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

MAR 05 2014

CERTIFIED MAIL

Novitas Solutions, Inc.
Timothy LeJeune
JH Provider Audit & Reimbursement
Union Trust Building
501 Grant Street, Suite 600
Pittsburgh, PA 19219

Houston Methodist Hospital System
Nan Chi
Director – Budget & Compliance
8100 Greenbriar GB240
Houston, TX 77054

RE: Methodist HCS 1991-2006 DSH SSI Proxy PRRB Case No. 00-1229GC
Specifically Participants San Jacinto Methodist Hospital Provider No. 45-0424, FYE 12/31/93; The Methodist Hospital, Provider No. 45-0358, FYE 12/31/96 and FYE 12/31/03; Methodist Willowbrook Hospital, Provider No. 45-0844, FYE 12/31/05

Dear Timothy LeJeune and Nan Chi:

The Provider Reimbursement Review Board (the Board) recently began a review of the above-captioned appeal in order to process a standard remand pursuant to CMS Ruling 1498-R for the SSI Ratio issue.

Upon review, the Board notes that the four providers referenced above should be dismissed from this group appeal based on the following:

- There is no evidence to support that the SSI Ratio was adjusted in the Revised Notice of Program Reimbursement for San Jacinto Methodist Hospital, Provider No. 45-0424, FYE 12/31/93.
- There is insufficient evidence to support that the SSI Ratio issue was added to the individual appeals for The Methodist Hospital, Provider No. 45-0358, FYE 12/31/96 and FYE 12/31/03 and Methodist Willowbrook Hospital, Provider No. 45-0844, FYE 12/31/05.

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 case on the merits.

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

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

FOR THE BOARD:

Board Member

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Enclosure: Standard Remand of SSI Ratio Under CMS Ruling CMS-1498-R

cc: Kevin D. Shanklin, Executive Director, BCBSA

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Refer to: 13-3629

CERTIFIED MAIL

MAR 07 2014

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

Palmetto GBA
Cecile K. Huggins
Supervisor
Provider Audit – Mail Code AG-380
2300 Springdale Drive – Bldg. ONE
Camden, SC 29020-1728

RE: Jurisdictional Decision – Grace Hospital, Inc.
Provider No.: 34-0075
FYE: 12/31/2006
PRRB Case No.: 13-3629

Dear Mr. Ravindran and Ms. Huggins,

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

Background

Grace Hospital, Inc. received a revised Notice of Program Reimbursement (NPR) for FYE 12/31/2006 on March 6, 2013. On September 3, 2013, the Board received the Provider's appeal request in which it appealed one issue: the Rural Floor Budget Neutrality Adjustment (RFBNA).

Board's Decision

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 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 receipt of the final determination. Before the Board can make a determination over all matters covered by the cost report, it must first determine that the Provider has filed a jurisdictionally valid appeal.

Although the Intermediary did not file a jurisdictional challenge, the Board nonetheless finds that it does not have jurisdiction over this appeal because the Provider appealed from a revised NPR in which the only issue on appeal, RFBNA, was not adjusted. The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2012) 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).

In accordance with 42 C.F.R. § 405.1889 (2012), a revised NPR is considered a separate and distinct determination from which the provider may appeal. The regulation provides:

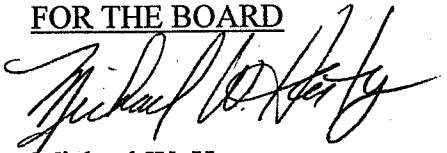
> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in § 405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of § 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.
>
> (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.

Here, the Provider's audit adjustment report associated with the March 6, 2013 revised NPR shows that DSH was adjusted in order to adjust the SSI%. Because the RFBNA was not specifically adjusted in the revised NPR, the Board finds that it does not have jurisdiction over this Provider's appeal as it lacks the specificity requirements for a revised NPR. As RFBNA was the sole issue in the appeal, case number 13-3629 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:
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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Refer to: 14-0286

CERTIFIED MAIL

MAR 07 2014

Quality Reimbursement Services, Inc.
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President
150 N. Santa Anita Avenue
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Arcadia, CA 91006

Palmetto GBA
Cecile K. Huggins
Supervisor
Provider Audit – Mail Code AG-380
2300 Springdale Drive – Bldg. ONE
Camden, SC 29020-1728

RE: Jurisdictional Decision – Durham Regional Hospital
Provider No.: 34-0155
FYE: 6/30/2007
PRRB Case No.: 14-0286

Dear Mr. Ravindran and Ms. Huggins,

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

Background

Durham Regional Hospital received a revised Notice of Program Reimbursement (NPR) for FYE 6/30/2007 on April 23, 2013. On October 24, 2013, the Board received the Provider's appeal request in which it appealed two issues: the Rural Floor Budget Neutrality Adjustment (RFBNA) and the impact of the contested RFBNA on the DRG factor of the DSH payment calculation.

Board's Decision

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 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 receipt of the final determination. Before the Board can make a determination over all matters covered by the cost report, it must first determine that the Provider has filed a jurisdictionally valid appeal.

Although the Intermediary did not file a jurisdictional challenge, the Board nonetheless finds that it does not have jurisdiction over this appeal because the Provider appealed from a revised NPR in which the only issues on appeal, RFBNA and DRGs, were not adjusted. The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2012) 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).

In accordance with 42 C.F.R. § 405.1889 (2012), a revised NPR is considered a separate and distinct determination from which the provider may appeal. The regulation provides:

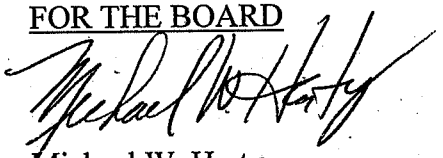
> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in § 405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of § 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.
>
> (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.

Here, the Provider's audit adjustment report associated with the April 23, 2013 revised NPR shows that DSH was adjusted in order to include Labor & Delivery Days pursuant to the Board's remand under CMS Ruling 1498-R. Because neither the RFBNA nor DRGs were specifically adjusted in the revised NPR, the Board finds that it does not have jurisdiction over this Provider's appeal as it lacks the specificity requirements for a revised NPR. As RFBNA and DRGs were the only issues in the appeal, case number 14-0286 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:
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
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Refer to: 05-1877G

MAR 27 2014

CERTIFIED MAIL

National Government Services, Inc.
Danene L. Hartley
Appeals Lead
MP INA101-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

Reed Smith LLP
Salvatore G. Rotella, Jr.
2500 One Liberty Place
1650 Market Street
Philadelphia, PA 19103-7301

RE: Reed Smith 2002 Medi-Medi Group
University of Missouri Hospital
Provider No.: 26-0141
FYE: 06/30/2002
PRRB Case No.: 05-1877G

Dear Danene Hartley and Salvatore Rotella, Jr.,

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

University of Missouri Hospital was issued an original Notice of Program Reimbursement (NPR) for FYE 06/30/2002 on August 25, 2005. On January 5, 2006, the Provider filed a request for hearing with the Board appealing two issues: Medi-Medi Days and SSI Days (Case Number 06-0500). That case was closed on May 18, 2006, following the transfer of the SSI Days issue to case number 05-1812G. However, there is no record that the Medi-Medi Days issue was ever transferred from the Provider's individual appeal to the group appeal in case number 05-1877G.

Provider's Position

In a letter received by the Board on December 23, 2013, the University of Missouri Hospital acknowledged that it was unable to locate a transfer letter for its 2002 Medi-Medi issue. It requested that the Board find that jurisdiction had been established for the Provider based upon the other jurisdictional documents submitted to the Board.

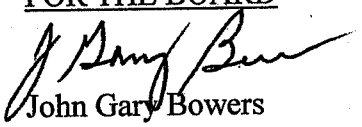
Board's Decision

Because University of Missouri Hospital was unable to provide documentation of its transfer from its individual appeal into the group appeal, case number 05-1877G, the Board finds that jurisdiction has not been established for this Provider as a participant within this group. The Board hereby dismisses University of Missouri Hospital from the group appeal.

Review of this determination may be 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
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD



John Gary Bowers
Board Member

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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Refer to: 08-2454GC

MAR 07 2014

CERTIFIED MAIL

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

Noridian Healthcare Solutions, LLC
Donna Kalafut
Senior Consultant
P.O. Box 6782
Fargo, ND 58108

RE: Jurisdictional Challenge – Seton Medical Center as part of Daughters of Charity DSH
SSI CIRP Group
Provider No.: 05-0289
FYE: 12/31/2001
PRRB Case No.: 08-2454GC

Dear Mr. Bunting and Ms. Kalafut,

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

Seton Medical Center was issued a revised Notice of Program Reimbursement (NPR) for FYE 12/31/2001 on March 20, 2008. On August 20, 2008, the Provider filed an appeal request with the Board appealing the following issue: accuracy of the SSI% provided by CMS and used by the Intermediary for calculating the Disproportionate Share Hospital (DSH) amounts. Finally, on March 19, 2009, the Provider requested to transfer the SSI% issue to the CIRP group appeal in case number 08-2454GC.

Board's Decision

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 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 the notice of the Intermediary's determination was mailed to the provider. However, before the Board can make a determination over all matters covered by the cost report, it must first determine that the Provider has filed a jurisdictionally valid appeal.

Although the Intermediary did not file a jurisdictional challenge, the Board nonetheless finds that it does not have jurisdiction over this Provider's appeal because the Provider appealed from a revised

NPR in which the only issue on appeal, the SSI%, was not adjusted. The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (effective August 21, 2008) 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).

In accordance with 42 C.F.R. § 405.1889 (2012), a revised NPR is considered a separate and distinct determination from which the provider may appeal. The regulation provides:

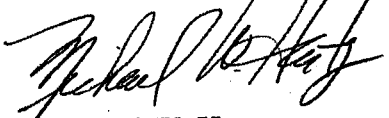
> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in § 405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of § 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.
>
> (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.

Here, the Provider's audit adjustment report associated with the March 20, 2008 revised NPR shows that DSH was adjusted generally. However, the Provider did not submit any documentation to establish that that the SSI% was specifically adjusted. Because the SSI% was not specifically adjusted in the revised NPR, the Board finds that it does not have jurisdiction over Seton Medical Center. This Provider is hereby dismissed from the group in case number 08-2454GC.

Review of this determination may be 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, BCBSA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to: 14-0307

MAR 07 2014

CERTIFIED MAIL

Quality Reimbursement Services, Inc.
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President
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Arcadia, CA 91006

Palmetto GBA
Cecile K. Huggins
Supervisor
Provider Audit – Mail Code AG-380
2300 Springdale Drive – Bldg. ONE
Camden, SC 29020-1728

RE: Jurisdictional Decision – Durham Regional Hospital
Provider No.: 34-0155
FYE: 6/30/2004
PRRB Case No.: 14-0307

Dear Mr. Ravindran and Ms. Huggins,

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

Background

Durham Regional Hospital received a revised Notice of Program Reimbursement (NPR) for FYE 6/30/2004 on May 10, 2013. On October 25, 2013, the Board received the Provider's appeal request in which it appealed two issues: the Rural Floor Budget Neutrality Adjustment (RFBNA) and the impact of the contested RFBNA on the DRG factor of the DSH payment calculation.

Board's Decision

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 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 receipt of the final determination. Before the Board can make a determination over all matters covered by the cost report, it must first determine that the Provider has filed a jurisdictionally valid appeal.

Although the Intermediary did not file a jurisdictional challenge, the Board nonetheless finds that it does not have jurisdiction over this appeal because the Provider appealed from a revised NPR in which the only issues on appeal, RFBNA and DRGs, were not adjusted. The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2012) provides in relevant part:

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In accordance with 42 C.F.R. § 405.1889 (2012), a revised NPR is considered a separate and distinct determination from which the provider may appeal. The regulation provides:

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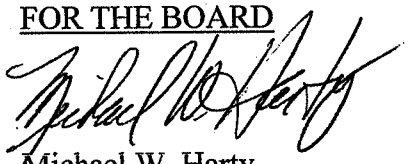
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered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

Here, the Provider's audit adjustment report associated with the May 10, 2013 revised NPR shows that DSH was adjusted in order to include Labor & Delivery Days pursuant to the Board's remand under CMS Ruling 1498-R. Because neither the RFBNA nor DRGs were specifically adjusted in the revised NPR, the Board finds that it does not have jurisdiction over this Provider's appeal as it lacks the specificity requirements for a revised NPR. As RFBNA and DRGs were the only issues in the appeal, case number 14-0307 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:
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
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Refer to: 13-3626

CERTIFIED MAIL

MAR 07 2014

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Palmetto GBA
Cecile K. Huggins
Supervisor
Provider Audit – Mail Code AG-380
2300 Springdale Drive – Bldg. ONE
Camden, SC 29020-1728

RE: Jurisdictional Decision – Northeast Medical Center
Provider No.: 34-0001
FYE: 9/30/2006
PRRB Case No.: 13-3626

Dear Mr. Ravindran and Ms. Huggins,

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

Background

Northeast Medical Center received a revised Notice of Program Reimbursement (NPR) for FYE 9/30/2006 on March 6, 2013. On September 3, 2013, the Board received the Provider's appeal request in which it appealed one issue: the Rural Floor Budget Neutrality Adjustment (RFBNA).

Board's Decision

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 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 receipt of the final determination. Before the Board can make a determination over all matters covered by the cost report, it must first determine that the Provider has filed a jurisdictionally valid appeal.

Although the Intermediary did not file a jurisdictional challenge, the Board nonetheless finds that it does not have jurisdiction over this appeal because the Provider appealed from a revised NPR in which the only issue on appeal, RFBNA, was not adjusted. The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2012) 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).

In accordance with 42 C.F.R. § 405.1889 (2012), a revised NPR is considered a separate and distinct determination from which the provider may appeal. The regulation provides:

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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.
>
> (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.

Here, the Provider's audit adjustment report associated with the March 6, 2013 revised NPR shows that DSH was adjusted in order to adjust SSI% and to include Labor & Delivery Days. There was no specific adjustments made to RFBNA; therefore, the Board finds that it does not have jurisdiction over this Provider's appeal as it lacks the specificity requirements for a revised NPR. As RFBNA was the only issue in the appeal, case number 13-3626 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:
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
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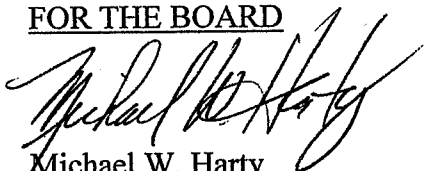
FOR THE BOARD



Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, BCBSA

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

CERTIFIED MAIL

MAR 10 2014

Toyon Associates, Inc.
Thomas P. Knight, CPA
President
1800 Sutter Street, Suite 600
Concord, CA 94520-2546

RE: **Community Hospital of the Monterey Peninsula**
Provider Number: 05-0145
FYE: 12/31/2001
Case Number: 08-1792

Dear Mr. Knight:

The Provider Reimbursement Review Board (the Board) recently began a review of the above-captioned appeal. The Board's determination is outlined below.

Pertinent Facts:

On April 8, 2008, the Provider appealed its Revised NPR, dated January 25, 2008. The appeal was established and assigned Case No. 08-1792. The Provider appealed the following issues:

1. DSH – Dual Eligible Days
2. DSH – Code 2 & 3 Eligible Days
3. DSH – SSI Ratio
4. DSH – Labor Room Days (Medicaid Fraction, Medicaid Days)
5. DSH – Labor/Delivery/Recovery/Post-Partum Unit (LDRP) Days (Medicaid Fraction – Total Days)
6. DSH – Operating DSH Entitlement

On September 29, 2008, the Provider requested to transfer the Labor Room Days issue to Group Case No. 07-2693G and the Labor/Delivery/Recovery/Post-Partum Unit Days issue to Group Case No. 07-2716G, which was subsequently withdrawn in 2010.

On November 12, 2008, the Provider transferred the DSH – Dual Eligible Days issue to Group Case No. 09-0272G and the DSH – SSI Ratio issue to Group Case No. 09-0273G, which was closed via remand on November 1, 2012.

On October 17, 2012, the Board requested the original NPR and all related jurisdictional documents in order to determine whether the issues appealed from the RNPR were jurisdictionally valid. On November 12, 2012, the Provider Rep. submitted the requested work papers, per the Board's request.

Board Determination:

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 ($50,000 for a group), and the request for a hearing is filed within 180 days of the date of the Notice of Program Reimbursement (NPR).[1]

Jurisdiction for reopening an intermediary determination rests exclusively with the intermediary (or successor intermediary) that rendered the determination.[2] 42 C.F.R. § 405.1885(a) (6) states that a determination or decision to reopen or not to reopen a determination is not a final determination within the meaning of Subpart R of Title 42 and is not subject to further administrative or judicial review.[3] A revised NPR is considered a separate and distinct determination from with the provider may appeal. 42 C.F.R. §405.1889, effective May 23, 2008, stated "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... the revision must be considered a separate and distinct determination or decision to which the provisions of Secs. 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877, and 405.1885 of this subpart are applicable." A Provider's appeal of a reopening is limited to the specific issues revisited on reopening, and does not extend further to all determinations underlying the original NPR.

DSH – Dual Eligible Days

Upon review of the jurisdictional documents, the Dual Eligible Days issue was not adjusted by the Intermediary on the Revised NPR nor were the days requested as part of the reopening; therefore, they could not be reviewed. The Board finds that it does not have jurisdiction over the DSH – Dual Eligible Days issue and deems the Provider's request to transfer the issue to Group Case No. 09-0272G, as invalid.

DSH – Code 2 & 3 Eligible Days

Upon review of the Revised NPR work papers, while the Provider requested review of the Code 2 & 3 Eligible Days, the 1,269 days were not reviewed or revised by the Intermediary on the Revised NPR. Only the 5,069 In-State Days were reviewed as part of the reopening. Therefore, the appeal of this issue is invalid.

DSH – SSI Ratio

The DSH – SSI Ratio was adjusted by the Intermediary on the Revised NPR with Adjustment R1-004; therefore, the appeal of this issue and the Provider's transfer to Group Case No. 09-0273G was valid. Case No. 09-0273G was remanded on November 5, 2012, and is closed.

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[1] 42 U.S.C. §1395oo(a) and 42 C.F.R. §§405.1835-1841.
[2] 42 C.F.R. §405.1885(c).
[3] *See* Your Home Visiting Nurse Services, Inc. v. Shalala, 119 S.Ct. 930 (1999).

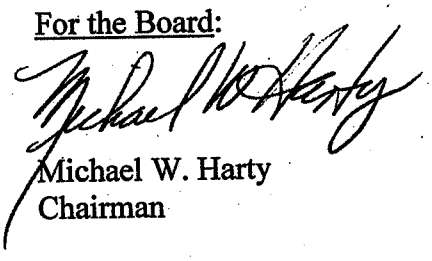
DSH – Operating DSH Entitlement

The Board finds the Provider's appeal of Operating DSH Entitlement is the impact of the specific DSH component issues under appeal and is not, in itself, a valid reimbursement issue. If the Provider prevails on valid DSH issues and the DSH percentage is above 15%, the Provider will receive a payment. The Board dismisses the entitlement issue from this appeal.

Since there are no remaining issues in this appeal, the Board hereby closes Case No. 08-1792.

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

For the Board:



Michael W. Harty
Chairman

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Refer to: 14-2100

MAR 12 2014

Certified Mail

Stephanie A. Webster, Esq.
Akin, Gump, Strauss, Hauer & Feld
Robert S. Strauss Building
1333 New Hampshire Avenue, NW
Washington, DC 20036-1564

RE: Tampa General Hospital
Provider No. 10-0128
FFY 2014
PRRB Case No. 14-2100

Dear Ms. Webster:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's February 11, 2014 request for expedited judicial review (EJR) which was received on February 12, 2014. The decision of the Board with respect to the request for EJR is set forth below.

Issue under Appeal

The Provider is seeking a correction of the calculation of its disproportionate share (DSH) payment under the new payment adjustment methodology found in Section 3133 of the Affordable Care Act (ACA), 42 U.S.C. § 1395ww(r). The Provider is challenging the Secretary's calculation of its DSH payment for uncompensated care costs for Federal fiscal year (FFY) 2014. The Provider alleges that a portion of its DSH payment under the new payment methodology used data that did not accurately reflect its portion of the aggregate amount of uncompensated care for all DSH hospitals. The question before the Board is whether it has the authority to set aside the disputed provisions of the final inpatient prospective payment system (IPPS) rule, compel the Secretary to use the best data available, and correct the Provider's uncompensated care figure as calculated in Factor 3 for FFY 2014 and pay the Provider an additional sum due as the result of the correction.[1]

Background

Section 3133 of the Patient Protection and Affordable Care Act (PPACA), as amended by section 10316 of PPACA and section 1104 of the Health Care and Education Reconciliation Act (P.L. 111-152) added new section 42 U.S.C. § 1395ww(r) to the statute that modifies the

[1] Provider's February 11, 2014 EJR Request at 1-2.

methodology for computing the Medicare DSH payment adjustment beginning in FFY 2014. This legislation is commonly known as section 3133 of ACA.[2]

Until FFY 2014, the Medicare DSH adjustment payments were calculated under a statutory formula that considers the hospital's Medicare utilization attributable to beneficiaries who receive Supplemental Security Income (SSI) benefits and the hospital's Medicaid utilization. Beginning for discharges in FY 2014, hospitals that qualify for Medicare DSH payments under 42 U.S.C. § 1395ww(d)(5)(F) will received 25 percent of the amount they previously would have received under the DSH formula. The remaining amount, equal to 75 percent of what otherwise would have been paid as Medicare DSH payments, reduced to reflect changes in the percentage of individuals under age 65 who are uninsured, will be available to make additional payments to each hospital that qualifies for Medicare DSH payments and that has uncompensated care. The payments to each hospital for a fiscal year will be based on the hospital's amount of uncompensated care for a given time period relative to the total amount of uncompensated care for that same time period reported by all hospitals that received Medicare DSH payments for that fiscal year.[3]

This will result in two payments to the hospital. Under 42 U.S.C. § 1395ww(r)(1), beginning in FFY 2014 a hospital that would receive a DSH payment under § 1395ww(d) will receive 25 percent of the amount the hospital would have received under § 1395ww(d)(5)(F) which the Secretary now calls "the empirically justified amount, as determined by the Medicare Payment Advisory Commission in its March 2007 Report to Congress." Section 1395ww(r)(2) provides that for fiscal year end 2014 and subsequent, the Secretary shall pay to each § 1395ww(d) hospital an additional amount equal to the product of three factors, collectively known as uncompensated care.

The first factor is the difference between the estimates of "the aggregate amount of payments that would be made to subsection (d) [DSH] hospitals under subsection (d)(5)(F) if this subsection did not apply" and "the aggregate amount of payment that are made to subsection (d) hospitals under paragraph [1395ww(r)] (1)." This factor amounts to the 75 percent of the payments that would otherwise have been paid as part of the DSH adjustment.[4]

For FYs 2014-2017, the second factor is 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured, determined by comparing the percent of such individuals who are uninsured in FY 2013, the last year before coverage expanded under ACA, minus 0.1 percentage point for FY 2014, and minus 0.2 percentage point for FYs 2015-2017. For FY 2018 and subsequent years, the second factor is 1 minus the percent change in the percent of individuals who are uninsured, as determined by comparing the percentage of individuals who are uninsured in 2013 and who are uninsured in the most recent period for which data is available minus 0.2 percentage points for FFY 2018 and 2019.[5]

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[2] 78 Fed. Reg. 50496, 50620 (August 19, 2013).
[3] *Id.* at 50621, *See also Id.* at 50627 (Factor 1 is the difference between the Secretary's estimate of (1) the amount of Medicare DSH payments that would otherwise be made in the absence of the new payment provision; and (2) the amount of empirically justified Medicare DSH payments that are made for FY 2014 and subsequent years, which takes into account the requirement to pay 25 percent of what would have otherwise been paid under [42 U.S.C. § 1395ww(d)(5)(F)].
[4] *Id.* at 50621.
[5] *Id.*

The third factor, and the subject of this EJR, is a percent that for each subsection [1395ww](d) hospital, "represents the quotient of . . . the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on appropriate data . . .)," including the use of alternative data "where the Secretary determines that alternative data is available which is a better proxy for the costs of subsection (d) hospitals for . . . treating the uninsured," and "the aggregate amount of . . . uncompensated care for all subsection (d) hospitals that receive a payment under this subsection."[6] The Secretary explains that this third factor represents a hospital's uncompensated care amount for a given time period relative to the uncompensated care amount for that same time period for all hospitals that received Medicare DSH payments in that year, expressed as a percent. For each hospital the product of these three factors represents its additional payment for uncompensated care for the applicable fiscal year.[7]

In addition, the statute, 42 U.S.C. § 1395ww(r)(3), precludes administrative and judicial review under 42 U.S.C. §§ 1395ff (beneficiary appeals) and1395oo (Board appeals) of:

> (A) Any estimate of the Secretary for purposes of determination factors described in paragraph (2).[8]
>
> (B) Any period selected by the Secretary for such purposes.

Factor 3 In-depth[9]

Factor 3 is defined in 42 U.S.C. § 1395(r)(2)(C) in the calculation of uncompensated care payment. It is a hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) (DSH) hospital with the potential to receive DSH payments relative to the estimated uncompensated care amount for all hospitals estimated to receive DSH payments in the fiscal year for which the uncompensated care payment is to be made. Factor 3 is applied to the product of Factor 1 and Factor 2 to determine the amount of the uncompensated care payment that each eligible hospital will receive for a FFY.[10]

In order to implement the statutory requirements, the Secretary determined:

> (1) the definition of uncompensated care, or in other words, the specific items that are to be included in the numerator

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[6] *Id.*
[7] *Id.*
[8] Paragraph (2) is a reference to the three factors: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FFY 2014 calculation; and (3) the hospital specific value that express the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. at 50627, 50631 and 50634, respectively.
[9] In the October 3, 2013 Federal Register (78 Fed. Reg. 61191), the Secretary determined that for hospitals with a FYE that spanned two FFYs, the DSH/uncompensated care payments would be prorated between the two FFYs based on a proportion of the applicable FFY that is included in the cost reporting period. In addition, data from the Indian Health Services hospitals would be added to the data issued to compute the "empirical justified amount" and the uncompensated care payment. The Secretary implemented this effective October 1, 2013 and waived the 30-day delay in the effective date under 5 U.S.C. § 553(b)(3)(B).
[10] 78 Fed Reg. at 50634.

> (that is the estimated uncompensated care amount for an individual hospital) and the denominator (that is the estimated uncompensated care amount for all hospitals estimated to receive DSH payments in the applicable FY);
>
> (2) the data source(s) for the uncompensated care amount; and
>
> (3) the timing and manner of computing the quotient for each hospital estimated to receive DSH payments.[11]

The Secretary considered using information from Worksheet S-10 in calculating Factor 3 for FFY 2014, but concluded that providers had not had enough experience with this worksheet to develop reliable calculations. Instead, for FFY 2014, she elected to use the definitions of Medicaid patients found in 42 C.F.R. § 412.106(b)(4) and inpatient days for Medicare-SSI patients found in 42 C.F.R. § 412.106(b)(2)(i). A hospital's individual low-income insured days based on this calculation would represent that hospital's numerator for Factor 3. The sum of the low-income insured days under this calculation for all the hospitals that the Secretary estimates would receive DSH payments (and thus uncompensated care payment) would represent the denominator of Factor 3. The Secretary believes that the data in the Medicare cost report (and the data that are used to update the SSI ratios in the cost report) are acceptable for use as a source for the alternative data because they include data for all Medicare hospitals. The Secretary considers the data from the Medicare cost reports have been historically publically available, subject to audit, and used for payment purposes, are appropriate as alternative data for the costs of subsection (d) (DSH) hospitals for treating the uninsured.[12]

Except for data on Worksheet S-10, which is not used in FFY 2014, the Medicare cost report does not currently include information that would allow calculation of the treatment costs for uninsured patients. Consequently, the Secretary will use information from S-3, Part I of CMS 2552-96 version of the Medicare cost report and Worksheet S-2, Part I of the CMS 2552-10 version of the Medicare cost report and data that are used to update the SSI ratios on Worksheet E, Part A as the source of alternative data to determine Factor 3 for FY 2014.[13]

The statute also allows the Secretary the discretion to determine the time periods from which she will derive the data to estimate the numerator and denominator of Factor 3. The time periods for which to estimate the numerator and denominator of Factor 3 need to be consistent with making interim and final payments. Specifically, Factor 3 values must be available for hospitals that will qualify for Medicare DSH payments, as well as those hospitals that are not estimated to qualify for DSH payments but ultimately do qualify for DSH payments. The estimates for the numerator and the denominator of Factor 3 were to be determined based on the most recently available full year of Medicare cost report data (including the most recent data used to update the SSI ratios). Therefore, for FFY 2014, data from the 2010/2011 cost reports for Medicaid days and the FY

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[11] *Id.*
[12] *Id. at* 50635-50637 (SSI ratios based on the FFY will be used in this calculation, not SSI ratios calculated on a provider's fiscal year).
[13] *Id.*at 50637.

2011 SSI ratios for the Medicare-SSI days (or if FY 2011 SSI ratios are unavailable, then 2010 SSI ratios) would be used to estimate Factor 3.[14]

The denominator for Factor 3 would reflect the estimated Medicare and Medicaid SSI days based on the data from the 2010/2011 Medicare cost report for all hospitals that are estimated to qualify for empirically justified Medicare DSH payments in 2014. The numerator of Factor 3 would be the estimated Medicaid and Medicare SSI patient days for the individual hospital based on its most recent 2010/2011 Medicare cost report data. This calculation will be done for any subsection (d) hospital that has the potential to receive a DSH payment. Hospitals have 60 days from the date of the display of the IPPS rules to notify CMS of a change in their subsection (d) (DSH) status. Hospitals that become eligible for a DSH payment when their cost reports are settled will receive an uncompensated care payment. Likewise, hospitals that receive DSH and uncompensated care payments for which they are ineligible would be subject to a recovery of an overpayment.[15]

Additional Medicaid Days

The Secretary stated that she would identify subsection (d) (DSH) hospitals eligible to receive interim compensation for uncompensated care based on the most recently available Medicaid fraction that is reported on the March 2013 update of the Provider Specific file.[16] In the comments to the proposed rule, hospitals questioned the accuracy of the data used in the calculation of the hospital's Factor 3 or indicated that the Medicaid days reported on Worksheet S-2 did not match Medicaid days reported on S-3. In addition, hospitals submitted supporting documentation of the additional Medicaid days and requested that their Medicaid days used in the calculation of Factor 3 be corrected in the final rule. The Secretary acknowledged that there are inconsistencies in reporting of days on Worksheet S-2 and Worksheet S-3 and that not all Medicaid days were reported on Worksheet S-2, if they were not eligible to received DSH payments based on that cost report. She stated that a transmittal had been released allowing these hospitals to report their Medicaid days on Worksheet S-2 and to ensure Medicaid days reported on Worksheet S-3 align with the Medicaid days reported on Worksheet S-2. The Secretary noted that those changes might not have been reflected on the March 2013 update of the Hospital Cost Report Information System (HCRIS).[17]

As a result, for hospitals that did not claim Medicare DSH payments on their CMS Form 2552-10 Medicare cost report for FY 2010 or 2011, Medicaid days would be calculated from Worksheet S-3 of the Medicare cost report from the most recently available cost report from 2011 or 2010. For DSH hospitals, Medicaid days from Worksheet S-2 of the Medicare cost report from the most recently available cost report from 2011 or 2010 would be used. The Secretary stated that she believed that this action would address most of the commentators concerns. She also reminded hospitals that they attested to the accuracy of the data that they submit on their cost reports.[18]

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[14] *Id.* at 50637-50638.
[15] *Id.* at 50640.
[16] *Id.* at 50641.
[17] *Id.* at 50642.
[18] *Id.*

The Provider's Request for EJR

The Provider explains that changes to the DSH payment are two-fold. First, the traditional DSH payment adjustment under IPPS was reduced effective October 1, 2013, to 25 percent of the amount that otherwise would be paid based on a hospital's number of low-income patient days. 42 U.S.C. § 1395ww(r)(1). Congress determined that this reduced payment is the "empirically justified" payment needed to compensate hospitals under IPPS for the higher-than-average operating cost per case attributable to the treatment of low-income patients who tend to be more costly to treat.

Second, Congress established a new, separate DSH payment for uncompensated costs of care furnished to uninsured patients. 42 U.S.C. § 1395ww(r). This payment was the product of three factors prescribed by the statute: (1) an estimate of the 75 percent of the national aggregate amount of DSH payments that would have been paid for in FFY 2014 under the traditional payment methodology; (2) an adjustment to the first factor to account for an estimated percentage change in the national uninsured rate in FFY 2014 as compared with the estimated rate for FFY 2013; and (3) each qualifying hospital's estimated percentage of the total uncompensated care costs incurred by all hospitals that are expected to qualify for the new DSH payment.

The Problem: Factor 3

Factor 3 is defined by the statute as a hospital's proportion of uncompensated care as compared to the aggregate amount of uncompensated care for all DSH hospitals.[19] The statute directs that the Secretary to determine this proportion based on "appropriate data" or "alternative" available data that are a "better proxy" for the costs of subsection (d) (DSH) hospitals for treating uninsured patients. In the Federal Register, the Secretary emphasized the importance of using the "most recently available data" to meet this requirement.[20]

Ultimately, to determine Factor 3, the Secretary stated that CMS used the sum of Medicaid eligible days reported in the hospital's most recent cost report for fiscal year ending 2010 or 2011; and the Medicare SSI days from the FFY 2011 Medicare Part A/SSI fraction calculation by CMS.[21] The Secretary stated that she collected the Medicaid eligible days data from "the March 2013 update of HCRIS"[22] However, the Provider asserts that CMS did not use the appropriate or best available data in establishing its rate. In addition, CMS ignored the Provider's request to correct the figures used to calculate its uncompensated care figure prior to the publication of the actual figure[23] although it made two corrections to the IPPS rule.[24]

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[19] 42 U.S.C. § 1395ww(f)(2)(C).
[20] *See e.g.* 78 Fed. Reg. 27486, 27589 (May 10, 2013) (discussing the agency's proposal to use the "most recently available historical data . . .from the most recently available cost report for the Medicaid days") and 78 Fed. Reg. at 50638 (August 19, 2013) ("estimate the numerator and the denominator of the Factor 3 hospitals based on the most recent available full year of Medicare cost report data").
[21] 42 C.F.R. § 412.106(g)(1)(iii)(C), 78 Fed. Reg. at 50638 (August 19, 2013).
[22] 78 Fed. Reg. at 50642.
[23] Provider's February 11, 2014 EJR Request, Ex. P-1 (September 11, 2013 letter to CMS seeking a correction to the data used to compute Factor 3. The hospital's contact with CMS began through a June 24, 2013 e-mail (as Attachment 1 to the September 11th letter)).
[24] *See* 78 Fed. Reg. 61191-97 and 61167-61202 (Oct. 3, 2013).

The Provider's Dispute of the Factor 3 Determination

The Provider is disputing the Secretary's assigned amount for FFY 2014 as inconsistent with the plain language and intent of the statute governing the new DSH methodology, arbitrary and capricious, not based upon substantial evidence, and is otherwise contrary to law. The Provider asserts that it unlawfully fails to reflect the best data available.[25]

The Provider explains that its as-filed cost report listed 81,459 Medicaid eligible days on Worksheet S-2, Part I, Line 24.[26] On April 3, 2013, using new data not available when the original cost report was filed, the Provider filed an amended cost report that reported 93,207 Medicaid eligible days on Worksheet S-2, Part I, Line 24. The MAC accepted the amended cost report and issued a tentative settlement based on that amended cost report on June 5, 2013.

The Provider notes that the final IPPS rule states that payment amounts listed in the Supplemental Data File will not change based on more accurate data:

> The final values for each of the three factors are determined for each fiscal year at the time of development of the annual final rule for the hospital inpatient prospective payment system, and these values are used for both interim and final payments.

78 Fed. Reg. 50966.

The Provider contends that this does not mean that the payment amounts listed in the Supplemental Data File are actually final. Final payment of those amounts is dependent upon a hospital qualifying for the traditional DSH payment for 2014, based on the hospitals actual patient-day data for 2014.[27]

The Provider is disputing the number of Medicare eligible days used by the agency to determine its FFY 2014 DSH payment for uncompensated care costs. In addition, the Provider is challenging the regulation, 412.106(g)(1)(iv) that fixes the timing of the final determination of the DSH uncompensated care payment amount as of the time that the IPPS rule is promulgated and not, as in the usual course, when the final determinations are made in the NPRs for the 2014 cost reporting period. The remedy the Provider is seeking is the prompt correction of Factor 3 to use the most recently available Medicare days for the Provider's 2011 FY that is reflected in the April 2013 amended cost report that was accepted by the MAC in June of 2013, well before CMS issued the final rule. The Provider asks that the 2011 Medicaid eligible days number used in Factor 3 be the 93,207.

Jurisdiction

The Provider notes that the statute, 42 U.S.C. § 1395ww(r)(3) and the regulation, 42 C.F.R § 412.106(g)(2)(2014) preclude administrative or judicial review of any estimate of the Secretary or period selected by the Secretary for purposes of determining the Factors in the calculation of the uncompensated care cost payment. The Provider asserts that the statute does not preclude a

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[25] Provider's February 11, 2014 EJR. Request at 7.
[26] FYE November 30, 2011 Cost Report-FYE identified from Ex. P-1, p.2 of the September 11, 2013 letter.
[27] Id. at 50966 and codified at 42 C.F.R. § 412.106(g).

review of the Secretary's determination of a hospital's DSH uncompensated care payment amount or review of the Secretary's appropriate data in making the determination or review of the regulation fixing the calculation of those payment amounts at the time when the Secretary promulgated the final IPPS rule for 2014. Although the Provider does not believe there is any preclusion to review of the challenge in this case, even if the statute was construed to bar the Provider's challenge such preclusion of the final rule would be invalid because it violates due process and the separation of powers.[28]

Decision of the Board

The Board concludes that it has jurisdiction over the issues under dispute that related to the calculation of the Provider's DSH payment under 42 U.S.C § 1395ww(r)(3) and the regulation, 412.106(g)(1)(iv) that established timing of the final determination of the DSH uncompensated care payment amount. The Provider is challenging the particular number of Medicaid eligible days as reported on its Worksheet S-2 for the purpose of calculating Factor 3 of the new payment adjustment methodology for Medicare DSH hospitals under ACA. The Provider is not challenging the estimate for determining the factors themselves, which by statute and regulation it is barred from challenging. Since the Provider is challenging the final rule itself, the Board has no authority to grant the relief sought; consequently, the Board grants the Provider's request for EJR.

The statute, 42 U.S.C. § 1395ww(r)(3) precludes administrative or judicial review of "any estimate of the Secretary for purposes of determining the factors described in paragraph (2)." Paragraph 1395ww(r)(2)(C) deals with Factor 3 which is the subject of this dispute. Factor 3 is equal to a percent for each DSH hospital that represents the quotient of "the amount of uncompensated care . . . (estimated . . . based on appropriate data) . . . for treating uninsured" and "the aggregate amount of . . . uncompensated care for all [DSH] hospitals that receive payment under this subsection."[29]

In this case the Provider is disputing the number of Medicaid eligible days used by the agency to determine its FFY 2014 DSH uncompensated care costs. The Provider is also challenging the regulation at section 412.106(g)(1)(iv) that fixes the timing of the final determination of the DSH uncompensated care payment amount as of the time when the final IPPS rule was promulgated and not, as in the usual course, when the final payment determinations are made in the NPRs for 2014.[30]

The Provider is not directly challenging the method of determining the amount of uncompensated care. Rather it is challenging the Medicaid eligible days from the 2011 cost report which was amended to include additional days that were not included in CMS' uncompensated care computation. The Factor 3 is based on the DSH reimbursement under 42 U.S.C. 1395ww(d)) which was calculated using the 2011 as-filed cost report.[31] The Provider believes that its total Medicaid days should be increased based on the June 13, 2013 tentative settlement of the amended cost report.

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[28] EJR request at 10-11
[29] 78 Fed. Reg. at 50621.
[30] EJR Request at 8.
[31] *See* 78 Fed. Reg. at 50638.

The methodology for calculating Factor 3 is found in 42 C.F.R. § 412.106(g)(1)(iii) (C) which states that for FY 2014

> CMS will base its estimates of the amount of hospital uncompensated care on the most recent available data on utilization for Medicare and Medicaid SSI patients as determined in accordance with paragraphs (b)(2)(i) and (b)(4) of this section

Section 412.106(b)(2)(i) states that the number of patient days are:

> (A) Are associated with discharges occurring during each month; and
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A (including Medicare Advantage (Part C)) and SSI, excluding those patients who received only State supplementation.

Section 412.106(b)(4) states that the second computation requires

> The fiscal Intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid, but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid Plan or under a waiver authorized under section 1115(a)(2) of the Act on that day, regardless of whether particular items or services were covered or paid under the State plan or authorized waiver.

The regulation, 42 C.F.R. § 412.106(g)(1)(iv), states that the final values for each of the three factors are determined for each fiscal year at the time of the development of the final rule for hospital inpatient PPS.

The statute regarding DSH/Charity Care limits review as follows:

> (3) Limitations on review
>
> There shall be no administrative or judicial review under section 1395ff of this title, section 1395*oo* of this title, or otherwise of the following:

> (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).
>
> (B) Any period selected by the Secretary for such purposes.

Paragraph (2)(C), dealing with Factor 3 which is under dispute here states:

> (C) Factor three
>
> A factor equal to the percent, for each subsection (d) hospital, that represents the quotient of--
>
> > (i) the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on appropriate data (including, in the case where the Secretary determines that alternative data is available which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured, the use of such alternative data)); and
> >
> > (ii) the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this subsection for such period (as so estimated, based on such data).

The Secretary did not provide a mechanism to deal with providers whose data was updated after the publication of the proposed rule (or requested before the proposed rule was published, as in this case). Since there is no remedy for the facts presented here EJR is appropriate.

42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permits expedited judicial review where the Board determines that it does not have the authority to decide a question of law, regulation or CMS ruling. In this case, the Provider is challenging the validity of the 42 U.S.C. § 1395ww(r) to permit it to correct the calculation of its (DSH) payment under the new payment methodology created under ACA and the regulation 42 C.F.R. § 412.106(g)(1)(iv), that fixes the timing of the final determination of the DSH uncompensated care payment amount as of the time of the IPPS rule is promulgated, not when the final determinations are made in the NPRs for the 2014 cost reporting period.

The Board has reviewed the submissions of the Provider pertaining to the request for hearing and expedited judicial review. The Intermediary did not oppose the request for EJR. The documentation shows that the estimated amount in controversy exceeds $10,000 and the appeal was timely filed.[32]

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[32] This appeal was received in the Board's offices on January 28, 2014 and appealed the August 19, 2013 Federal

The Board finds that:

1) it has jurisdiction over the matter for the subject year and the Provider is entitled to a hearing before the Board;

2) based upon the Provider's assertions regarding the uncompensated care calculation under 42 U.S.C. § 1395ww(r) and the regulation, 412.106(g)(1)(iv), that fixes the timing of the final determination of the DSH compensated care payment amount, there are no findings of fact for resolution by the Board;

3) it is bound by the regulation; and

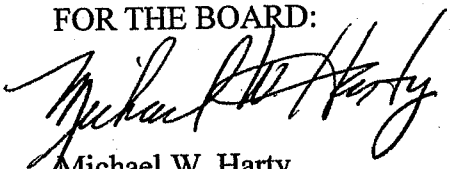
4) it is without the authority to decide the legal question of whether the statute, 42 U.S.C. § 1395ww(r), and the regulation, 412.106(g)(1)(iv), are valid.

Accordingly, the Board finds that the calculation of the DSH payment methodology issue with respect to Factor 3 properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provider's request for expedited judicial review for the issue and the subject year. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

Board Members Participating

Michael W. Harty
John Gary Blowers CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:



Michael W. Harty
Chairman

Enclosure: 42 U.S.C. § 1395oo(f)(1)

cc: Geoff Pike, First Coast Services Options
Kevin Shanklin, BCBSA

Register. In accordance with the Administrator's decision in *District of Columbia Hospital Association Wage Index Group Appeal*, (HCFA Adm. Dec. January 15, 1993) Medicare & Medicaid Guide (CCH) ¶ 41,025, notice published in the Federal Register is a final determination. The amount in controversy is estimated to be $2,909,037 (*See* Tab 3 of Providers January 27, 2014 hearing request).

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to: 14-2154G

Certified Mail

MAR 12 2014

Dennis M. Barry, Esq.
King & Spalding
1700 Pennsylvania Avenue, N.W.
Washington, D.C. 20006-4706

RE: King & Spalding FFY 2014 0.2% IPPS Reduction Group
Provider Nos. Various
FFY 2014
PRRB Case No. 14-2154G

Dear Mr. Barry:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' January 28, 2014 request for hearing (received January 29, 2014 appealing the August 19, 2013 Federal Register[1] and the February 10, 2014 request for expedited judicial review (EJR) (received February 11, 2014). The Board's determination with respect to the request for EJR is set forth below.

Issues

The issues under appeal are:

> Whether the Secretary's adjustment to the Medicare hospital inpatient prospective payment system (IPPS) standardized amount to account for the adoption of the "two midnight" rule is lawful; and
>
> If lawful, whether the adjustment (-0.2 percent) was in the correct amount or should it have been less of a reduction or an increase in the standardized amount?

The Providers assert that the Board lacks the authority to overturn the Secretary's decision to apply a downward 0.2 percent adjustment to IPPS rates for Federal fiscal year (FFY) 2014 as set forth in the August 19, 2014 Federal Register.[2]

Statutory and Regulatory Background

In the final IPPS rule for FFY 2014, the Secretary indicated that she had expressed concern in the

[1] *See District of Columbia Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993), *Medicare and Medicaid Guide (CCH)* ¶ 41,025 (the Administrator held that the publication of the wage index in the Federal Register was a final determination which can be appealed to the Board).
[2] 78 Fed. Reg. 50496, 50953-54 (August 19, 2013).

proposed calendar year (CY) Outpatient PPS rule[3] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving observation services. In recent years, the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours increased from approximately 3 percent in 2006 to 8 percent in 2011. This raised a concern about the financial impact on Medicare beneficiaries who may incur greater financial liability than they would if they were admitted to the hospital as inpatients.[4]

The Secretary noted that the trend towards the extended observation services may be attributable, in part, to hospitals' concerns about their ability to receive payment from Medicare under Part B when a Part A hospital inpatient claim is denied because a Medicare review contractor determines that the inpatient admission was not reasonable and necessary under 42 U.S.C. § 1395y(a)(1)(A). Centers for Medicare & Medicaid Services (CMS) has been advised by stakeholders that the hospitals appear to be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays that may later be denied upon contractor review by electing to treat beneficiaries as outpatients receiving observation services for long periods of time, rather than admitting them as inpatients. These hospitals believe that Medicare's standards for inpatient admission were not clear.[5]

In response to this concern, the Secretary proposed clarifications and changes regarding hospital payment under both Part A and Part B. The Secretary proposed to revise Part B inpatient payment policy to allow payment under Part B for all hospital services that furnished and were reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted as an inpatient. This policy would apply when a Medicare Part A hospital inpatient claim was denied or when a hospital determines after a discharge that the inpatient visit was not reasonable and necessary. The timely filing restrictions for Part B billing were not changed (claims must be filed within 1 year from the date of service).[6]

Medicare Part A

In addition, the Secretary reviewed hospital inpatient status criteria to improve CMS' policies governing when a Medicare beneficiary should be admitted as an inpatient and how hospitals should be paid for associated costs. The Medicare Benefit Policy Manual[7] states that the typical decision to admit a beneficiary as an inpatient should be made within 24 to 48 hours after observation care and that an overnight stay may be a factor in the admission decision. Physicians should use the 24-hour or overnight period as a benchmark, i.e., they should order admission for patients who are expected to need care for 24 hours or overnight. Generally, a beneficiary is considered an inpatient if formally admitted with the expectation that he or she will remain in the hospital overnight, whether or not there is a later transfer or discharge and the patient is not present overnight. Only rarely and in exceptional cases do reasonable and necessary observation services span more than 48 hours. Length of stay is not the basis for payment and it is the physician responsible for patient care who decides if the patient should be admitted.[8]

In the Federal fiscal year (FFY) 2014 IPPS proposed rule[9] the Secretary proposed a new benchmark for purposes of medical review of hospital inpatient admissions (Medicare Part A

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[3] 77 Fed. Reg. 45061, 45155-45157 (July 30, 2012) and the final rule with comments, 77 Fed. Reg. 68,210, 68426-68433 (November 15, 2012).
[4] *78 Fed. Reg.* at 50907.
[5] *Id.*
[6] *Id.*
[7] Chapter 6, §20.6 and Chapter 1, §10.
[8] 78 Fed. Reg. at 50907-08.
[9] *See generally* 78 Fed. Reg. 27486 (May 10, 2013).

payment). Under this proposal, beneficiaries who were expected to remain in the hospital to receive medically necessary care surpassing 2-midnights after the initiation of care would generally be appropriate for inpatient admission and inpatient payment (known as the "2-midnight rule"). Medicare contractors were to consider all the time after the initiation of care at the hospital in applying the benchmark that inpatient admissions are generally reasonable and necessary (as long as a hospital was not prolonging the provision of care to surpass the 2-midnight timeframe).[10]

Medicare Part B

In the final IPPS rule, the Secretary noted there had been an increasing number of cases in which hospitals had appealed Part A inpatient claim denials in which it was determined the inpatient admission was not reasonable or necessary. These claims had received partial favorable treatment by the Medicare Appeals Council or Administrative Law Judges (ALJs). In those cases, the Medicare review contractor determinations that the inpatient admission was not reasonable or necessary was upheld, but the Medicare Appeals Council and ALJ decisions ordered payment of the services as if they were rendered in an outpatient or observation level of care. These decisions effectively required Medicare to issue payment for all Part B services that would have been payable had the patient been treated as an outpatient (rather than an inpatient). In addition, these payments were made whether the subsequent hospital claim for payment was made within the applicable time limit for filing Part B claims. The Secretary pointed out that this was contrary to longstanding polices that permit billing only for a limited list of Part B inpatient services and require the services be billed within specific timeframes.[11]

As a result of the number of these administrative adjudications, the CMS Administrator issued CMS Ruling CMS-1455-P[12] (the Ruling) which established a standard process for effectuating the decisions granting Part B coverage. Among other things, where the administrative adjudicator had issued an order for payment under Medicare Part B, the request for Part B payment would not be rejected if more than one year had elapsed (the time period for filing Part B claims), if the Part A claim had been submitted timely. The Ruling was to remain in effect until the effective date of regulations that finalized "proposed rule CMS-1455-P." In the August 19, 2013 Federal Register, the Secretary revised the Part B inpatient payment policy to allow payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require outpatient status.[13] The one-year deadline for filing claims remains unchanged and the Secretary stated that she was not creating an exception to this requirement (as found in 42 C.F.R. § 424.44(b)(1)-(4)) even though the contractor claims review and appeal process could exceed the 1-year filing period.[14]

The 2-Midnight Rule

In the final IPPS rule, the Secretary pointed out that CMS had established policy that recognized that there were certain situations in which an inpatient hospital admission was rarely appropriate. This IPPS rule included instructions that provided a benchmark to ensure that all beneficiaries receive consistent application of their Part A benefits to whatever clinical services were medically necessary.[15]

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[10] 78 Fed. Reg. 50908.
[11] *Id.*
[12] *See* 78 Fed. Reg. 16614 (March 18, 2013) and on the internet at http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings.html.
[13] 78 Fed. Reg. at 50909.
[14] *Id.* at 50927.
[15] *Id.* at 50944.

Due to persistently large, improper payment rates for short-stay hospital inpatient claims, and, in response to requests to provide additional guidance regarding proper billing of those services, the Secretary proposed to modify and clarify 42 C.F.R. § 412.3(c)(1). This regulation designates services that are inpatient only (without regard to duration of care), surgical procedures, diagnostic tests and other treatments that would be appropriate for inpatient admission and inpatient payment under Medicare Part A when the physician expects the beneficiary to require a stay that crosses 2 midnights and admits the beneficiary based on that expectation. The starting point for this 2-midnight instruction would be when the beneficiary is moved from any outpatient area to a bed in the hospital in which additional services would be provided and is based on the judgment of the physician and the physician order (the physician must certify that the inpatient services were medically necessary).[16] The Secretary maintains that she has consistently provided physicians with a time-based admission framework to effectuate appropriate inpatient hospital admission decisions.[17]

The Secretary's actuaries estimated that the 2-midnight rule would increase IPPS expenditures by approximately $220 million. These additional expenditures would result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving from OPPS [outpatient PPS] to IPPS and some encounters of less than 2 midnights moving from IPPS to OPPS. The actuaries estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient from the approximately 11 million encounters paid under IPPS. This shift of 40,000 encounters represents an increase of approximately 1.2 percent in the number of shorter stay hospital inpatient encounters paid under IPPS. This additional expenditure would be partially offset by reduced expenditures from the shift of shorter stay hospital encounters to hospital outpatient encounters. The actuaries estimated that, on average, the per encounter payments for these hospital outpatient encounters would be approximately 30 percent of the per encounter payments for the inpatient encounters. In light of the impact of the 2-midnight rule on IPPS and the systematic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, the Secretary decided it was appropriate to use her exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i) to offset the $220 million in additional IPPS expenditures associated with the 2-midnight policy. Consequently, the standardized amount was reduced by 0.2 percent.[18] The Secretary made the same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[19]

Providers' Request for EJR

The Providers contend that the Secretary's decision to apply a downward 0.2 percent adjustment to the operating IPPS standardized amount and the capital standard Federal payment rate for FFY 2014 is unlawful and should be reversed because:

- The adjustment exceeds the Secretary's statutory authority to adjust IPPS standardized amounts;
- The amount of the adjustment is unsupported by data and is arbitrary and capricious; and

[16] *Id.*
[17] *Id.* at 50945.
[18] *Id.* at 50952-53.
[19] *Id.* at 50990.

- The Secretary violated the Administrative Procedure Act notice and comment ruling making requirements because of insufficient discussion of the data and assumptions purporting to support the amount of the adjustments and failing to address or take into account public comments to the proposed rule.

The Providers assert that following a period of notice and comment the Secretary failed to respond adequately to comments opposing the proposed reduction and adopted the 0.2 percent reduction to IPPS to offset the perceived impact of the 2-midnight rule. The Providers do not believe the Secretary's calculations are supported by the data she cites, and she ignored comments identify errors in the agency's reasoning. The commenters used publicly available Medicare files to determine whether they could duplicate the Secretary's conclusions on the number of encounters that would move from inpatient status to outpatient status (and vice versa). The commenters informed CMS that the calculations were not replicable and argued that the adoption of the 0.2 percent payment calculation was improper and not supported by data.[20]

The Providers point out that, although the Secretary asserted that only 360,000 patient days would shift from inpatient to outpatient days, the Providers contend that this is incorrect. In calendar year 2011, the year used by the Secretary to analyze to support the need for the 0.2 percent reduction, she estimated that there were 1,569,693 inpatient stays of one day. The commenters noted that under the 2-midnight rule, nearly all of those inpatient stays would shift to outpatient encounters. The commenters estimate included excluding days for patients who died, transferred to another hospital or SNF or left the hospital against medical advice. But the Secretary asserted that only 360,000 stays would shift to outpatient status without explanation. The Providers assert that a similar lack of reasoned analysis by the Secretary applies to extended observation bed encounters and the shift from outpatient to inpatient stays.

Violation of the APA

The Providers argue that the Secretary's adoption of the 0.2 percent adjustment to IPPS violates the APA, and is arbitrary and capricious in several respects. First, the adopted proposal runs counter to the data upon which it relied and the Secretary offers no explanation for the difference—the Secretary did not explain how 1.5 million one-day stays in 2011 could be reduced to 360,000 or how 400,000 outpatient encounters would move to inpatient status.

Second, the Secretary failed to respond to the commenters' analysis of the data in the final rule. An agency has a duty to respond to significant comments that directly challenge the basis and purpose of an agency rule.

Third, the Secretary failed to articulate a rational connection between the facts found and the choice made. The Supreme Court has stated that an agency must "examine the relevant data and articulate a satisfactory explanation for its action including a 'rational connection between the facts found and the choice made.'" *Motor Vehicle Mgrs. Ass'n*, 463 U.S. at 43 (internal citations omitted).

Further, the Secretary's actions violate the APA because the calculations are incorrect and she has refused to acknowledge the error through the rulemaking process. The Secretary did not adequately explain the methodology, including assumptions used to derive the proposed adjustments or the

[20] *See* Provider's EJR Request, Ex. P-1, Letters dated June 25 and May 17, 2013 to CMS furnishing comments on proposed regulations.

decision to finalize the adjustments. The Providers believe that the Secretary either failed to make a full disclosure of the data that led to her conclusion or bungled the math.

Finally, the Providers argue, even if the Secretary's actions were not arbitrary and capricious, she lacks the authority under 42 U.S.C. § 1395ww(d)(5)(I)(i), or any other provision of the law, to make a downward adjustment in the rates set under §1395ww(d) announced in the proposed and final IPPS rules. The 2-Midnight Rule affects the number of cases that would be paid under IPPS rates—that is, it affects the number of cases that are covered under Part A. Applying what the Providers characterize as "budget neutrality adjustments" to volume changes caused by policy decisions violates the fundamental structure and policy that has governed IPPS since its inception in 1983. Specifically, IPPS adjusts automatically to both the service mix and volume of hospital admissions, which vary from year to year, based on many factors. The Providers believe that Congress did not intend to permit the Secretary to use § 1395ww(d) to make changes to account for changes in volume.[21]

Jurisdiction and 42 C.F.R. § 405.1804

The Providers mention that the Board can take jurisdiction over this issue as a budget neutrality matter under § 405.1804[22] based on the December 10, 2013 Federal Register Notice[23] which made a "Technical Conforming Change" to certain matters under IPPS which are not subject to administrative or judicial review.

Decision of the Board

The Board has reviewed the submissions of the Providers pertaining to the requests for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy for the appeal exceeds $50,000, as required for a group appeal. The estimated amount in controversy is subject to recalculation by the Medicare Administrative Contractor for the actual final amount. With respect to the Providers' assertion regarding jurisdiction under 42 C.F.R. § 405.1804, the Board finds that this assertion is not relevant to the issue before the Board. As explained in the preamble to the final rule, the Secretary exercised her authority under 42 U.S.C. § 1395ww(d)(5)(I)(i) to make the 0.2 percent reduction.[24] Pursuant to the statute, this authority can only be exercised "by regulation." As a result, it is clear that the Secretary's actions with respect to this issue were intended to be a binding regulation. The Board's own regulation, 42 C.F.R. § 405.1867, precludes the Board review of the challenge to the validity of a regulation.

The Board finds that:

1) it has jurisdiction over the matter for the subject year and the Providers are entitled to a hearing before the Board;

2) based upon the Providers' assertions regarding the 0.2 percent reduction to the standardized amount and the capital standard Federal payment rate, there are no findings of fact for resolution by the Board;

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[21] Provider's February 10, 2014 EJR Request at 10.
[22] *Id.* at 3.
[23] 78 Fed. Reg. 74,826, 75162 (December 10, 2014).
[24] 78 Fed. Reg. at 50953.

3) it is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

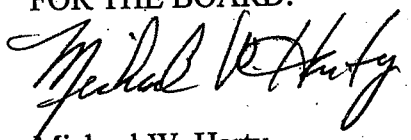
4) it is without the authority to decide the legal question of whether the Secretary's 0.2 percent reduction to the standardized amount and capital Federal payment rate, is valid.

Accordingly, the Board finds that the 0.2 percent reduction issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for expedited judicial review for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

Board Members Participating

Michael W. Harty
John Gary Blowers, 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. § 405.1877 and 405.1877
Schedule of Providers

cc: Cecile Huggins, Cahaba GBS (w/Schedule of Providers)
Kevin Shanklin, BCBSA (w/Schedule of Providers)

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Refer to: 04-2012G

MAR 18 2014

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Noridian Healthcare Solutions, LLC
Donna Kalafut
Senior Consultant
P.O. Box 6782
Fargo, ND 58108

RE: Jurisdictional Determination
San Mateo Medical Center as part of Toyon 1995 DSH SSI Ratio Group
Provider No.: 05-0113
FYE: 6/30/1995
PRRB Case No.: 04-2012G

Dear Mr. Knight and Ms. Kalafut,

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

San Mateo Medical Center was issued a revised Notice of Program Reimbursement (NPR) for FYE 6/30/1995 on January 10, 2007. On March 23, 2007, the Provider filed an appeal request with the Board appealing the following issue: accuracy of the SSI% provided by CMS and used by the Intermediary for calculating the Disproportionate Share Hospital (DSH) amounts. On May 10, 2007, the Provider requested to transfer the issue from its individual appeal to the group appeal in case number 06-2204G. Finally, on April 22, 2010, the Provider requested to transfer the SSI% issue from case number 06-2204G to the group appeal in case number 04-2012G as San Mateo Medical Center was the sole remaining participant in the prior group appeal.

Board's Decision

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 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 the notice of the Intermediary's determination was received by the provider.

Although the Intermediary did not file a jurisdictional challenge, the Board nonetheless finds that it does not have jurisdiction over this Provider's appeal because the Provider appealed from a revised

NPR in which the only issue on appeal, the SSI%, was not adjusted. The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2006) 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 of 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, as the case may be, either on motion of such intermediary officer or panel of hearing officers, Board, or Secretary, or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings.

In accordance with 42 C.F.R. § 405.1889 (2006), a revised NPR is considered a separate and distinct determination from which the provider may appeal. The regulation provides:

> 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, 405.1835, 405.1875 and 405.1877 are applicable.

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.

Here, the Provider's audit adjustment report associated with the January 10, 2007 revised NPR shows that the DSH capital payments were adjusted and that DSH was adjusted generally. However, the Provider did not submit any documentation to establish that that the SSI% was specifically adjusted, either within the capital DSH payment or the operating DSH payment. Per the Notice of Reopening dated March 5, 2004 and the revised NPR dated January 10, 2007, the cost report was reopened "[t]o include unpaid Medicaid eligible inpatient days in the calculation of DSH payments on provisions of HCFA Ruling 97-2." Because the SSI% was not specifically adjusted in the revised NPR, the Board finds that it does not have jurisdiction over San Mateo Medical Center. This Provider is hereby dismissed from case number 04-2012G.

Review of this determination may be 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, BCBSA

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Refer to: 06-1626GC

MAR 18 2014

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RE: Jurisdictional Challenge – St. Rose Dominican Hospital – De Lima as part of CHW 2002 DSH SSI Ratio CIRP Group
Provider No.: 29-0012
FYE: 6/30/2002
PRRB Case No.: 06-1626GC

Dear Mr. Knight and Ms. Kalafut,

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

St. Rose Dominican Hospital – De Lima was issued a revised Notice of Program Reimbursement (NPR) for FYE 6/30/2002 on January 19, 2007. On July 19, 2007, the Provider filed an appeal request with the Board. Subsequently, on August 14, 2007, the Provider requested to add the following issue to the appeal: accuracy of the SSI% provided by CMS and used by the Intermediary for calculating the Disproportionate Share Hospital (DSH) amounts. On that same date, the Provider requested to transfer the SSI% issue to the CIRP group appeal in case number 06-1626GC.

Board's Decision

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 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 the notice of the Intermediary's determination was mailed to the provider.

Although the Intermediary did not file a jurisdictional challenge, the Board nonetheless finds that it does not have jurisdiction over this Provider's appeal because the Provider appealed from a revised NPR in which the only issue on appeal, the SSI%, was not adjusted. The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2002) provides in relevant part:

NPR in which the only issue on appeal, the SSI%, was not adjusted. The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2002) 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 of 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, as the case may be, either on motion of such intermediary officer or panel of hearing officers, Board, or Secretary, or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings.

In accordance with the language of 42 C.F.R. § 405.1889 effective at the time the Provider's revised NPR was issued, a revised NPR is considered a separate and distinct determination from which the provider may appeal. The regulation provides:

> 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, 405.1835, 405.1875 and 405.1877 are applicable.

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.

Here, the Provider's audit adjustment report associated with the January 19, 2007 revised NPR shows that Medicaid Days on the W/S S-3 and the associated DSH payment on W/S E Part A Line 4.03 were revised, but there is no evidence that the SSI% which is reported on E Part A Line 4 was specifically adjusted. Because the SSI% was not specifically adjusted in the revised NPR, the Board finds that it does not have jurisdiction over St. Rose Dominican Hospital – De Lima. This Provider is hereby dismissed from the group in case number 06-1626GC; the case will remain open because the appeal is still pending for other Providers in the group.

Review of this determination may be 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, BCBSA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to: 14-1753GC
Certified Mail

MAR 20 2014

Sherree R. Kanter, Esq.
Hogan Lovells US, LLP
555 Thirteenth Street, N.W.
Washington D.C. 20004

RE: Wake Forest University Baptist Medical Center FYE 2014
0.2% Reduction Group
Provider Nos. Various
FFY 2014
PRRB Case No. 14-1753GC

Dear Ms. Kanter:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' January 22, 2014 request for hearing appealing the August 19, 2013 Federal Register[1] and January 22, 2014 request for expedited judicial review (EJR) (both documents were received on January 23, 2014), as well as the Providers' February 25, 2014 response (received same day) to the Board's February 20, 2014 request for additional information. The Board's determination with respect to the request for EJR is set forth below.

Issue

The Providers are challenging the validity of the Secretary's 0.2 percent reduction to the standardized amounts[2] and the hospital specific rates used to calculate the rates paid under the inpatient prospective payment system (IPPS). The Providers contend that the 0.2 percent payment cut is unlawful and must be set aside.

Statutory and Regulatory Background

In the final IPPS rule for FFY 2014, the Secretary indicated that she had expressed concern in the proposed calendar year (CY) Outpatient PPS rule[3] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving observation services. In recent

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[1] *See District of Columbia Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993), *Medicare and Medicaid Guide (CCH)* ¶ 41,025 (the Administrator held that the publication of the wage index in the Federal Register was a final determination which can be appealed to the Board).

[2] The standardized amount is the sum of: (1) a labor component which represents labor cost variations among different areas of the country and (2) a non-labor component which represents a geographic calculation based on whether the hospital is located in a large urban or other area. The labor component is then adjusted by the wage index. *See* "Medicare Hospital Prospective Payment System: How DRG Rates are Calculated and Updated" (CMS Office of the Inspector General Report OEI-09-00-00200, August 2001) on the internet at http://oig.hhs.gov/oei/reports/oei-09-00-00200.pdf.

[3] 77 Fed. Reg. 45061, 45155-45157 (July 30, 2012) and the final rule with comments, 77 Fed. Reg. 68,210, 68426-68433 (November 15, 2012).

years, the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours increased from approximately 3 percent in 2006 to 8 percent in 2011. This raised a concern about the financial impact on Medicare beneficiaries who may incur greater financial liability than they would if they were admitted to the hospital as inpatients.[4]

The Secretary noted that the trend towards the extended observation services may be attributable, in part, to hospitals' concerns about their ability to receive payment from Medicare under Part B when a Part A hospital inpatient claim is denied because a Medicare review contractor determines that the inpatient admission was not reasonable and necessary under 42 U.S.C. § 1395y(a)(1)(A). Centers for Medicare & Medicaid Services (CMS) has been advised by stakeholders that the hospitals appear to be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays that may later be denied upon contractor review by electing to treat beneficiaries as outpatients receiving observation services for long periods of time, rather than admitting them as inpatients. These hospitals believe that Medicare's standards for inpatient admission were not clear.[5]

In response to this concern, the Secretary proposed clarifications and changes regarding hospital payment under both Part A and Part B. The Secretary proposed to revise Part B inpatient payment policy to allow payment under Part B for all hospital services that furnished and were reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted as an inpatient. This policy would apply when a Medicare Part A hospital inpatient claim was denied or when a hospital determines after a discharge that the inpatient visit was not reasonable and necessary. The timely filing restrictions for Part B billing were not changed (claims must be filed within 1 year from the date of service).[6]

Medicare Part A

In addition, the Secretary reviewed hospital inpatient status criteria to improve CMS' policies governing when a Medicare beneficiary should be admitted as an inpatient and how hospitals should be paid for associated costs. The Medicare Benefit Policy Manual[7] states that the typical decision to admit a beneficiary as an inpatient should be made within 24 to 48 hours after observation care and that an overnight stay may be a factor in the admission decision. Physicians should use the 24-hour or overnight period as a benchmark, i.e., they should order admission for patients who are expected to need care for 24 hours or overnight. Generally, a beneficiary is considered an inpatient if formally admitted with the expectation that he or she will remain in the hospital overnight, whether or not there is a later transfer or discharge and the patient is not present overnight. Only rarely and in exceptional cases do reasonable and necessary observation services span more than 48 hours. Length of stay is not the basis for payment and it is the physician responsible for patient care who decides if the patient should be admitted.[8]

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[4] 78 Fed. Reg. at 50907.
[5] *Id.*
[6] *Id.*
[7] Chapter 6, §20.6 and Chapter 1, §10.
[8] 78 Fed. Reg. at 50907-08.

In the Federal fiscal year (FFY) 2014 IPPS proposed rule[9] the Secretary proposed a new benchmark for purposes of medical review of hospital inpatient admissions (Medicare Part A payment). Under this proposal, beneficiaries who were expected to remain in the hospital to receive medically necessary care surpassing 2-midnights after the initiation of care would generally be appropriate for inpatient admission and inpatient payment (known as the "2-midnight rule"). Medicare contractors were to consider all the time after the initiation of care at the hospital in applying the benchmark that inpatient admissions are generally reasonable and necessary (as long as a hospital was not prolonging the provision of care to surpass the 2-midnight timeframe).[10]

Medicare Part B

In the final IPPS rule, the Secretary noted there had been an increasing number of cases in which hospitals had appealed Part A inpatient claim denials in which it was determined the inpatient admission was not reasonable or necessary. These claims had received partial favorable treatment by the Medicare Appeals Council or Administrative Law Judges (ALJs). In those cases, the Medicare review contractor determinations that the inpatient admission was not reasonable or necessary was upheld, but the Medicare Appeals Council and ALJ decisions ordered payment of the services as if they were rendered in an outpatient or observation level of care. These decisions effectively required Medicare to issue payment for all Part B services that would have been payable had the patient been treated as an outpatient (rather than an inpatient). In addition, these payments were made whether the subsequent hospital claim for payment was made within the applicable time limit for filing Part B claims. The Secretary pointed out that this was contrary to longstanding polices that permit billing only for a limited list of Part B inpatient services and require the services be billed within specific timeframes.[11]

As a result of the number of these administrative adjudications, the CMS Administrator issued CMS Ruling CMS-1455-P[12] (the Ruling) which established a standard process for effectuating the decisions granting Part B coverage. Among other things, where the administrative adjudicator had issued an order for payment under Medicare Part B, the request for Part B payment would not be rejected if more than one year had elapsed (the time period for filing Part B claims), if the Part A claim had been submitted timely. The Ruling was to remain in effect until the effective date of regulations that finalized "proposed rule CMS-1455-P." In the August 19, 2013 Federal Register, the Secretary revised the Part B inpatient payment policy to allow payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require outpatient status.[13] The one-year deadline for filing claims remains unchanged and the Secretary stated that she was not

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[9] *See generally* 78 Fed. Reg. 27486 (May 10, 2013).
[10] 78 Fed. Reg. 50908.
[11] *Id.*
[12] *See* 78 Fed. Reg. 16614 (March 18, 2013) and on the internet at http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings.html.
[13] 78 Fed. Reg. at 50909.

creating an exception to this requirement (as found in 42 C.F.R. § 424.44(b)(1)-(4)) even though the contractor claims review and appeal process could exceed the 1-year filing period.[14]

The 2-Midnight Rule

In the final IPPS rule, the Secretary pointed out that CMS had established policy that recognized that there were certain situations in which an inpatient hospital admission was rarely appropriate. This IPPS rule included instructions that provided a benchmark to ensure that all beneficiaries receive consistent application of their Part A benefits to whatever clinical services were medically necessary.[15]

Due to persistently large, improper payment rates for short-stay hospital inpatient claims, and, in response to requests to provide additional guidance regarding proper billing of those services, the Secretary proposed to modify and clarify 42 C.F.R. § 412.3(c)(1). This regulation designates services that are inpatient only (without regard to duration of care), surgical procedures, diagnostic tests and other treatments that would be appropriate for inpatient admission and inpatient payment under Medicare Part A when the physician expects the beneficiary to require a stay that crosses 2 midnights and admits the beneficiary based on that expectation. The starting point for this 2-midnight instruction would be when the beneficiary is moved from any outpatient area to a bed in the hospital in which additional services would be provided and is based on the judgment of the physician and the physician order (the physician must certify that the inpatient services were medically necessary).[16] The Secretary maintains that she has consistently provided physicians with a time-based admission framework to effectuate appropriate inpatient hospital admission decisions.[17]

The Secretary's actuaries estimated that the 2-midnight rule would increase IPPS expenditures by approximately $220 million. These additional expenditures would result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving from OPPS [outpatient PPS] to IPPS and some encounters of less than 2 midnights moving from IPPS to OPPS. The actuaries estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient from the approximately 11 million encounters paid under IPPS. This shift of 40,000 encounters represents an increase of approximately 1.2 percent in the number of shorter stay hospital inpatient encounters paid under IPPS. This additional expenditure would be partially offset by reduced expenditures from the shift of shorter stay hospital encounters to hospital outpatient encounters. The actuaries estimated that, on average, the per encounter payments for these hospital outpatient encounters would be approximately 30 percent of the per encounter payments for the inpatient encounters. In light of the impact of the 2-midnight rule on IPPS and the systematic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, the Secretary decided it was appropriate to use her exceptions and adjustments authority under 42 U.S.C.

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[14] *Id.* at 50927.
[15] *Id.* at 50944.
[16] *Id.*
[17] *Id.* at 50945.

§ 1395ww(d)(5)(I)(i) to offset the $220 million in additional IPPS expenditures associated with the 2-midnight policy. Consequently, the standardized amount was reduced by 0.2 percent.[18] The Secretary made the same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[19]

Providers' Request for EJR

The Providers contend that the 0.2 percent payment cut is unlawful and must be set aside for the following reasons: (1) the reduction is arbitrary and capricious because the Secretary[20] relied on indefensible assumptions and offered no reasoned explanation for those assumptions; (2) the reduction is invalid because the Secretary failed to comply with notice and comment procedures required by the Administrative Procedure Act (APA); and (3) the reduction is invalid because the Secretary failed to codify it in the Code of Federal Regulations, as required by the statute and the APA. The Providers believe that the 0.2 percent reduction must be set aside and the Providers reimbursed for the reduced payments they received for hospital discharges on or after October 1, 2013.

The Providers explain that when the final IPPS rule was adopted in the August 19, 2013 Federal Register the Secretary explained that as a result of changes in hospital admission policies, detailed above, her actuaries estimated that expenditures under IPPS would increase by approximately $220 million due to an expected net increase in in hospital inpatient encounters.[21] The actuaries examined FY 2009 through FY 2011 Medicare claims data and estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient, a net shift of 40,000 encounters.[22]

The Providers believe that EJR is appropriate for this appeal because although the Board has jurisdiction over the appeal, it does not have the authority to grant the relief sought: reversal of the 0.2 percent reduction. 42 C.F.R. § 405.1842. The Providers assert that the Secretary's actions are arbitrary, capricious, an abuse of discretion or otherwise not in accordance with the law and must be set aside under the Administrative Procedures Act.[23] Here, the Providers believe that the Secretary has relied on assumptions that appear arbitrary or flawed on their face and the Secretary has failed to justify them. Further, they contend, agency rules that leave important assumptions unexplained or fails to explain result that appear arbitrary on their face, are in fact reasonable must be vacated.[24] The Providers maintain that the 0.2 percent reduction cannot stand because it relies on several assumptions that appear indefensible on their face, and

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[18] *Id.* at 50952-53.
[19] *Id.* at 50990.
[20] of the Department of Health & Human Services.
[21] 78 Fed. Reg. at 50952.
[22] *Id.*
[23] 5 U.S.C. § 706(2)(A), (C).
[24] Citing *West Virginia v. EPA,* 362 F.3d 862, 866 (D.C. Cir. 2004).

the Secretary failed to explain those assumptions at all, let alone "provide a complete analytic defense."[25]

The Providers note that the Secretary's actuaries estimated how many encounters would shift from outpatient to inpatient, examining only surgical MS-DRGs, but ignored medical DRGs—this action ignored an entire category of cases. They do not believe that it is reasonable to assume that two kinds of cases will behave in the same way. Rather, surgical cases are often easier for doctors to predict how long a patient will be hospitalized and easier to meet the 2-might criteria for inpatient payment. This is in contrast to medical cases where the patient is hospitalized with symptoms that have not been diagnosed making a definitive prediction of the length of hospitalization more difficult.

In addition, the Providers point out that the Secretary did not impose similar surgical-cases-only limitation when it counted how many encounters would shift in the other direction, from outpatient to inpatient. The Secretary examined only "outpatient claims for observation or a major procedure."[26] This approach did not track on the approach used in counting inpatient-out-outpatient shifts because it includes observation cases which were excluded from the inpatient-to-outpatient count. The Providers believe this creates a critical disconnect because the Secretary's 0.2 percent reductions turns entirely on its conclusion that more encounters would shift from outpatient to inpatient and vice versa.[27]

Further, the Providers believe that the Secretary undercounted the cases shifting from inpatient to outpatient. They note that the Secretary concluded that 360,000 cases would shift in that direction under the new 2-midnight policy.[28] However, there are about one million zero or one-midnight stay inpatient cases each year[29] and the Secretary elsewhere stated her expectation that a "majority of short (total of zero or one midnight) Medicare hospital stays will be provided as outpatient services."[30] Based on the Secretary's statement, the Providers contend that this would mean at least 500,000 short-stay cases, perhaps more, shift to outpatient status. If that is the case, the Secretary should have increased IPPS rates, not decreased them.

Decision of the Board

The Board has reviewed the submissions of the Providers pertaining to the requests for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy for the appeal exceeds $50,000, as required for a group appeal. The estimated

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[25] Citing *Appalachian Power v. EPA*, 251 F.3d 1026, 1035 (D.C. Cir. 2001).
[26] 78 Fed. Reg. at 50953.
[27] *Id.*
[28] *Id.*
[29] *See* CMS, FY 2014 Final Rule Data Files, AOR?BOR File, http://www.cms.gov/Medicare/Medicaid-Fee-for-Service-Payment/AcuteInpatientPPS/FY2014-IPPS-Final-Rule-Home-Page.html (click on "FY 2014 Data Files and download the "AOR/BOR File").
[30] CMS, FREQUENTLY ASKED QUESTIONS 2 Midnight Admission Guidance & Patient Status Reviews for Admissions on or after October 1,2 013, Question 13, available at http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/Downloads/QAs forWebsitePosting-110413-v2-Clean.pdf.

amount in controversy is subject to recalculation by the Medicare Administrative Contractor for the actual final amount.

The Board finds that:

1) it has jurisdiction over the matter for the subject year and the Providers are entitled to a hearing before the Board;

2) based upon the Providers' assertions regarding the 0.2 percent reduction to the standardized amount and the hospital specific rate, there are no findings of fact for resolution by the Board;

3) it is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

4) it is without the authority to decide the legal question of whether the Secretary's 0.2 percent reduction to the standardized amount and the hospital specific rate, is valid.

Accordingly, the Board finds that the 0.2 percent reduction issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for expedited judicial review for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

Board Members Participating

Michael W. Harty
John Gary Blowers, 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. § 405.1877 and 405.1877
Schedule of Providers

cc: Cecile Huggins, Palmetto GBA (w/Schedule of Providers)
Kevin Shanklin, BCBSA (w/Schedule of Providers)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to: 14-1754

Certified Mail

MAR 20 2014

Sherree R. Kanter, Esq.
Hogan Lovells US, LLP
555 Thirteenth Street, N.W.
Washington D.C. 20004

RE: The Mount Sinai Hospital
Provider Nos. 33-0024
FFY 2014
PRRB Case No. 14-1754

Dear Ms. Kanter:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's January 22, 2014 request for hearing appealing the August 19, 2013 Federal Register[1] and January 22, 2014 request for expedited judicial review (EJR) (both documents were received on January 23, 2014), as well as the Provider's February 25, 2014 response (received same day) to the Board's February 20, 2014 request for additional information. The Board's determination with respect to the request for EJR is set forth below.

Issue

The Provider is challenging the validity of the Secretary's 0.2 percent reduction to the standardized amounts[2] and the hospital specific rates used to calculate the rates paid under the inpatient prospective payment system (IPPS). The Provider contends that the 0.2 percent payment cut is unlawful and must be set aside.

Statutory and Regulatory Background

In the final IPPS rule for FFY 2014, the Secretary indicated that she had expressed concern in the proposed calendar year (CY) Outpatient PPS rule[3] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving observation services. In recent

[1] *See District of Columbia Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993), *Medicare and Medicaid Guide (CCH)* ¶ 41,025 (the Administrator held that the publication of the wage index in the Federal Register was a final determination which can be appealed to the Board).

[2] The standardized amount is the sum of: (1) a labor component which represents labor cost variations among different areas of the country and (2) a non-labor component which represents a geographic calculation based on whether the hospital is located in a large urban or other area. The labor component is then adjusted by the wage index. *See* "Medicare Hospital Prospective Payment System: How DRG Rates are Calculated and Updated" (CMS Office of the Inspector General Report OEI-09-00-00200, August 2001) on the internet at http://oig.hhs.gov/oei/reports/oei-09-00-00200.pdf.

[3] 77 Fed. Reg. 45061, 45155-45157 (July 30, 2012) and the final rule with comments, 77 Fed. Reg. 68,210, 68426-68433 (November 15, 2012).

years, the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours increased from approximately 3 percent in 2006 to 8 percent in 2011. This raised a concern about the financial impact on Medicare beneficiaries who may incur greater financial liability than they would if they were admitted to the hospital as inpatients.[4]

The Secretary noted that the trend towards the extended observation services may be attributable, in part, to hospitals' concerns about their ability to receive payment from Medicare under Part B when a Part A hospital inpatient claim is denied because a Medicare review contractor determines that the inpatient admission was not reasonable and necessary under 42 U.S.C. § 1395y(a)(1)(A). Centers for Medicare & Medicaid Services (CMS) has been advised by stakeholders that the hospitals appear to be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays that may later be denied upon contractor review by electing to treat beneficiaries as outpatients receiving observation services for long periods of time, rather than admitting them as inpatients. These hospitals believe that Medicare's standards for inpatient admission were not clear.[5]

In response to this concern, the Secretary proposed clarifications and changes regarding hospital payment under both Part A and Part B. The Secretary proposed to revise Part B inpatient payment policy to allow payment under Part B for all hospital services that furnished and were reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted as an inpatient. This policy would apply when a Medicare Part A hospital inpatient claim was denied or when a hospital determines after a discharge that the inpatient visit was not reasonable and necessary. The timely filing restrictions for Part B billing were not changed (claims must be filed within 1 year from the date of service).[6]

Medicare Part A

In addition, the Secretary reviewed hospital inpatient status criteria to improve CMS' policies governing when a Medicare beneficiary should be admitted as an inpatient and how hospitals should be paid for associated costs. The Medicare Benefit Policy Manual[7] states that the typical decision to admit a beneficiary as an inpatient should be made within 24 to 48 hours after observation care and that an overnight stay may be a factor in the admission decision. Physicians should use the 24-hour or overnight period as a benchmark, i.e., they should order admission for patients who are expected to need care for 24 hours or overnight. Generally, a beneficiary is considered an inpatient if formally admitted with the expectation that he or she will remain in the hospital overnight, whether or not there is a later transfer or discharge and the patient is not present overnight. Only rarely and in exceptional cases do reasonable and necessary observation services span more than 48 hours. Length of stay is not the basis for payment and it is the physician responsible for patient care who decides if the patient should be admitted.[8]

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[4] 78 Fed. Reg. at 50907.
[5] *Id.*
[6] *Id.*
[7] Chapter 6, §20.6 and Chapter 1, §10.
[8] 78 Fed. Reg. at 50907-08.

In the Federal fiscal year (FFY) 2014 IPPS proposed rule[9] the Secretary proposed a new benchmark for purposes of medical review of hospital inpatient admissions (Medicare Part A payment). Under this proposal, beneficiaries who were expected to remain in the hospital to receive medically necessary care surpassing 2-midnights after the initiation of care would generally be appropriate for inpatient admission and inpatient payment (known as the "2-midnight rule"). Medicare contractors were to consider all the time after the initiation of care at the hospital in applying the benchmark that inpatient admissions are generally reasonable and necessary (as long as a hospital was not prolonging the provision of care to surpass the 2-midnight timeframe).[10]

Medicare Part B

In the final IPPS rule, the Secretary noted there had been an increasing number of cases in which hospitals had appealed Part A inpatient claim denials in which it was determined the inpatient admission was not reasonable or necessary. These claims had received partial favorable treatment by the Medicare Appeals Council or Administrative Law Judges (ALJs). In those cases, the Medicare review contractor determinations that the inpatient admission was not reasonable or necessary was upheld, but the Medicare Appeals Council and ALJ decisions ordered payment of the services as if they were rendered in an outpatient or observation level of care. These decisions effectively required Medicare to issue payment for all Part B services that would have been payable had the patient been treated as an outpatient (rather than an inpatient). In addition, these payments were made whether the subsequent hospital claim for payment was made within the applicable time limit for filing Part B claims. The Secretary pointed out that this was contrary to longstanding polices that permit billing only for a limited list of Part B inpatient services and require the services be billed within specific timeframes.[11]

As a result of the number of these administrative adjudications, the CMS Administrator issued CMS Ruling CMS-1455-P[12] (the Ruling) which established a standard process for effectuating the decisions granting Part B coverage. Among other things, where the administrative adjudicator had issued an order for payment under Medicare Part B, the request for Part B payment would not be rejected if more than one year had elapsed (the time period for filing Part B claims), if the Part A claim had been submitted timely. The Ruling was to remain in effect until the effective date of regulations that finalized "proposed rule CMS-1455-P." In the August 19, 2013 Federal Register, the Secretary revised the Part B inpatient payment policy to allow payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require outpatient status.[13] The one-year deadline for filing claims remains unchanged and the Secretary stated that she was not

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[13] 78 Fed. Reg. at 50909.

creating an exception to this requirement (as found in 42 C.F.R. § 424.44(b)(1)-(4)) even though the contractor claims review and appeal process could exceed the 1-year filing period.[14]

The 2-Midnight Rule

In the final IPPS rule, the Secretary pointed out that CMS had established policy that recognized that there were certain situations in which an inpatient hospital admission was rarely appropriate. This IPPS rule included instructions that provided a benchmark to ensure that all beneficiaries receive consistent application of their Part A benefits to whatever clinical services were medically necessary.[15]

Due to persistently large, improper payment rates for short-stay hospital inpatient claims, and, in response to requests to provide additional guidance regarding proper billing of those services, the Secretary proposed to modify and clarify 42 C.F.R. § 412.3(c)(1). This regulation designates services that are inpatient only (without regard to duration of care), surgical procedures, diagnostic tests and other treatments that would be appropriate for inpatient admission and inpatient payment under Medicare Part A when the physician expects the beneficiary to require a stay that crosses 2 midnights and admits the beneficiary based on that expectation. The starting point for this 2-midnight instruction would be when the beneficiary is moved from any outpatient area to a bed in the hospital in which additional services would be provided and is based on the judgment of the physician and the physician order (the physician must certify that the inpatient services were medically necessary).[16] The Secretary maintains that she has consistently provided physicians with a time-based admission framework to effectuate appropriate inpatient hospital admission decisions.[17]

The Secretary's actuaries estimated that the 2-midnight rule would increase IPPS expenditures by approximately $220 million. These additional expenditures would result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving from OPPS [outpatient PPS] to IPPS and some encounters of less than 2 midnights moving from IPPS to OPPS. The actuaries estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient from the approximately 11 million encounters paid under IPPS. This shift of 40,000 encounters represents an increase of approximately 1.2 percent in the number of shorter stay hospital inpatient encounters paid under IPPS. This additional expenditure would be partially offset by reduced expenditures from the shift of shorter stay hospital encounters to hospital outpatient encounters. The actuaries estimated that, on average, the per encounter payments for these hospital outpatient encounters would be approximately 30 percent of the per encounter payments for the inpatient encounters. In light of the impact of the 2-midnight rule on IPPS and the systematic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, the Secretary decided it was appropriate to use her exceptions and adjustments authority under 42 U.S.C.

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[14] *Id.* at 50927.
[15] *Id.* at 50944.
[16] *Id.*
[17] *Id.* at 50945.

§ 1395ww(d)(5)(I)(i) to offset the $220 million in additional IPPS expenditures associated with the 2-midnight policy. Consequently, the standardized amount was reduced by 0.2 percent.[18] The Secretary made the same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[19]

Provider's Request for EJR

The Provider contends that the 0.2 percent payment cut is unlawful and must be set aside for the following reasons: (1) the reduction is arbitrary and capricious because the Secretary[20] relied on indefensible assumptions and offered no reasoned explanation for those assumptions; (2) the reduction is invalid because the Secretary failed to comply with notice and comment procedures required by the Administrative Procedure Act (APA); and (3) the reduction is invalid because the Secretary failed to codify it in the Code of Federal Regulations, as required by the statute and the APA. The Provider believes that the 0.2 percent reduction must be set aside and it should be reimbursed for the reduced payments it received for hospital discharges on or after October 1, 2013.

The Provider explains that when the final IPPS rule was adopted in the August 19, 2013 Federal Register the Secretary explained that as a result of changes in hospital admission policies, detailed above, her actuaries estimated that expenditures under IPPS would increase by approximately $220 million due to an expected net increase in in hospital inpatient encounters.[21] The actuaries examined FY 2009 through FY 2011 Medicare claims data and estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient, a net shift of 40,000 encounters.[22]

The Provider believes that EJR is appropriate for this appeal because although the Board has jurisdiction over the appeal, it does not have the authority to grant the relief sought: reversal of the 0.2 percent reduction. 42 C.F.R. § 405.1842. The Provider asserts that the Secretary's actions are arbitrary, capricious, an abuse of discretion or otherwise not in accordance with the law and must be set aside under the Administrative Procedures Act.[23] Here, the Provider believes that the Secretary has relied on assumptions that appear arbitrary or flawed on their face and the Secretary has failed to justify them. Further, it contends, agency rules that leave important assumptions unexplained or fails to explain result that appear arbitrary on their face, are in fact reasonable must be vacated.[24] The Provider maintains that the 0.2 percent reduction cannot stand because it relies on several assumptions that appear indefensible on their face, and

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[18] *Id.* at 50952-53.
[19] *Id.* at 50990.
[20] of the Department of Health & Human Services.
[21] 78 Fed. Reg. at 50952.
[22] *Id.*
[23] 5 U.S.C. § 706(2)(A), (C).
[24] Citing *West Virginia v. EPA,* 362 F.3d 862, 866 (D.C. Cir. 2004).

the Secretary failed to explain those assumptions at all, let alone "provide a complete analytic defense."[25]

The Provider notes that the Secretary's actuaries estimated how many encounters would shift from outpatient to inpatient, examining only surgical MS-DRGs, but ignored medical DRGs—this action ignored an entire category of cases. It does not believe that it is reasonable to assume that two kinds of cases will behave in the same way. Rather, surgical cases are often easier for doctors to predict how long a patient will be hospitalized and easier to meet the 2-might criteria for inpatient payment. This is in contrast to medical cases where the patient is hospitalized with symptoms that have not been diagnosed making a definitive prediction of the length of hospitalization more difficult.

In addition, the Provider points out that the Secretary did not impose similar surgical-cases-only limitation when it counted how many encounters would shift in the other direction, from outpatient to inpatient. The Secretary examined only "outpatient claims for observation or a major procedure."[26] This approach did not track on the approach used in counting inpatient-out-outpatient shifts because it includes observation cases which were excluded from the inpatient-to-outpatient count. The Provider believes this creates a critical disconnect because the Secretary's 0.2 percent reduction turns entirely on its conclusion that more encounters would shift from outpatient to inpatient and vice versa.[27]

Further, the Provider believes that the Secretary undercounted the cases shifting from inpatient to outpatient. It notes that the Secretary concluded that 360,000 cases would shift in that direction under the new 2-midnight policy.[28] However, there are about one million zero or one-midnight stay inpatient cases each year[29] and the Secretary elsewhere stated her expectation that a "majority of short (total of zero or one midnight) Medicare hospital stays will be provided as outpatient services."[30] Based on the Secretary's statement, the Provider contends that this would mean at least 500,000 short-stay cases, perhaps more, shift to outpatient status. If that is the case, the Secretary should have increased IPPS rates, not decreased them.

Decision of the Board

The Board has reviewed the submissions of the Provider pertaining to the requests for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy for the appeal exceeds $10,000, as required for an individual appeal. The estimated

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[25] Citing *Appalachian Power v. EPA*, 251 F.3d 1026, 1035 (D.C. Cir. 2001).
[26] 78 Fed. Reg. at 50953.
[27] *Id.*
[28] *Id.*
[29] *See* CMS, FY 2014 Final Rule Data Files, AOR?BOR File, http://www.cms.gov/Medicare/Medicaid-Fee-for-Service-Payment/AcuteInpatientPPS/FY2014-IPPS-Final-Rule-Home-Page.html (click on "FY 2014 Data Files and download the "AOR/BOR File").
[30] CMS, FREQUENTLY ASKED QUESTIONS 2 Midnight Admission Guidance & Patient Status Reviews for Admissions on or after October 1,2 013, Question 13, available at http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/Downloads/QAs forWebsitePosting-110413-v2-Clean.pdf.

amount in controversy is subject to recalculation by the Medicare Administrative Contractor for the actual final amount.

The Board finds that:

1) it has jurisdiction over the matter for the subject year and the Provider is entitled to a hearing before the Board;

2) based upon the Provider's assertions regarding the 0.2 percent reduction to the standardized amount and the hospital specific rate, there are no findings of fact for resolution by the Board;

3) it is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

4) it is without the authority to decide the legal question of whether the Secretary's 0.2 percent reduction to the standardized amount and the hospital specific rate, is valid.

Accordingly, the Board finds that the 0.2 percent reduction issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provider's request for expedited judicial review for the issue and the subject year. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

Board Members Participating

Michael W. Harty
John Gary Blowers, 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. § 405.1877 and 405.1877

cc: Kyle Browning, NGS
Kevin Shanklin, BCBSA

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Refer to: 14-1755GC

Certified Mail

MAR 20 2014

Sherree R. Kanter, Esq.
Hogan Lovells US, LLP
555 Thirteenth Street, N.W.
Washington D.C. 20004

RE: Albert Einstein Healthcare Network FYE 2014
0.2% Reduction Group
Provider Nos. Various
FFY 2014
PRRB Case No. 14-1755GC

Dear Ms. Kanter:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' January 22, 2014 request for hearing appealing the August 19, 2013 Federal Register[1] and January 22, 2014 request for expedited judicial review (EJR) (both documents were received on January 23, 2014), as well as the Providers' February 25, 2014 response (received the same day) to the Board's February 20, 2014 request for additional information. The Board's determination with respect to the request for EJR is set forth below.

Issue

The Providers are challenging the validity of the Secretary's 0.2 percent reduction to the standardized amounts[2] and the hospital specific rates used to calculate the rates paid under the inpatient prospective payment system (IPPS). The Providers contend that the 0.2 percent payment cut is unlawful and must be set aside.

Statutory and Regulatory Background

In the final IPPS rule for FFY 2014, the Secretary indicated that she had expressed concern in the proposed calendar year (CY) Outpatient PPS rule[3] about the length of time Medicare

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[1] *See District of Columbia Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993), *Medicare and Medicaid Guide (CCH)* ¶ 41,025 (the Administrator held that the publication of the wage index in the Federal Register was a final determination which can be appealed to the Board).

[2] The standardized amount is the sum of: (1) a labor component which represents labor cost variations among different areas of the country and (2) a non-labor component which represents a geographic calculation based on whether the hospital is located in a large urban or other area. The labor component is then adjusted by the wage index. *See* "Medicare Hospital Prospective Payment System: How DRG Rates are Calculated and Updated" (CMS Office of the Inspector General Report OEI-09-00-00200, August 2001) on the internet at http://oig.hhs.gov/oei/reports/oei-09-00-00200.pdf.

[3] 77 Fed. Reg. 45061, 45155-45157 (July 30, 2012) and the final rule with comments, 77 Fed. Reg. 68,210, 68426-68433 (November 15, 2012).

beneficiaries were spending as hospital outpatients receiving observation services. In recent years, the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours increased from approximately 3 percent in 2006 to 8 percent in 2011. This raised a concern about the financial impact on Medicare beneficiaries who may incur greater financial liability than they would if they were admitted to the hospital as inpatients.[4]

The Secretary noted that the trend towards the extended observation services may be attributable, in part, to hospitals' concerns about their ability to receive payment from Medicare under Part B when a Part A hospital inpatient claim is denied because a Medicare review contractor determines that the inpatient admission was not reasonable and necessary under 42 U.S.C. § 1395y(a)(1)(A). Centers for Medicare & Medicaid Services (CMS) has been advised by stakeholders that the hospitals appear to be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays that may later be denied upon contractor review by electing to treat beneficiaries as outpatients receiving observation services for long periods of time, rather than admitting them as inpatients. These hospitals believe that Medicare's standards for inpatient admission were not clear.[5]

In response to this concern, the Secretary proposed clarifications and changes regarding hospital payment under both Part A and Part B. The Secretary proposed to revise Part B inpatient payment policy to allow payment under Part B for all hospital services that furnished and were reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted as an inpatient. This policy would apply when a Medicare Part A hospital inpatient claim was denied or when a hospital determines after a discharge that the inpatient visit was not reasonable and necessary. The timely filing restrictions for Part B billing were not changed (claims must be filed within 1 year from the date of service).[6]

Medicare Part A

In addition, the Secretary reviewed hospital inpatient status criteria to improve CMS' policies governing when a Medicare beneficiary should be admitted as an inpatient and how hospitals should be paid for associated costs. The Medicare Benefit Policy Manual[7] states that the typical decision to admit a beneficiary as an inpatient should be made within 24 to 48 hours after observation care and that an overnight stay may be a factor in the admission decision. Physicians should use the 24-hour or overnight period as a benchmark, i.e., they should order admission for patients who are expected to need care for 24 hours or overnight. Generally, a beneficiary is considered an inpatient if formally admitted with the expectation that he or she will remain in the hospital overnight, whether or not there is a later transfer or discharge and the patient is not present overnight. Only rarely and in exceptional cases do reasonable and necessary observation services span more than 48 hours. Length of stay is not the basis for

[4] 78 Fed. Reg. at 50907.
[5] *Id.*
[6] *Id.*
[7] Chapter 6, §20.6 and Chapter 1, §10.

payment and it is the physician responsible for patient care who decides if the patient should be admitted.[8]

In the Federal fiscal year (FFY) 2014 IPPS proposed rule[9] the Secretary proposed a new benchmark for purposes of medical review of hospital inpatient admissions (Medicare Part A payment). Under this proposal, beneficiaries who were expected to remain in the hospital to receive medically necessary care surpassing 2-midnights after the initiation of care would generally be appropriate for inpatient admission and inpatient payment (known as the "2-midnight rule"). Medicare contractors were to consider all the time after the initiation of care at the hospital in applying the benchmark that inpatient admissions are generally reasonable and necessary (as long as a hospital was not prolonging the provision of care to surpass the 2-midnight timeframe).[10]

Medicare Part B

In the final IPPS rule, the Secretary noted there had been an increasing number of cases in which hospitals had appealed Part A inpatient claim denials in which it was determined the inpatient admission was not reasonable or necessary. These claims had received partial favorable treatment by the Medicare Appeals Council or Administrative Law Judges (ALJs). In those cases, the Medicare review contractor determinations that the inpatient admission was not reasonable or necessary was upheld, but the Medicare Appeals Council and ALJ decisions ordered payment of the services as if they were rendered in an outpatient or observation level of care. These decisions effectively required Medicare to issue payment for all Part B services that would have been payable had the patient been treated as an outpatient (rather than an inpatient). In addition, these payments were made whether the subsequent hospital claim for payment was made within the applicable time limit for filing Part B claims. The Secretary pointed out that this was contrary to longstanding polices that permit billing only for a limited list of Part B inpatient services and require the services be billed within specific timeframes.[11]

As a result of the number of these administrative adjudications, the CMS Administrator issued CMS Ruling CMS-1455-P[12] (the Ruling) which established a standard process for effectuating the decisions granting Part B coverage. Among other things, where the administrative adjudicator had issued an order for payment under Medicare Part B, the request for Part B payment would not be rejected if more than one year had elapsed (the time period for filing Part B claims), if the Part A claim had been submitted timely. The Ruling was to remain in effect until the effective date of regulations that finalized "proposed rule CMS-1455-P." In the August 19, 2013 Federal Register, the Secretary revised the Part B inpatient payment policy to allow payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the

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[8] 78 Fed. Reg. at 50907-08.
[9] *See generally* 78 Fed. Reg. 27486 (May 10, 2013).
[10] 78 Fed. Reg. 50908.
[11] *Id.*
[12] *See* 78 Fed. Reg. 16614 (March 18, 2013) and on the internet at http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings.html.

hospital as an inpatient, except for those services that specifically require outpatient status.[13] The one-year deadline for filing claims remains unchanged and the Secretary stated that she was not creating an exception to this requirement (as found in 42 C.F.R. § 424.44(b)(1)-(4)) even though the contractor claims review and appeal process could exceed the 1-year filing period.[14]

The 2-Midnight Rule

In the final IPPS rule, the Secretary pointed out that CMS had established policy that recognized that there were certain situations in which an inpatient hospital admission was rarely appropriate. This IPPS rule included instructions that provided a benchmark to ensure that all beneficiaries receive consistent application of their Part A benefits to whatever clinical services were medically necessary.[15]

Due to persistently large, improper payment rates for short-stay hospital inpatient claims, and, in response to requests to provide additional guidance regarding proper billing of those services, the Secretary proposed to modify and clarify 42 C.F.R. § 412.3(c)(1). This regulation designates services that are inpatient only (without regard to duration of care), surgical procedures, diagnostic tests and other treatments that would be appropriate for inpatient admission and inpatient payment under Medicare Part A when the physician expects the beneficiary to require a stay that crosses 2 midnights and admits the beneficiary based on that expectation. The starting point for this 2-midnight instruction would be when the beneficiary is moved from any outpatient area to a bed in the hospital in which additional services would be provided and is based on the judgment of the physician and the physician order (the physician must certify that the inpatient services were medically necessary).[16] The Secretary maintains that she has consistently provided physicians with a time-based admission framework to effectuate appropriate inpatient hospital admission decisions.[17]

The Secretary's actuaries estimated that the 2-midnight rule would increase IPPS expenditures by approximately $220 million. These additional expenditures would result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving from OPPS [outpatient PPS] to IPPS and some encounters of less than 2 midnights moving from IPPS to OPPS. The actuaries estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient from the approximately 11 million encounters paid under IPPS. This shift of 40,000 encounters represents an increase of approximately 1.2 percent in the number of shorter stay hospital inpatient encounters paid under IPPS. This additional expenditure would be partially offset by reduced expenditures from the shift of shorter stay hospital encounters to hospital outpatient encounters. The actuaries estimated that, on average, the per encounter payments for these hospital outpatient encounters would be approximately 30 percent of the per encounter payments for the inpatient encounters. In light of the impact of the

[13] 78 Fed. Reg. at 50909.
[14] *Id.* at 50927.
[15] *Id.* at 50944.
[16] *Id.*
[17] *Id.* at 50945.

2-midnight rule on IPPS and the systematic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, the Secretary decided it was appropriate to use her exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i) to offset the $220 million in additional IPPS expenditures associated with the 2-midnight policy. Consequently, the standardized amount was reduced by 0.2 percent.[18] The Secretary made the same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[19]

Providers' Request for EJR

The Providers contend that the 0.2 percent payment cut is unlawful and must be set aside for the following reasons: (1) the reduction is arbitrary and capricious because the Secretary[20] relied on indefensible assumptions and offered no reasoned explanation for those assumptions; (2) the reduction is invalid because the Secretary failed to comply with notice and comment procedures required by the Administrative Procedure Act (APA); and (3) the reduction is invalid because the Secretary failed to codify it in the Code of Federal Regulations, as required by the statute and the APA. The Providers believe that the 0.2 percent reduction must be set aside and the Providers reimbursed for the reduced payments they received for hospital discharges on or after October 1, 2013.

The Providers explain that when the final IPPS rule was adopted in the August 19, 2013 Federal Register the Secretary explained that as a result of changes in hospital admission policies, detailed above, her actuaries estimated that expenditures under IPPS would increase by approximately $220 million due to an expected net increase in in hospital inpatient encounters.[21] The actuaries examined FY 2009 through FY 2011 Medicare claims data and estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient, a net shift of 40,000 encounters.[22]

The Providers believe that EJR is appropriate for this appeal because although the Board has jurisdiction over the appeal, it does not have the authority to grant the relief sought: reversal of the 0.2 percent reduction. 42 C.F.R. § 405.1842. The Providers assert that the Secretary's actions are arbitrary, capricious, an abuse of discretion or otherwise not in accordance with the law and must be set aside under the Administrative Procedures Act.[23] Here, the Providers believe that the Secretary has relied on assumptions that appear arbitrary or flawed on their face and the Secretary has failed to justify them. Further, they contend, agency rules that leave important assumptions unexplained or fails to explain result that appear arbitrary on their face, are in fact reasonable must be vacated.[24] The Providers maintain that the 0.2 percent reduction

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[18] *Id.* at 50952-53.
[19] *Id.* at 50990.
[20] of the Department of Health & Human Services.
[21] 78 Fed. Reg. at 50952.
[22] *Id.*
[23] 5 U.S.C. § 706(2)(A), (C).
[24] Citing *West Virginia v. EPA,* 362 F.3d 862, 866 (D.C. Cir. 2004).

cannot stand because it relies on several assumptions that appear indefensible on their face, and the Secretary failed to explain those assumptions at all, let alone "provide a complete analytic defense."[25]

The Providers note that the Secretary's actuaries estimated how many encounters would shift from outpatient to inpatient, examining only surgical MS-DRGs, but ignored medical DRGs—this action ignored an entire category of cases. They do not believe that it is reasonable to assume that two kinds of cases will behave in the same way. Rather, surgical cases are often easier for doctors to predict how long a patient will be hospitalized and easier to meet the 2-might criteria for inpatient payment. This is in contrast to medical cases where the patient is hospitalized with symptoms that have not been diagnosed making a definitive prediction of the length of hospitalization more difficult.

In addition, the Providers point out that the Secretary did not impose similar surgical-cases-only limitation when it counted how many encounters would shift in the other direction, from outpatient to inpatient. The Secretary examined only "outpatient claims for observation or a major procedure."[26] This approach did not track on the approach used in counting inpatient-out-outpatient shifts because it includes observation cases which were excluded from the inpatient-to-outpatient count. The Providers believe this creates a critical disconnect because the Secretary's 0.2 percent reductions turns entirely on its conclusion that more encounters would shift from outpatient to inpatient and vice versa.[27]

Further, the Providers believe that the Secretary undercounted the cases shifting from inpatient to outpatient. They note that the Secretary concluded that 360,000 cases would shift in that direction under the new 2-midnight policy.[28] However, there are about one million zero or one-midnight stay inpatient cases each year[29] and the Secretary elsewhere stated her expectation that a "majority of short (total of zero or one midnight) Medicare hospital stays will be provided as outpatient services."[30] Based on the Secretary's statement, the Providers contend that this would mean at least 500,000 short-stay cases, perhaps more, shift to outpatient status. If that is the case, the Secretary should have increased IPPS rates, not decreased them.

Decision of the Board

The Board has reviewed the submissions of the Providers pertaining to the requests for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy for the appeal exceeds $50,000, as required for a group appeal. The estimated

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[25] Citing *Appalachian Power v. EPA*, 251 F.3d 1026, 1035 (D.C. Cir. 2001).
[26] 78 Fed. Reg. at 50953.
[27] *Id.*
[28] *Id.*
[29] *See* CMS, FY 2014 Final Rule Data Files, AOR?BOR File, http://www.cms.gov/Medicare/Medicaid-Fee-for-Service-Payment/AcuteInpatientPPS/FY2014-IPPS-Final-Rule-Home-Page.html (click on "FY 2014 Data Files and download the "AOR/BOR File").
[30] CMS, FREQUENTLY ASKED QUESTIONS 2 Midnight Admission Guidance & Patient Status Reviews for Admissions on or after October 1,2 013, Question 13, available at http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/Downloads/QAs forWebsitePosting-110413-v2-Clean.pdf.

amount in controversy is subject to recalculation by the Medicare Administrative Contractor for the actual final amount.

The Board finds that:

1) it has jurisdiction over the matter for the subject year and the Providers are entitled to a hearing before the Board;

2) based upon the Providers' assertions regarding the 0.2 percent reduction to the standardized amount and the hospital specific rate, there are no findings of fact for resolution by the Board;

3) it is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

4) it is without the authority to decide the legal question of whether the Secretary's 0.2 percent reduction to the standardized amount and the hospital specific rate, is valid.

Accordingly, the Board finds that the 0.2 percent reduction issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for expedited judicial review for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

Board Members Participating

Michael W. Harty
John Gary Blowers, 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. § 405.1877 and 405.1877
Schedule of Providers

cc: Bruce Snyder, Novitas (w/Schedule of Providers)
Kevin Shanklin, BCBSA (w/Schedule of Providers)

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14-1756GC
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MAR 20 2014

Sherree R. Kanter, Esq.
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555 Thirteenth Street, N.W.
Washington D.C. 20004

RE: Banner Health FYE 2014 0.2% Reduction Group
Provider Nos. Various
FFY 2014
PRRB Case No. 14-1756GC

Dear Ms. Kanter:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' January 22, 2014 request for hearing appealing the August 19, 2013 Federal Register[1] and January 22, 2014 request for expedited judicial review (EJR) (both documents were received on January 23, 2014), as well as the Providers' February 25, 2014 response (received same day) to the Board's February 20, 2014 request for additional information. The Board's determination with respect to the request for EJR is set forth below.

Issue

The Providers are challenging the validity of the Secretary's 0.2 percent reduction to the standardized amounts[2] and the hospital specific rates used to calculate the rates paid under the inpatient prospective payment system (IPPS). The Providers contend that the 0.2 percent payment cut is unlawful and must be set aside.

Statutory and Regulatory Background

In the final IPPS rule for FFY 2014, the Secretary indicated that she had expressed concern in the proposed calendar year (CY) Outpatient PPS rule[3] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving observation services. In recent

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[1] *See District of Columbia Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993), *Medicare and Medicaid Guide (CCH)* ¶ 41,025 (the Administrator held that the publication of the wage index in the Federal Register was a final determination which can be appealed to the Board).

[2] The standardized amount is the sum of: (1) a labor component which represents labor cost variations among different areas of the country and (2) a non-labor component which represents a geographic calculation based on whether the hospital is located in a large urban or other area. The labor component is then adjusted by the wage index. *See* "Medicare Hospital Prospective Payment System: How DRG Rates are Calculated and Updated" (CMS Office of the Inspector General Report OEI-09-00-00200, August 2001) on the internet at http://oig.hhs.gov/oei/reports/oei-09-00-00200.pdf.

[3] 77 Fed. Reg. 45061, 45155-45157 (July 30, 2012) and the final rule with comments, 77 Fed. Reg. 68,210, 68426-68433 (November 15, 2012).

years, the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours increased from approximately 3 percent in 2006 to 8 percent in 2011. This raised a concern about the financial impact on Medicare beneficiaries who may incur greater financial liability than they would if they were admitted to the hospital as inpatients.[4]

The Secretary noted that the trend towards the extended observation services may be attributable, in part, to hospitals' concerns about their ability to receive payment from Medicare under Part B when a Part A hospital inpatient claim is denied because a Medicare review contractor determines that the inpatient admission was not reasonable and necessary under 42 U.S.C. § 1395y(a)(1)(A). Centers for Medicare & Medicaid Services (CMS) has been advised by stakeholders that the hospitals appear to be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays that may later be denied upon contractor review by electing to treat beneficiaries as outpatients receiving observation services for long periods of time, rather than admitting them as inpatients. These hospitals believe that Medicare's standards for inpatient admission were not clear.[5]

In response to this concern, the Secretary proposed clarifications and changes regarding hospital payment under both Part A and Part B. The Secretary proposed to revise Part B inpatient payment policy to allow payment under Part B for all hospital services that furnished and were reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted as an inpatient. This policy would apply when a Medicare Part A hospital inpatient claim was denied or when a hospital determines after a discharge that the inpatient visit was not reasonable and necessary. The timely filing restrictions for Part B billing were not changed (claims must be filed within 1 year from the date of service).[6]

Medicare Part A

In addition, the Secretary reviewed hospital inpatient status criteria to improve CMS' policies governing when a Medicare beneficiary should be admitted as an inpatient and how hospitals should be paid for associated costs. The Medicare Benefit Policy Manual[7] states that the typical decision to admit a beneficiary as an inpatient should be made within 24 to 48 hours after observation care and that an overnight stay may be a factor in the admission decision. Physicians should use the 24-hour or overnight period as a benchmark, i.e., they should order admission for patients who are expected to need care for 24 hours or overnight. Generally, a beneficiary is considered an inpatient if formally admitted with the expectation that he or she will remain in the hospital overnight, whether or not there is a later transfer or discharge and the patient is not present overnight. Only rarely and in exceptional cases do reasonable and necessary observation services span more than 48 hours. Length of stay is not the basis for payment and it is the physician responsible for patient care who decides if the patient should be admitted.[8]

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[4] 78 Fed. Reg. at 50907.
[5] *Id.*
[6] *Id.*
[7] Chapter 6, §20.6 and Chapter 1, §10.
[8] 78 Fed. Reg. at 50907-08.

In the Federal fiscal year (FFY) 2014 IPPS proposed rule[9] the Secretary proposed a new benchmark for purposes of medical review of hospital inpatient admissions (Medicare Part A payment). Under this proposal, beneficiaries who were expected to remain in the hospital to receive medically necessary care surpassing 2-midnights after the initiation of care would generally be appropriate for inpatient admission and inpatient payment (known as the "2-midnight rule"). Medicare contractors were to consider all the time after the initiation of care at the hospital in applying the benchmark that inpatient admissions are generally reasonable and necessary (as long as a hospital was not prolonging the provision of care to surpass the 2-midnight timeframe).[10]

Medicare Part B

In the final IPPS rule, the Secretary noted there had been an increasing number of cases in which hospitals had appealed Part A inpatient claim denials in which it was determined the inpatient admission was not reasonable or necessary. These claims had received partial favorable treatment by the Medicare Appeals Council or Administrative Law Judges (ALJs). In those cases, the Medicare review contractor determinations that the inpatient admission was not reasonable or necessary was upheld, but the Medicare Appeals Council and ALJ decisions ordered payment of the services as if they were rendered in an outpatient or observation level of care. These decisions effectively required Medicare to issue payment for all Part B services that would have been payable had the patient been treated as an outpatient (rather than an inpatient). In addition, these payments were made whether the subsequent hospital claim for payment was made within the applicable time limit for filing Part B claims. The Secretary pointed out that this was contrary to longstanding polices that permit billing only for a limited list of Part B inpatient services and require the services be billed within specific timeframes.[11]

As a result of the number of these administrative adjudications, the CMS Administrator issued CMS Ruling CMS-1455-P[12] (the Ruling) which established a standard process for effectuating the decisions granting Part B coverage. Among other things, where the administrative adjudicator had issued an order for payment under Medicare Part B, the request for Part B payment would not be rejected if more than one year had elapsed (the time period for filing Part B claims), if the Part A claim had been submitted timely. The Ruling was to remain in effect until the effective date of regulations that finalized "proposed rule CMS-1455-P." In the August 19, 2013 Federal Register, the Secretary revised the Part B inpatient payment policy to allow payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require outpatient status.[13] The one-year deadline for filing claims remains unchanged and the Secretary stated that she was not

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[9] *See generally* 78 Fed. Reg. 27486 (May 10, 2013).
[10] 78 Fed. Reg. 50908.
[11] *Id.*
[12] *See* 78 Fed. Reg. 16614 (March 18, 2013) and on the internet at http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings.html.
[13] 78 Fed. Reg. at 50909.

creating an exception to this requirement (as found in 42 C.F.R. § 424.44(b)(1)-(4)) even though the contractor claims review and appeal process could exceed the 1-year filing period.[14]

The 2-Midnight Rule

In the final IPPS rule, the Secretary pointed out that CMS had established policy that recognized that there were certain situations in which an inpatient hospital admission was rarely appropriate. This IPPS rule included instructions that provided a benchmark to ensure that all beneficiaries receive consistent application of their Part A benefits to whatever clinical services were medically necessary.[15]

Due to persistently large, improper payment rates for short-stay hospital inpatient claims, and, in response to requests to provide additional guidance regarding proper billing of those services, the Secretary proposed to modify and clarify 42 C.F.R. § 412.3(c)(1). This regulation designates services that are inpatient only (without regard to duration of care), surgical procedures, diagnostic tests and other treatments that would be appropriate for inpatient admission and inpatient payment under Medicare Part A when the physician expects the beneficiary to require a stay that crosses 2 midnights and admits the beneficiary based on that expectation. The starting point for this 2-midnight instruction would be when the beneficiary is moved from any outpatient area to a bed in the hospital in which additional services would be provided and is based on the judgment of the physician and the physician order (the physician must certify that the inpatient services were medically necessary).[16] The Secretary maintains that she has consistently provided physicians with a time-based admission framework to effectuate appropriate inpatient hospital admission decisions.[17]

The Secretary's actuaries estimated that the 2-midnight rule would increase IPPS expenditures by approximately $220 million. These additional expenditures would result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving from OPPS [outpatient PPS] to IPPS and some encounters of less than 2 midnights moving from IPPS to OPPS. The actuaries estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient from the approximately 11 million encounters paid under IPPS. This shift of 40,000 encounters represents an increase of approximately 1.2 percent in the number of shorter stay hospital inpatient encounters paid under IPPS. This additional expenditure would be partially offset by reduced expenditures from the shift of shorter stay hospital encounters to hospital outpatient encounters. The actuaries estimated that, on average, the per encounter payments for these hospital outpatient encounters would be approximately 30 percent of the per encounter payments for the inpatient encounters. In light of the impact of the 2-midnight rule on IPPS and the systematic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, the Secretary decided it was appropriate to use her exceptions and adjustments authority under 42 U.S.C.

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[14] *Id.* at 50927.
[15] *Id.* at 50944.
[16] *Id.*
[17] *Id.* at 50945.

§ 1395ww(d)(5)(I)(i) to offset the $220 million in additional IPPS expenditures associated with the 2-midnight policy. Consequently, the standardized amount was reduced by 0.2 percent.[18] The Secretary made the same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[19]

Providers' Request for EJR

The Providers contend that the 0.2 percent payment cut is unlawful and must be set aside for the following reasons: (1) the reduction is arbitrary and capricious because the Secretary[20] relied on indefensible assumptions and offered no reasoned explanation for those assumptions; (2) the reduction is invalid because the Secretary failed to comply with notice and comment procedures required by the Administrative Procedure Act (APA); and (3) the reduction is invalid because the Secretary failed to codify it in the Code of Federal Regulations, as required by the statute and the APA. The Providers believe that the 0.2 percent reduction must be set aside and the Providers reimbursed for the reduced payments they received for hospital discharges on or after October 1, 2013.

The Providers explain that when the final IPPS rule was adopted in the August 19, 2013 Federal Register the Secretary explained that as a result of changes in hospital admission policies, detailed above, her actuaries estimated that expenditures under IPPS would increase by approximately $220 million due to an expected net increase in in hospital inpatient encounters.[21] The actuaries examined FY 2009 through FY 2011 Medicare claims data and estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient, a net shift of 40,000 encounters.[22]

The Providers believe that EJR is appropriate for this appeal because although the Board has jurisdiction over the appeal, it does not have the authority to grant the relief sought: reversal of the 0.2 percent reduction. 42 C.F.R. § 405.1842. The Providers assert that the Secretary's actions are arbitrary, capricious, an abuse of discretion or otherwise not in accordance with the law and must be set aside under the Administrative Procedures Act.[23] Here, the Providers believe that the Secretary has relied on assumptions that appear arbitrary or flawed on their face and the Secretary has failed to justify them. Further, they contend, agency rules that leave important assumptions unexplained or fails to explain result that appear arbitrary on their face, are in fact reasonable must be vacated.[24] The Providers maintain that the 0.2 percent reduction cannot stand because it relies on several assumptions that appear indefensible on their face, and

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[18] *Id.* at 50952-53.
[19] *Id.* at 50990.
[20] of the Department of Health & Human Services.
[21] 78 Fed. Reg. at 50952.
[22] *Id.*
[23] 5 U.S.C. § 706(2)(A), (C).
[24] Citing *West Virginia v. EPA,* 362 F.3d 862, 866 (D.C. Cir. 2004).

the Secretary failed to explain those assumptions at all, let alone "provide a complete analytic defense."[25]

The Providers note that the Secretary's actuaries estimated how many encounters would shift from outpatient to inpatient, examining only surgical MS-DRGs, but ignored medical DRGs—this action ignored an entire category of cases. They do not believe that it is reasonable to assume that two kinds of cases will behave in the same way. Rather, surgical cases are often easier for doctors to predict how long a patient will be hospitalized and easier to meet the 2-might criteria for inpatient payment. This is in contrast to medical cases where the patient is hospitalized with symptoms that have not been diagnosed making a definitive prediction of the length of hospitalization more difficult.

In addition, the Providers point out that the Secretary did not impose similar surgical-cases-only limitation when it counted how many encounters would shift in the other direction, from outpatient to inpatient. The Secretary examined only "outpatient claims for observation or a major procedure."[26] This approach did not track on the approach used in counting inpatient-out-outpatient shifts because it includes observation cases which were excluded from the inpatient-to-outpatient count. The Providers believe this creates a critical disconnect because the Secretary's 0.2 percent reductions turns entirely on its conclusion that more encounters would shift from outpatient to inpatient and vice versa.[27]

Further, the Providers believe that the Secretary undercounted the cases shifting from inpatient to outpatient. They note that the Secretary concluded that 360,000 cases would shift in that direction under the new 2-midnight policy.[28] However, there are about one million zero or one-midnight stay inpatient cases each year[29] and the Secretary elsewhere stated her expectation that a "majority of short (total of zero or one midnight) Medicare hospital stays will be provided as outpatient services."[30] Based on the Secretary's statement, the Providers contend that this would mean at least 500,000 short-stay cases, perhaps more, shift to outpatient status. If that is the case, the Secretary should have increased IPPS rates, not decreased them.

Decision of the Board

The Board has reviewed the submissions of the Providers pertaining to the requests for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy for the appeal exceeds $50,000, as required for a group appeal. The estimated

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[25] Citing *Appalachian Power v. EPA*, 251 F.3d 1026, 1035 (D.C. Cir. 2001).
[26] 78 Fed. Reg. at 50953.
[27] *Id.*
[28] *Id.*
[29] *See* CMS, FY 2014 Final Rule Data Files, AOR?BOR File, http://www.cms.gov/Medicare/Medicaid-Fee-for-Service-Payment/AcuteInpatientPPS/FY2014-IPPS-Final-Rule-Home-Page.html (click on "FY 2014 Data Files and download the "AOR/BOR File").
[30] CMS, FREQUENTLY ASKED QUESTIONS 2 Midnight Admission Guidance & Patient Status Reviews for Admissions on or after October 1,2 013, Question 13, available at http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/Downloads/QAs forWebsitePosting-110413-v2-Clean.pdf.

amount in controversy is subject to recalculation by the Medicare Administrative Contractor for the actual final amount.

The Board finds that:

1) it has jurisdiction over the matter for the subject year and the Providers are entitled to a hearing before the Board;

2) based upon the Providers' assertions regarding the 0.2 percent reduction to the standardized amount and the hospital specific rate, there are no findings of fact for resolution by the Board;

3) it is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

4) it is without the authority to decide the legal question of whether the Secretary's 0.2 percent reduction to the standardized amount and the hospital specific rate, is valid.

Accordingly, the Board finds that the 0.2 percent reduction issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for expedited judicial review for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

Board Members Participating

Michael W. Harty
John Gary Blowers, 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. § 405.1877 and 405.1877
Schedule of Providers

cc: Byron Lamprecht, WPS (w/Schedule of Providers)
Kevin Shanklin, BCBSA (w/Schedule of Providers)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
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Phone: 410-786-2671
Internet: www.cms.gov/PRRBReview FAX: 410-786-5298

Refer to:

MAR 21 2014

CERTIFIED MAIL

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

RE: QRS 1988 & 1990-2000 DSH/SSI Group
PRRB Case No. 98-2692G

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeal which is subject to CMS Ruling 1498-R. The Board notes that there are jurisdictional impediments for a number of the participants in the group appeal. The pertinent facts for these participants and the Board's jurisdictional determinations are set forth below.

Pertinent Facts:

QRS filed the request for this SSI group appeal on May 6, 1998. There are currently 85 participants in the group appeal. On April 30, 2012 the Representative submitted the Schedule of Providers and associated jurisdictional documentation to the Board. In the cover letter to the Schedule, QRS advised that four common issue related parties (CIRPs) were included in the group, but were listed on separate Schedules of Providers.[1] Upon review of these Schedules, the Board notes that three of the CIRPs identified have only one participant appealing multiple years. Consequently, the Board has bifurcated the four CIRPs from this appeal and created a separate group to which it has assigned case number 14-2934G, the QRS Pre-2000 SSI Proxy Group II.

Board Determination:

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 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 receipt of the NPR.

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[1] The four CIRPs initially included in case number 98-2692G are Wheaton Franciscan Health Care; Saint Luke's Health System; Trinity Health & Baylor Healthcare.

Providers Lacking Sufficient Documentation:

After review of the supporting documentation, the Board notes that Parkview Episcopal Hospital (06-0020) for FYE 6/30/1995 (#39), did not supply a copy of its Notice of Program Reimbursement (NPR), its initial appeal request or an audit adjustment page. Further, the Provider did not submit proof of the addition or transfer of the SSI issue. The Board hereby dismisses Parkview Episcopal Hospital for FYE 6/30/1995 from the group based on its failure to provide sufficient documentation.

Providers that Appealed from Revised NPRs:

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(b)(1) explains the effect of a cost report revision: "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."

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 Board finds that there are five participants in the group that filed from revised NPRs but did not support that the SSI ratio was specifically adjusted: Lester E. Cox Medical Center (#3, 8, 14, 19) and University of Michigan Hospitals (#30).

- Participants 3 and 8 - The request to reopen is specific to employee hospitalization & Medicaid days. The Provider did not supply workpapers so there is no evidence to support an adjustment specific to SSI.

- Participants 14 & 19 - The request to reopen is specific to employee hospitalization & Medicaid days. The Provider did not supply workpapers so there is no evidence to support an adjustment specific to SSI. In addition, the reopening is a result of an administrative resolution from a prior case, thus demonstrating the Provider's agreement that the dissatisfaction had been resolved in that case. Therefore the

Provider cannot show the dissatisfaction necessary to appeal the revised NPR as required by 42 U.S.C. § 1395(a)(1)(A) and 42 C.F.R. §§ 405.1835 and 405.1837.[2]

- Participant 30 - The revised adjustment page references "DSH" but there is not enough evidence to support a specific adjustment to the SSI ratio. In addition, the notice of reopening indicates it is being issued to incorporate changes from an administrative resolution of FYE 1994. Therefore the Provider cannot show the dissatisfaction necessary to appeal the revised NPR as required by 42 U.S.C. § 1395(a)(1)(A) and 42 C.F.R. §§ 405.1835 and 405.1837.

Consequently, the Board finds it lacks jurisdiction over Lester E. Cox Medical Center for FYEs 1990 through 1993 and University of Michigan Hospitals for FYE 1994 and dismisses these Providers from the group.

Proof that SSI Issue was Properly Appealed/Transferred to Group:

With regard to San Joaquin Community Hospital (05-0455) for FYE 12/31/1996 (#51), the Provider's request to transfer the SSI issue to the group appeal is dated 4/23/2003, a week after the individual appeal (case number 99-3149) was closed on 4/16/2003. Because an issue cannot be transferred from a closed case, the Board hereby dismisses San Joaquin Community Hospital for FYE 12/31/1996 from the group.

Naples Community Hospital (10-0018) for FYE 9/30/1995 (# 42) does not have proof that the SSI issue was transferred to the subject group. The documentation provided to evidence proof of the transfer is a copy of a proposed administrative resolution (A/R) that indicates the provider "... *will* formally transfer the SSI percentage issue ... to 98-2692G." (Emphasis added) The Provider also supplied a copy of a letter which was titled "Request to Transfer Issues to Groups and Withdrawal of Appeal." Unfortunately, the text of the letter says only that the "Provider accepts and approves the A/R ... and wishes to withdraw its appeal and close case number 99-2913... ". This is not sufficient evidence to support the transfer of the SSI issue to the group. Therefore, the Board dismisses Naples Community Hospital for FYE 9/30/1995 from the group.

St. Francis Hospital (50-0141) for FYE 6/30/1998 (# 77) included the SSI issue in its individual appeal request but, in the same letter, requested the transfer of the SSI issue to a different group appeal, case number 00-3406G – the CHI 98 DSH SSI Group. The Provider is listed on the Schedule of Providers as a participant in that group appeal for which the Board granted expedited judicial review (EJR). Although there is a subsequent request to add the SSI issue back to the individual appeal and transfer it to this group, Board Rule 4.5 prohibits an issue from being pursued in more than one case. Consequently, the Board dismisses St. Francis Hospital for FYE 6/30/1998 from this group.

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[2] Had the Provider been only partially satisfied with the resolution, it had an open appeal and an opportunity to bring the remaining issues before the Board for hearing.

Providers Subject to Remand under CMS Ruling 1498-R

Participants 3, 8, 14, 19, 30, 39, 42, 51 and 77 have been dismissed from the group as noted. The Board finds that the remaining participants (#s 1, 2, 4-7, 9-13, 15-18, 20-29, 31-38, 40, 41, 43-50, 52-76 and 78-85) are covered under CMS Ruling 1498-R. Enclosed, please find a Remand of the SSI Percentage issue under the standard procedure.

Since there are no remaining issues in this case, the group appeal 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:
John Gary Bowers, CPA
Michael W. Harty
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 .1877
Standard Remand of the SSI fraction under CMS Ruling CMS-1498-R
Schedule of Providers

cc: National Government Services, Inc. (w/enclosures)
Danene L. Hartley, Appeals Lead
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Indianapolis, IN 46206 6474

Blue Cross Blue Shield Association (w/enclosures)
Senior Government Initiatives
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Refer to:

MAR 21 2014

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: 2014 PPS Rate Reduction Groups
FFY 2014
PRRB Case Nos. See attached list

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' January 2014 requests for hearing appealing the August 19, 2013 Federal Register[1] and their February 26, 2014 requests for expedited judicial review (EJR) (received on February 27, 2014). The Board's determination with respect to the requests for EJR is set forth below.

Issues

The Providers are seeking a correction of their Medicare payment rates per discharge for operating and capital related costs of inpatient services furnished during FFY 2014. In the final inpatient prospective payment system (IPPS) rule for FFY 2014 the Secretary effected a 0.2% reduction to the standardized amount[2] paid for operating costs under IPPS, the hospital specific rates for some sole community hospitals and Medicare dependent hospitals[3] and the Federal rate

[1] *See District of Columbia Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993), *Medicare and Medicaid Guide (CCH)* ¶ 41,025 (the Administrator held that the publication of the wage index in the Federal Register was a final determination which can be appealed to the Board).

[2] The standardized amount is the sum of: (1) a labor component which represents labor cost variations among different areas of the country and (2) a non-labor component which represents a geographic calculation based on whether the hospital is located in a large urban or other area. The labor component is then adjusted by the wage index. *See* "Medicare Hospital Prospective Payment System: How DRG Rates are Calculated and Updated" (CMS Office of the Inspector General Report OEI-09-00-00200, August 2001) on the internet at http://oig.hhs.gov/oei/reports/oei-09-00-00200.pdf.

[3] Although payments to most hospitals under IPPS are made on the basis of the standardized amounts, some categories of hospitals are paid in whole or in part based on their hospital specific rate, which is determined from their costs in a base year. Sole community hospitals (SCHs) receive payment on the higher of the hospital specific rate based on their updated costs in a base year (the highest of FY 1982, FYE 1987, FY1996, or FY 2006) or the IPPS Federal rate based on their standardized amount whichever yields the greatest payment. Medicare dependent hospitals (MDHs) received the higher of the Federal rate or the Federal rate plus 50% of the amount by which the Federal rate is exceeded by the higher of its FY 1982 or FY 1987 hospital-specific rate. For discharges occurring on or after October 1, 2007, but before October 1, 2013, a MDH would receive the higher of the Federal rate or the

for capital costs.[4,5] The Secretary applied this reduction to the payment rates in connection with CMS' adoption of a policy known as the "2-midnight rule." The Providers believe that the payment rate reduction should be set aside because it exceeds the Secretary's statutory authority under the prospective payment statute, 42 U.S.C. §§ 1395ww(d) and 1395ww(g), is contrary to the plain language and intent of the statute, and is arbitrary, capricious, not based upon substantial evidence, and otherwise contrary to the law. *See* 5 U.S.C. § 706.

Statutory and Regulatory Background

In the final IPPS rule for FFY 2014, the Secretary[6] indicated that she had expressed concern in the proposed calendar year (CY) Outpatient PPS rule[7] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving observation services. In recent years, the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours increased from approximately 3 percent in 2006 to 8 percent in 2011. This raised a concern about the financial impact on Medicare beneficiaries who may incur greater financial liability than they would if they were admitted to the hospital as inpatients.[8]

The Secretary noted that the trend towards the extended observation services may be attributable, in part, to hospitals' concerns about their ability to receive payment from Medicare under Part B when a Part A hospital inpatient claim is denied because a Medicare review contractor determines that the inpatient admission was not reasonable and necessary under 42 U.S.C. § 1395y(a)(1)(A). Centers for Medicare & Medicaid Services (CMS) has been advised by stakeholders that the hospitals appear to be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays that may later be denied upon contractor review by electing to treat beneficiaries as outpatients receiving observation services for long periods of time, rather than admitting them as inpatients. These hospitals believe that Medicare's standards for inpatient admission were not clear.[9]

In response to this concern, the Secretary proposed clarifications and changes regarding hospital payment under both Part A and Part B. The Secretary proposed to revise Part B inpatient payment policy to allow payment under Part B for all hospital services that furnished and were reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted as an inpatient. This policy would apply when a Medicare Part A hospital inpatient claim was denied or when a hospital determines after a discharge that the inpatient visit was not

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Federal rate plus 75% of the amount by which the Federal rate is exceeded by the highest of its FY 1982, FY 1987 or FY 2002 hospital-specific rate. *See* 78 Fed. Reg. 50496, 50509 and 50987 (August 19, 2013). The MDH provision was to expire on 9/30/2013; however, the Bipartisan Budget Act of 2013, P.L. 113-67, § 1106 amended 42 U.S.C. § 1395ww(d)(5)(G), extended the deadline to April 1, 2014.

[4] *See* 78 Fed. Reg. 50496, 50746-54 (August 19, 2013).

[5] More specifically see 78 Fed. Reg. at 50949 (The Secretary believes that *all* hospitals, LTCHs and CAHs, with the exception of IRFs, would appropriately be included in our final polices regarding the 2-midnight admission guidance and medical review criteria for determining the general appropriateness of inpatient admission and Part A payment. (emphasis added)).

[6] of the Department of Health and Human Services.

[7] 77 Fed. Reg. 45061, 45155-45157 (July 30, 2012) and the final rule with comments, 77 Fed. Reg. 68,210, 68426-68433 (November 15, 2012).

[8] *78 Fed. Reg.* at 50907.

[9] *Id.*

reasonable and necessary. The timely filing restrictions for Part B billing were not changed (claims must be filed within 1 year from the date of service).[10]

Medicare Part A

In addition, the Secretary reviewed hospital inpatient status criteria to improve CMS' policies governing when a Medicare beneficiary should be admitted as an inpatient and how hospitals should be paid for associated costs. The Medicare Benefit Policy Manual[11] states that the typical decision to admit a beneficiary as an inpatient should be made within 24 to 48 hours after observation care and that an overnight stay may be a factor in the admission decision. Physicians should use the 24-hour or overnight period as a benchmark, i.e., they should order admission for patients who are expected to need care for 24 hours or overnight. Generally, a beneficiary is considered an inpatient if formally admitted with the expectation that he or she will remain in the hospital overnight, whether or not there is a later transfer or discharge and the patient is not present overnight. Only rarely and in exceptional cases do reasonable and necessary observation services span more than 48 hours. Length of stay is not the basis for payment and it is the physician responsible for patient care who decides if the patient should be admitted.[12]

In the Federal fiscal year (FFY) 2014 IPPS proposed rule[13] the Secretary proposed a new benchmark for purposes of medical review of hospital inpatient admissions (Medicare Part A payment). Under this proposal, beneficiaries who were expected to remain in the hospital to receive medically necessary care surpassing 2-midnights after the initiation of care would generally be appropriate for inpatient admission and inpatient payment (known as the "2-midnight rule"). Medicare contractors were to consider all the time after the initiation of care at the hospital in applying the benchmark that inpatient admissions are generally reasonable and necessary (as long as a hospital was not prolonging the provision of care to surpass the 2-midnight timeframe).[14]

Medicare Part B

In the final IPPS rule, the Secretary noted there had been an increasing number of cases in which hospitals had appealed Part A inpatient claim denials in which it was determined the inpatient admission was not reasonable or necessary. These claims had received partial favorable treatment by the Medicare Appeals Council or Administrative Law Judges (ALJs). In those cases, the Medicare review contractor determinations that the inpatient admission was not reasonable or necessary was upheld, but the Medicare Appeals Council and ALJ decisions ordered payment of the services as if they were rendered in an outpatient or observation level of care. These decision effectively required Medicare to issue payment for all Part B services that would have been payable had the patient been treated as an outpatient (rather than an inpatient). In addition, these payments were made whether the subsequent hospital claim for payment was made within the applicable time limit for filing Part B claims. The Secretary pointed out that this

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[10] *Id.*
[11] Chapter 6, §20.6 and Chapter 1, §10.
[12] 78 Fed. Reg. at 50907-08.
[13] *See generally* 78 Fed. Reg. 27486 (May 10, 2013).
[14] 78 Fed. Reg. 50908.

was contrary to longstanding polices that permit billing only for a limited list of Part B inpatient services and require the services be billed within specific timeframes.[15]

As a result of the number of these administrative adjudications, the CMS Administrator issued CMS Ruling CMS-1455-P[16] (the Ruling) which established a standard process for effectuating the decisions granting Part B coverage. Among other things, where the administrative adjudicator had issued an order for payment under Medicare Part B, the request for Part B payment would not be rejected if more than one year had elapsed (the time period for filing Part B claims), if the Part A claim had been submitted timely. The Ruling was to remain in effect until the effective date of regulations that finalized "proposed rule CMS-1455-P." In the August 19, 2013 Federal Register, the Secretary revised the Part B inpatient payment policy to allow payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require outpatient status.[17] The one-year deadline for filing claims remains unchanged and the Secretary stated that she was not creating an exception to this requirement (as found in 42 C.F.R. § 424.44(b)(1)-(4)) even though the contractor claims review and appeal process could exceed the 1-year filing period.[18]

The 2-Midnight Rule

In the final IPPS rule, the Secretary pointed out that CMS had established policy that recognized that there were certain situations in which an inpatient hospital admission was rarely appropriate. This IPPS rule included instructions that provided a benchmark to ensure that all beneficiaries receive consistent application of their Part A benefits to whatever clinical services were medically necessary.[19]

Due to persistently large, improper payment rates for short-stay hospital inpatient claims, and, in response to requests to provide additional guidance regarding proper billing of those services, the Secretary proposed to modify and clarify 42 C.F.R. § 412.3(c)(1). This regulation designates services that are inpatient only (without regard to duration of care), surgical procedures, diagnostic tests and other treatments that would be appropriate for inpatient admission and inpatient payment under Medicare Part A when the physician expects the beneficiary to require a stay that crosses 2 midnights and admits the beneficiary based on that expectation. The starting point for this 2-midnight instruction would be when the beneficiary is moved from any outpatient area to a bed in the hospital in which additional services would be provided and is based on the judgment of the physician and the physician order (the physician must certify that the inpatient services were medically necessary).[20] The Secretary maintains that she has consistently provided physicians with a time-based admission framework to effectuate appropriate inpatient hospital admission decisions.[21]

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[15] *Id.*
[16] *See* 78 Fed. Reg. 16614 (March 18, 2013) and on the internet at http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings.html.
[17] 78 Fed. Reg. at 50909.
[18] *Id.* at 50927.
[19] *Id.* at 50944.
[20] *Id.*
[21] *Id.* at 50945.

The Secretary's actuaries estimated that the 2-midnight rule would increase IPPS expenditures by approximately $220 million. These additional expenditures would result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving from OPPS [outpatient PPS] to IPPS and some encounters of less than 2 midnights moving from IPPS to OPPS. The actuaries estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient from the approximately 11 million encounters paid under IPPS. This shift of 40,000 encounters represents an increase of approximately 1.2 percent in the number of shorter stay hospital inpatient encounters paid under IPPS. This additional expenditure would be partially offset by reduced expenditures from the shift of shorter stay hospital encounters to hospital outpatient encounters. The actuaries estimated that, on average, the per encounter payments for these hospital outpatient encounters would be approximately 30 percent of the per encounter payments for the inpatient encounters. In light of the impact of the 2-midnight rule on IPPS and the systematic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, the Secretary decided it was appropriate to use her exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i) to offset the $220 million in additional IPPS expenditures associated with the 2-midnight policy. Consequently, the standardized amount was reduced by 0.2 percent.[22] The Secretary made the same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[23]

Providers' Request for EJR

The Providers request that the Board grant EJR with respect to the correction of their Medicare payment rates per discharge for operating and capital-related costs of IPPS services furnished in FFY 2014 relative to the 2-midnight rule. The Providers are not contesting the coverage change, but contend that, even if the coverage change is appropriate, the payment reduction should be set aside because it exceeds the Secretary's statutory authority under the PPS statute,[24] is contrary to the plain language and intent of the statue, and is arbitrary, capricious, not based on substantial evidence, and otherwise contrary to the law. *See* 5 U.S.C. § 706.

Background

Under both inpatient and capital PPS, Medicare pays prospectively-established rates for each patient case. In addition to a base payment rate per discharge, payment adjustments are provided for extraordinary costly "outlier" cases, indirect medical education costs and costs for treating a disproportionate share of low-income patients. 42 U.S.C. § 1395ww(d).

Under PPS for operating costs, the payment per discharge is the product of the national payment rate, called the standardized amount, a "wage index" value reflecting labor costs in each hospital's area relative to a national average, and a weighting for the diagnosis related group (DRG) assigned to the patient's illness or condition for that discharge. The statute prescribes the calculation of the base rate—the standardized amount—in precise detail, specifically detailing what the rate "is equal to" for a fiscal year based on specific, precisely defined determination that

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[22] *Id.* at 50952-53.
[23] *Id.* at 50990.
[24] 42 U.S.C. §§ 1395ww(d) (inpatient PPS),1395ww(g) (capital PPS).

the Secretary "shall" make. 42 U.S.C. § 1395ww(d)(1) (the capital PPS amount is similarly based on a Federal payment per discharge that is established in 42 U.S.C. § 1395ww(g)).

The standard payment rate is subject to several upward payment adjustments and exceptions for special cases that are extraordinary costly (outliers) and for particular categories of hospitals that reasonably incur high than average costs per case (for example, graduate medical education and disproportionate share hospitals). In addition, the statute exempts some types of hospitals (sole community and Medicare dependent hospitals) from the standard payment rate so they may receive greater payment based on their own "hospital-specific" cost per discharge. 42 U.S.C. §§ 1395ww(d)(5)(D) & (G). The statute also grants the Secretary authority to establish other appropriate adjustments and exceptions by regulations. 42 U.S.C. § 1395ww(d)(5)(I). Congress enacted that provision to permit additional adjustments and exceptions, for special cases or discrete types of hospitals with special circumstances to ensure payment equity in the IPPS payment system. *See* H.R. Rep. No 98-47, 195 (1983 (Conf. Rep.) *reprinted in* 1983 U.S.C.C.A.N. 404, 485.

The 0.2% Payment Rate Reduction

The Providers believe that the 0.2% reduction exceeds the Secretary's authority. The statute precisely prescribes the calculation of the standardized amount for operating costs, 42 U.S.C. §§ 1395ww(d)(1), (3), the federal rate for capital costs, *id.* § 1395ww(g), and the hospital specific rates for sole community and Medicare dependent hospitals, *id.* § 1395ww(d)(5)(D) and (G), and those provisions do not provide or allow for the Secretary's 0.2% reduction. The 0.2% reduction also exceeds the Secretary's authority to adopt additional adjustments and exceptions under section 1395ww(d)(5)(I), and violates the language and intent of that provision and the IPPS statute as a whole. 42 U.S.C. §§ 1395ww(d).

The Providers believe the 0.2% reduction is also arbitrary and capricious, and is not a reasonable interpretation of the statute because it constitutes an unacknowledged and unexplained departure from the Secretary's prior, more limited application of the adjustments and exceptions authority under section 1395ww(d)(5)(I). The Secretary has never before interpreted that section to effect a global payment rate reduction that applies across the board to all cases, all types of hospitals, and to both prospective payment rates for operating and capital costs as well as the hospital-specific rate for exception hospitals

Further, the Providers do not believe the Secretary provided an adequate explanation of a justification for the across the Board reduction in the payment rate per discharge. They do not believe there is an adequate explanation for the 0.2% reduction. In particular, the Providers do not believe the Secretary has adequately explained how the agency derived the estimates that were used to calculate the 0.2% reduction.

Since the Board lacks the authority to grant the relief sought—elimination of the 0.2% reduction— the Providers request that the Board grant the request for EJR.

Decision of the Board

The Board has reviewed the submissions of the Providers pertaining to the requests for hearing and expedited judicial review. The documentation shows that the estimated amount in

controversy for each appeal exceeds $50,000, as required for a group appeal. The estimated amount in controversy is subject to recalculation by the Medicare Administrative Contractor for the actual final amount.

The Board finds that:

1) it has jurisdiction over the matter for the subject year and the Providers are entitled to a hearing before the Board;

2) based upon the Providers' assertions regarding the 0.2 percent reduction to the standardized amount, the hospital specific rate for some SCH and MDH hospitals and Federal rate of capital cost issues, there are no findings of fact for resolution by the Board;

3) it is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

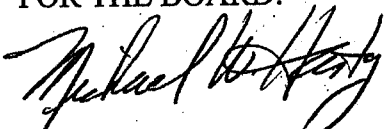
4) it is without the authority to decide the legal question of whether the Secretary's 0.2 percent reduction to the standardized amount, the hospital specific rate for some SCH and MDH hospitals, and Federal rate of capital cost issues, is valid.

Accordingly, the Board finds that the 0.2 percent reduction issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for expedited judicial review for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the cases.

Board Members Participating

Michael W. Harty
John Gary Blowers, 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. § 405.1877 and 405.1877
List of PPS Rate Reduction Groups, Schedules of Providers

cc: Kyle Browning, NGS (w/Schedules of Providers)
Danene Hartley, NGS (w/Schedules of Providers)
Geoff Pike, First Coast Service Options (w/Schedules of Providers)
Bruce Snyder, Novitas (w/Schedules of Providers)
Donna Kalafut, Noridian Healthcare Solutions (w/Schedules of Providers)
Byron Lamprecht, WPS (w/Schedules of Providers)
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James Ward, Noridian Healthcare Solutions (w/Schedules of Providers)
Cecile Huggins, Palmetto GBA (w/Schedules of Providers)
Kevin Shanklin, BCBSA (w/Schedules of Providers)

PPS Rate Reduction Groups

Case No.	Group Name	Intermediary	MAC Code
14-1886GE	Akin Gump 2014 PPS Rate Reduction Group	National Government Services, Inc.	J-K
14-1888EGC	Allina Health 2014 PPS Rate Reduction CIRP	National Government Services, Inc.	J-6
14-1891EGC	BayCare Health System 2014 PPS Rate Reduction CIRP	First Coast Service Options, Inc. - FL	J-9
14-1892EGC	Barnabas Health 2014 PPS Rate Reduction CIRP	Novitas Solutions, Inc.	J-L
14-1894EGC	Baptist Health South Florida 2014 PPS Rate Reduction CIRP	First Coast Service Options, Inc. - FL	J-9
14-1896EGC	Daughters of Charity 2014 PPS Rate Reduction CIRP	Noridian Healthcare Solutions, LLC	J-E
14-1898EGC	Crozer-Keystone Health System 2014 PPS Rate Reduction CIRP	Novitas Solutions, Inc.	J-L
14-1899EGC	CoxHealth 2014 PPS Rate Reduction CIRP	Wisconsin Physicians Service	J-5
14-1900EGC	Catholic Health System 2014 PPS Rate Reduction CIRP	National Government Services, Inc.	J-K
14-1902EGC	Catholic Health Services of Long Island 2014 PPS Rate Reduction CIRP	National Government Services, Inc.	J-K
14-1904EGC	Catholic Health Initiatives 2014 PPS Rate Reduction CIRP	Novitas Solutions, Inc.	J-H
14-1906EGC	Cape Cod Healthcare 2014 PPS Rate Reduction CIRP	National Government Services, Inc.	J-K
14-1912EGC	Integris Health 2014 PPS Rate Reduction CIRP Group	Novitas Solutions, Inc.	J-H
14-1916EGC	Legacy Health 2014 PPS Rate Reduction CIRP Group	Noridian Healthcare Solutions, LLC	J-F
14-1917EGC	Dignity Health 2014 PPS Rate Reduction CIRP	Noridian Healthcare Solutions, LLC	J-E
14-1919EGC	Duke University Health System 2014 PPS Rate Reduction CIRP	Palmetto GBA	J-11
14-1921EGC	Geisinger Health System 2014 PPS Rate Reduction CIRP	Novitas Solutions, Inc.	J-L
14-1922EGC	Lehigh Valley Health Network 2014 PPS Rate Reduction CIRP Group	Novitas Solutions, Inc.	J-L
14-1923EGC	Georgetown Hospital System 2014 PPS Rate Reduction CIRP	Palmetto GBA	J-11
14-1924EGC	Medisys Health Network 2014 PPS Rate Reduction CIRP Group	National Government Services, Inc.	J-K
14-1925EGC	Iasis Healthcare 2014 PPS Rate Reduction CIRP	Noridian Healthcare Solutions, LLC	J-F
14-1926EGC	Inova Health System 2014 PPS Rate Reduction CIRP	Palmetto GBA	J-11
14-1927EGC	Memorial Healthcare System 2014 PPS Rate Reduction CIRP Group	First Coast Service Options, Inc. - FL	J-9
14-1928EGC	Memorial Hermann Health System 2014 PPS Rate Reduction CIRP Grou	Novitas Solutions, Inc.	J-L
14-1929EGC	Methodist Health System 2014 PPS Rate Reduction CIRP Group	Novitas Solutions, Inc.	J-L
14-1930EGC	BJC Health System 2014 PPS Rate Reduction CIRP Group	Wisconsin Physicians Service	J-5
14-1931EGC	Orlando Health 2014 PPS Rate Reduction CIRP Group	First Coast Service Options, Inc. - FL	J-9
14-1932EGC	Yale New Haven Health System 2014 PPS Rate Reduction CIRP Group	National Government Services, Inc.	J-K
14-1933EGC	Prospect Medical Holdings 2014 PPS Rate Reduction CIRP Group	Noridian Healthcare Solutions, LLC	J-E
14-1935EGC	UPMC 2014 PPS Rate Reduction CIRP Group	Novitas Solutions, Inc.	J-L
14-1936EGC	Providence Health and Services 2014 PPS Rate Reduction CIRP Group	Noridian Healthcare Solutions, LLC	J-E
14-1940EGC	Univ. of Rochester Medical Center 2014 PPS Rate Reduction CIRP Grou	National Government Services, Inc.	J-K
14-1941EGC	Summit Health 2014 PPS Rate Reduction CIRP Group	Novitas Solutions, Inc.	J-L
14-1943EGC	St. Luke's Health System 2014 PPS Rate Reduction CIRP Group	Wisconsin Physicians Service	J-5
14-1952EGC	Spartanburg Regional 2014 PPS Rate Reduction CIRP Group	Palmetto GBA	J-11
14-1954EGC	Southern Illinois Healthcare 2014 PPS Rate Reduction CIRP Group	National Government Services, Inc.	J-6
14-1955EGC	Sentara Healthcare 2014 PPS Rate Reduction CIRP Group	Palmetto GBA	J-11
14-1956EGC	Schuylkill Health System 2014 PPS Rate Reduction CIRP Group	Novitas Solutions, Inc.	J-L
14-1972EGC	Centra Health 2014 PPS Rate Reduction CIRP Group	Palmetto GBA	J-11
14-1973EGC	Catholic Health East - Trinity 2014 PPS Rate Reduction CIRP Group	Wisconsin Physicians Service	J-5
14-2069GE	Akin Gump 2014 PPS Rate Reduction Group 2	Novitas Solutions, Inc.	J-L
14-2073EGC	Theda Care 2014 PPS Rate Reduction CIRP Group	National Government Services, Inc.	J-6
14-2214EGC	St. Luke's University Health Network 2014 PPS Rate Reduction CIRP Gro	Novitas Solutions, Inc.	J-L
14-2233EGC	Circle Health 2014 PPS Rate Reduction CIRP Group	National Government Services, Inc.	J-K

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Refer to:

MAR 24 2014

CERTIFIED MAIL

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Donna Kalafut
JE Part A Appeals Coordinator
Noridian Healthcare Solutions, LLC
P.O. Box 6782
Fargo, ND 58108-6782

RE: Starcare 89-95 Outlier Payments Group
PRRB Case No. 97-2232G

Dear Mr. Weiss and Ms. Kalafut:

The Provider Reimbursement Review Board (Board) has reviewed the record in the above-referenced case. The sole issue in this case is "[w]hether the Medicare outlier payments were determined in accordance with the Federal statutes Title 42 U.S.C. Section 1395ww(d)(5)(A)(iv)."[1] The Board has considered on its own motion whether expedited judicial review (EJR) is appropriate for this matter.[2]

BACKGROUND

A. Outlier Payments

This appeal challenges the computation of "outlier payments," which are designed to compensate Medicare Part A providers for the care of beneficiaries with abnormally high treatment costs.[3] The method for calculating outlier payments is established by statute and refined through regulations promulgated by the Secretary of Health and Human Services ("the Secretary"). Statue requires the Secretary to prospectively establish "outlier thresholds" to determine which situations are appropriate for outlier payment.[4] Under this framework, the total projected outlier payments made in a given fiscal year

[1] *See* Initial Request for Hearing – Group Appeal, dated April 8, 1997 at 1. This language was used repeatedly to transfer claims into the present group.

[2] *See* 42 C.F.R. § 405.1842(c).

[3] 42 U.S.C. § 1395ww(d)(5)(A).

[4] *Id.*

will "not be less than 5 percent nor more than 6 percent of the total payment projected ... based on [Inpatient Prospective Payment] rates for discharges in that year."[5] Each year, the Secretary issues a regulation that sets forth the projected outlier payment thresholds.[6]

B. Case No. 97-2232G

The current appeal group was formed in April 1997 through the transfer of two providers from various individual appeals. Since that time, a number of providers have been added and withdrawn from the case. At present, the Schedule of Providers indicates that the appeal is comprised of seventeen (17) cost reporting year claims, brought by seven (7) providers.

The group frames its appeal as a question of, "[w]hether the Medicare outlier payments were determined in accordance with the Federal Statutes Title 42 U.S.C. Section 1395ww(d)(5)(A)(iv)."[7] The group representative, Starcare International, believes that the Secretary's methodology in determining outlier payment amounts was flawed in a number of ways, as reflected in its claim that aggregate payments for the cost reporting years in question was not greater than five percent of the total payments. The representative further refines its case as follows: "[b]ecause the outlier methodology is contained in the Secretary's regulations and addenda thereto, [the] challenge is, in essence, a challenge to the Secretary's regulations."[8]

C. Expedited Judicial Review

In situations where the Board finds that it has jurisdiction over an appeal but lacks the authority to decide the question at hand, EJR may be an appropriate remedy.[9] EJR may be granted at the request of the parties or by the Board's own motion. Where the Board undertakes an EJR consideration on its own volition, program regulations state that the Board must provide a written notice to the parties identifying the specific matter(s) at issue for which the Board is considering EJR, and provide an opportunity for the parties to submit a written response.[10]

By letter dated May 31, 2006, the Board provided notice to the parties that it was considering issuing a determination on its own motion that EJR is appropriate because it

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[5] *Id.*

[6] *See, e.g.*. MEDICARE PROGRAM; CHANGES TO HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEMS AND FISCAL YEAR 1993 RATES, 57 Fed. Reg. 23618, 23633 (June 4, 1992) (noted by Group Representative in multiple transfer letters, *infra* note 7).

[7] *Supra* note 1. *See also, e.g.,* Schedule of Providers, Tab 14G, December 1, 1998 letter from Representative to Board transferring Mark Twain Hospital claim to Group Appeal ("Transfer Letters") at 1.

[8] Transfer Letters at 2.

[9] *See* 42 U.S.C. § 1395oo(f)(1).

[10] 42 C.F.R. § 405.1842(c).

lacks the authority to decide the question of whether [the] Secretary's failure to pay the full amount of outlier payments was arbitrary and capricious. The letter also requested that both parties file comments regarding this proposed action within 30 days. Neither party provided comments in response to the Board's request letter.

JURISDICTION

A. Hoag Memorial Hospital (Participant Nos. 11, 12, 13)

The most recent Schedule of Providers lists three claims by Hoag Memorial Hospital ("Hoag"), covering cost reporting years 1990, 1991 and 1992. Pertinent facts related to the initial individual appeals and transfer requests for these participants are identified below:

	FYE 9/15/1990	FYE 9/14/1991	FYE 9/12/1992
Individual Case No.	93-0294	94-2287	95-0210
Individual Hearing Request Filed	12/11/1992	3/16/1994	11/10/1994
Individual Case Closed	4/20/1995	5/22/1996	8/24/2000
Reason for Closure	Withdrawal	Dismissal[11]	Withdrawal
Request to Join Case No. 97-2232G[12]	4/8/1997	4/8/1997	4/8/1997
Request to Join Case No. 98-1010G[13]	6/9/1998	6/9/1998	n/a
Request to transfer issue from Case No. 97-2232G to 98-1010G[14]	9/13/1999	9/13/1999	9/13/1999

In a jurisdictional challenge filed October 13, 2003, the Intermediary indicated that fiscal years 1990 and 1991 were denied transfer to the group appeal.[15] The MAC also noted that the Provider appeared as a participant within Case No. 98-1010G for all three fiscal

[11] Case No. 94-2287 was dismissed due to the Provider's failure to timely file its preliminary position paper.

[12] The Provider was one of the two initial participants to request the formation of this group. The group appeal request referenced all three fiscal years and individual case numbers, but this request was not initially associated with the individual case files.

[13] On June 23, 1998, the Board sent letter denying the request for transfer from the 1990 and 1991 individual appeals to Case No. 98-1010G because the individual cases were in a closed status at the time of the request. A similar determination has not been made with respect to the earlier transfer requests to Case No. 97-2232G.

[14] Case No. 98-1010G was subsequently closed on March 28, 2008 pursuant to a withdrawal request.

[15] Although the Intermediary indicates that the transfer denials were to the current case, Case No. 97-2232G, the Board's records indicate that the denials were specific to Case No. 98-1010G.

periods. In the MAC's position paper filed in 2006, the MAC stated that the individual appeal for FY 1990 was closed prior to the Provider's April 8, 1997 request to add the issue and transfer to Case No. 97-2232G. The MAC also stated that it did not have sufficient documentation to fully evaluate Hoag's inclusion within the group for the subsequent two periods.[16]

On November 18, 2003, the Provider's representative responded to the Intermediary's initial jurisdictional challenge. The Provider contended that all three fiscal years were properly transferred to this group appeal by letter dated April 8, 1997. The Provider also indicated that it had no knowledge of transfer denials or duplicate transfers to Case No. 98-1010G, and requested copies of the letters referenced by the Intermediary. The Provider did not respond to the jurisdictional concerns raised in the Intermediary's final position paper, but did submit additional supporting documentation in response to a Board request dated May 31, 2006.

The Board finds that for fiscal years 1990 and 1991, the initial transfers from the individual cases, Case Nos. 93-0294 and 94-2287, were both invalid as the individual cases were closed prior to the April 8, 1997 request to transfer to the group appeal, Case No. 97-2232G. Thus, the transfers are hereby denied and Hoag Memorial Hospital is dismissed from the group for fiscal years 1990 and 1991.

With regard to fiscal year 1992, the individual case was still active at the time of the initial transfer to Case No. 97-2232G and, therefore, the transfer was timely. However, the Provider subsequently requested that the facility's outlier claims be transferred to another, completely separate outlier appeal group: "Through this letter, the Provider is transferring the Outlier Issue from the Starcare International Outlier Group, Case No. 97-2232G, to the National Outlier Group Appeal, PRRB Case No. 98-1010G."[17] The Board hereby formally acknowledges the Provider's group to group transfer request and dismisses Hoag Memorial Hospital from Case No. 97-2232G for fiscal year 1992.

B. Davies Medical Center (Participant Nos. 6, 7, 8, 9)

The most recent Schedule of Providers lists four claims raised by Davies Medical Center ("Davies"), covering cost reporting years 1990 – 1993. While the Intermediary did not raise a formal jurisdictional challenge regarding these participants, the Board notes that via letter dated July 7, 2006, it has already denied the attempt to transfer Davies' outlier claims for fiscal years 1990 – 1993 into the present group appeal. At that time, the Board noted that Davies had previously withdrawn these claims and the underlying individual appeals were closed between 1998 and 2000. As Davies' outlier claims were not actively

[16] The record includes documentation of the group representative's attempts to obtain jurisdictional documentation via the Freedom of Information Act. *See* Schedule of Providers, tabs 11-13.

[17] *See* letter from Hoag Memorial Hospital to Board, September 13, 1999.

pending before the Board in 2006, the Board denied the requested transfers. The Board hereby reiterates its previous transfer denial decision and dismisses Davies Medical Center from Case No. 97-2232G for fiscal years 1990, 1991, 1992, and 1993.

C. Current Appeal Group Composition

Upon dismissal of the claims raised by Hoag and Davies, the appeal group is comprised of the following remaining participants:

	Provider	FYE	Original Case
1.	Dameron Hospital	12/31/1989	92-2209
2.	Dameron Hospital	12/31/1990	93-1339
3.	Dameron Hospital	12/31/1991	94-1971
4.	Dameron Hospital	12/31/1992	95-1814
5.	Dameron Hospital	12/31/1993	96-2173
10.	Good Samaritan	12/31/1993	97-0233
14.	Mark Twain District Hospital	8/31/1990	93-0294
15.	Mark Twain District Hospital	12/31/1992	95-1515
16.	St. Agnes Medical Center	5/31/1993	96-2050
17.	Community Hospital of San Buenaventura	12/31/1995	98-2514

The remaining providers in the group have each raised claims stemming from their respective notices of program reimbursement, the amount in controversy exceeds the statutory threshold, and each claim was timely raised within the underlying appeals and properly transferred to the group appeal. Thus, the Board finds that it has jurisdiction of the remaining Providers.

DECISION OF THE BOARD REGARDING EXPEDITED JUDICIAL REVIEW

Based on a review of the record in Case No. 97-2232G, the Board finds that:

1) it has jurisdiction over the matter for the subject years, pursuant to the specific participant dismissals noted above, and the Providers are entitled to a hearing before the Board;

2) based upon the Providers' assertions regarding the nature of the appeal, there are no findings of fact for resolution by the Board;

3) the Board is bound by the applicable existing Medicare law regarding outlier payments (42 U.S.C. § 1395ww(d)(5)(A)) and the regulations promulgated by the Secretary regarding projected outlier payment thresholds;

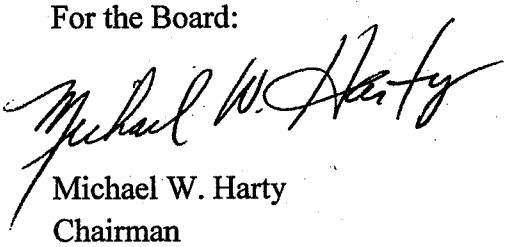
4) the Board is without authority to decide the legal question of whether the Medicare outlier payment methodology contained in the Secretary's regulations was valid and determined in accordance with 42 U.S.C. Section 1395ww(d)(5)(A)(iv).

The Board therefore finds that the group appeal properly falls within the provisions of 42 U.S.C. §1395oo(f)(1) and grants expedited judicial review for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review.

As this matter is the only issue under dispute, the Board hereby closes the underlying appeal. Review 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

ENCLOSURE: Schedule of Providers (January 16, 2006)

CC: Kevin D. Shanklin
Executive Director
Senior Government Initiatives
Blue Cross Blue Shield Association
225 North Michigan Avenue
Chicago, IL 60601-7680

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CERTIFIED MAIL

MAR 25 2014

Thomas P. Knight, CPA
Toyon Associates, Inc.
1800 Sutter Street, Suite 600
Concord, CA 94520

RE: Provider: Natividad Medical Center as a participant in "Toyon 90-94 DSH SSI Ratio Group"
Provider No: 05-0248
FYE: 06/30/1995
PRRB Case No.: 98-2853G

Dear Mr. Knight:

The Provider Reimbursement Review Board (PRRB or Board) has reviewed the Schedule of Providers and the associated jurisdictional documents incident to its review of the group appeal which is subject to remand pursuant to CMS Ruling 1498-R. The jurisdictional decision of the Board with respect to Provider# 45, Natividad Medical Center (Provider No. 05-0248, FYE 06/30/95), included on the final Schedule of Providers, is set forth below.

Background

On September 23, 1997, a Notice of Program Reimbursement (NPR) was issued to the Provider, Natividad Medical Center, provider number 05-0248, for the cost reporting period ending June 30, 1995. On February 18, 1998, the Provider filed an appeal of the NPR challenging Medicare Settlement Data, DSH SSI ratio, Outlier payment, Medi-Cal days, Federal DRG payments, Indirect Medical Education, Medicare Bad Debts, Reverse Net Down of Total Physicians' Charges, Ambulatory Care Administration Expenses and B-1 Cost Finding Statistics, Malpractice Insurance Premiums and Emergency Room EMSF Overhead Recovery Grant Revenue. The Board assigned case number 98-1051 to the case. On May 27, 2004, the Provider requested to transfer the SSI ratio issue from case number 98-1051 to case number 98-2853G.

On March 18, 2014, the Board remanded the SSI ratio issue in a separate appeal, PRRB case number 04-2012G. The Provider, Natividad Medical Center (Provider number 05-0248, FYE 6/30/95), was one of the Providers for which the issue was remanded.

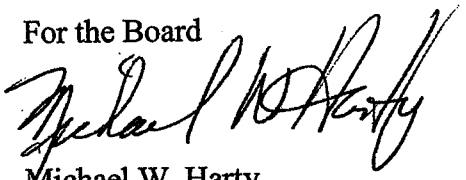
Decision of the Board

Since the SSI ratio issue has already been remanded for this Provider in case number 04-2012G, the Board hereby dismisses Natividad Medical Center (Provider No. 05-0248, FYE 06/30/95) from case number 98-2853G.

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
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PROVIDER REIMBURSEMENT REVIEW BOARD
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Refer to: 07-2884GC

CERTIFIED MAIL

MAR 25 2014

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RE: Jurisdiction Decision – Northridge Hospital Medical Center as part of CHW 2000 DSH SSI Ratio CIRP Group
Provider No.: 05-0299
FYE: 12/31/2000
PRRB Case No.: 07-2884GC

Dear Mr. Bunting and Ms. Kalafut,

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

Northridge Hospital Medical Center was issued a revised Notice of Program Reimbursement (NPR) for FYE 12/31/2000 on August 3, 2007. On September 6, 2007, the Provider filed an appeal request with the Board appealing the following issue: accuracy of the SSI% provided by CMS and used by the Intermediary for calculating the Disproportionate Share Hospital (DSH) amounts. Finally, on October 24, 2007, the Provider requested to transfer the SSI% issue to the CIRP group appeal in case number 07-2884GC.

Board's Decision

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 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 the notice of the Intermediary's determination was mailed to the provider. However, before the Board can make a determination over all matters covered by the cost report, it must first determine that the Provider has filed a jurisdictionally valid appeal.

Although the Intermediary did not file a jurisdictional challenge, the Board nonetheless finds that it does not have jurisdiction over this Provider's appeal because the Provider appealed from a revised

NPR in which the only issue on appeal, the SSI%, was not adjusted. The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2002) 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 of 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, as the case may be, either on motion of such intermediary officer or panel of hearing officers, Board, or Secretary, or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings.

In accordance with 42 C.F.R. § 405.1889, a revised NPR is considered a separate and distinct determination from which the provider may appeal. The regulation provides:

> 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, 405.1835, 405.1875 and 405.1877 are applicable.

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.

Here, the Provider's audit adjustment report associated with the August 3, 2007 revised NPR shows that Medicaid days were adjusted on Worksheet S-3 and a corresponding adjustment was made to the DSH payment on W/S E Part A. Neither the adjustment report, nor the other documents in the record support that the actual SSI% was adjusted. Because the record does not support that the SSI%, a separate and distinct component of the DSH payment was specifically adjusted in the revised NPR, the Board finds that it does not have jurisdiction over Northridge Hospital Medical Center. This Provider is hereby dismissed from case number 07-2884GC.

Review of this determination may be 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
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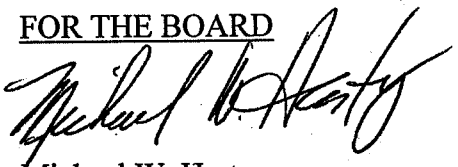
FOR THE BOARD



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
cc: Kevin D. Shanklin, BCBSA