery days could not have been adjusted as required in 42 CFR 405.1889 in the RNPRs issued pursuant to the A/R.

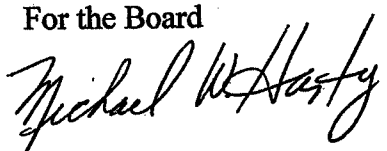
In addition, as the RNPRs were issued based on a signed administrative resolution which withdrew the PRRB appeal, the signed resolution and subsequent withdrawal signifies the Providers' agreement that the dissatisfaction in that appeal had been resolved for the issue in dispute in the group appeal (and as it was a group appeal, there could have only been one specific issue in dispute pending in that

appeal). The Board finds that the Providers 1.) could not have had a second and distinct issue of labor and delivery days in case 07-0690G as the single group issue was the paid vs. unpaid Medicaid days issue, and 2.) the providers resolved/withdrew their dissatisfaction with the issue appealed when they withdrew the case before the Board. Had the Providers been only "partially" satisfied with the resolution, they had the opportunity to any remaining dissatisfaction issues before the Board for hearing. Therefore, the Board finds that the Providers cannot show the dissatisfaction necessary to appeal the RNPRs as required by of 42 U.S.C. §1395oo(a)(1)(A) and 42 C.F.R. §§405.1835 and 405.1837.

As the Board has found it lacks jurisdiction over each participant in the group, the appeal is hereby dismissed. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:
John Gary Bowers, CPA
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

For the Board



Michael W. Harty
Chairman

Enclosures: Schedule of Providers

cc: Kevin D. Shanklin, Executive Director, BCBSA

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Refer to: 08-2662GC

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NOV 29 2013

Noridian Administrative Services
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Darwin San Luis
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Fargo, ND 58108-6782

Toyon Associates, Inc.
Glenn S. Bunting
Vice President
1800 Sutter Street
Suite 600
Concord, CA 94520-2546

RE: Sutter Merced Medical Center
Provider No.: 05-0444
FYE: 6/30/1993
PRRB Case No.: 08-2662GC

Dear Mr. San Luis and Mr. Bunting,

The Provider Reimbursement Review Board (the Board) has reviewed the jurisdiction documentation submitted in the above-captioned case. The Board's jurisdiction decision is set forth below.

Pertinent Facts

On March 10, 1997 the Provider was issued a revised Notice of Program Reimbursement ("NPR") for FYE 6/30/1993. The revised NPR specifically stated that the revision was as a result of adjusting Medi-Cal days to the State's audited and corrected payment summary, and recomputed DSH accordingly. The Intermediary's review did not include an SSI ratio adjustment. The Provider appealed from the revised NPR on September 8, 1997, appealing the following issues: DSH SSI; the Medi-Cal ratio used in determining DSH; and Medicare settlement data used to determine DSH. On March 9, 2001, the Provider transferred to a group appeal, Case No. 98-2853G and subsequently transferred to this Common Issue Related Party ("CIRP") group appeal, Case No. 08-2662GC on August 1, 2008. The issue for this CIRP group appeal is SSI ratio.

The Intermediary did not identify any jurisdictional impediments in this CIRP group appeal.

Board's Decision

The Board finds that it does not have jurisdiction over Sutter Merced Medical Center because it is appealing from a revised NPR which does not adjust the SSI ratio.

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 1885 provides in relevant part:

> (a) General. (1) A Secretary determination, an intermediary determination, or a decision by a reviewing entity (as described in § 405.1801(a) of this subpart) may be reopened, for findings on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the intermediary (with respect to intermediary determinations) or by the reviewing entity that made the decision (as described in § 405.1885(c) of this subpart).

42 C.F.R. § 405.1889 explains the effect of a cost report revision:

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> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (b)(2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

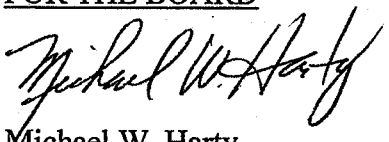
This regulation has also been addressed and explained in the decision *HCA Health Services of Oklahoma v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994). In that case the Court held that when a fiscal intermediary reopens its original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening.

The Board finds that it does not have jurisdiction over Sutter Merced Medical Center because the revised NPR does not adjust SSI ratio. This Provider is hereby dismissed from the group. The remaining participants in the group will be remanded pursuant to CMS Ruling 1498-R.

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

Board Members
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Standard Remand and Schedule of Providers

cc: Kevin Shanklin, BCBSA
Darwin San Luis, Noridian Administrative Services
Glenn Bunting, Toyon Associates