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

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

Refer to:

CERTIFIED MAIL

MAY 01 2014

Tenet Healthcare Corporation
John M. Maguire
Manager, Appeals
1445 Ross Avenue, Suite 1400
Dallas, TX 75202 2703

RE: Tenet 2007 DSH SSI Proxy CIRP Group, Case No. 09-0032GC

Requests to transfer:
Metro West Hospital (22-0175) from individual appeal, 13-0645;
St. Vincent Hospital (22-0176) from individual appeal, 13-0746; and
West Valley Hospital (03-0642) from individual appeal 13-0647

Dear Mr. Maguire:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeals in response to your January 27, 2014 requests to transfer the SSI Part C Days issue from the individual appeals to the subject group appeal. The pertinent facts of the cases, a review of participants in the group and the Board's determination are set forth below.

Pertinent Facts:

The Tenet 2007 SSI DSH Proxy group appeal was filed on 10/03/2008. The group issue statement described the issue in dispute as:

> "... whether the published SSI percentage rate for the Federal Fiscal Year 2007 includes all eligible SSI patients."

The original participant used to form the group, RHD Memorial Medical Center (45-0379), filed from an original Notice of Program Reimbursement (NPR) dated April 30, 2008.

On November 24, 2008 (received on 11/28/2009), January 9, 2009 (received on 1/12/2009), February 9, 2009 (received on 2/17/2009) and March 9, 2009 (received on 3/16/2009), Tenet filed Requests to Join an Existing Group Appeal, Direct Appeal From Final Determination (Direct Add Requests) impacting 27 providers.[1]

Between January 3, 2013 and March 20, 2013, Tenet filed five more Direct Add Requests impacting 18 more providers.[2] The NPRs in dispute for these providers were issued after the issuance of CMS Ruling 1498-R (Ruling) which revised the published SSI Percentages.[3]

---

[1] See enclosed copies of Schedules of Providers in Groups (pre-Ruling).
[2] See enclosed copies of Schedules of Providers in Groups (post-Ruling).
[3] CMS Ruling 1498-R became effective on April 28, 2010.

The description of the issue on the Direct Add Requests listed the issue as "Inclusion of correct DSH SSI Proxy on Cost Report" and included the participants listed below:

- **Direct Add dated 1/03/2013, (received 1/9/2013)**
  Participant: 19-0204
- **Direct Add dated 1/29/2013, (received 2/4/2013)**
  Participant: 45-0656
- **Direct Add dated 2/08/2013, (received 2/25/2013)**
  Participants: 45-0716, 39-0290, 26-0105, 05-0693, 10-0183, 39-0285, 11-0031, 11-0198, 45-0885, 45-0742, 42-0089, 10-0268, 10-0210, 45-0659
- **Direct Add dated 4/25/2013, (received 4/29/2013)**
  Participant: 05-0158
- **Direct Add dated 3/20/2013, (received 3/25/2013)**
  Participant: 45-0730
- **Direct Add dated 8/27/2013, (received 8/29/2013)** [4]
  Participants: 05-0230, 05-0588, 39-0304

On January 27, 2014, the Board received Requests to Transfer Issue to a Group Appeal (Transfer Requests) for the "DSH **SSI Part C Days** Issue" (emphasis added) for three providers (Metro West Hospital - case 13-0645; St. Vincent Hospital – case 13-0746 and West Valley Hospital – case 13-0647) to the Tenet 2007 DSH SSI Proxy Group, case number 09-0032GC. The issue statement attached to each Provider's Transfer Request, however, describes the SSI issue in dispute as

> "The Provider specifically contends that Medicare Advantage (MA) days were improperly included in the Medicare/SSI fraction. The Provider contends that once a beneficiary elects **Medicare Part C**, those patient days attributable to the beneficiary should not be include **in the Medicare fraction** of the DSH patient percentage." (emphasis added)

[4] The Schedule of Providers in Group attached to this Direct Add Request was titled "Inclusion of all eligible SSI patients in the SSI Percentage *including the proper treatment of Medicare Part C days.*" (emphasis added) The Board considers this discrepancy to be an administrative error as the Direct Add Request included the same issue description as all other Direct Adds submitted in the group, which stated the issue as "Inclusion of correct DSH SSI Proxy on Cost Report."

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.

CMS Ruling 1498-R – Pre-Ruling/Post-Ruling SSI Proxy Issues:

As noted in the facts above, the Tenet 2007 DSH SSI Proxy CIRP Group (case no. 09-0032GC) was established with a provider that appealed from an NPR that was issued prior to CMS Ruling 1498-R. Between November 24, 2008 and March 9, 2009, twenty seven (27) Providers with pre-Ruling NPRs filed Direct Add Requests to the group.

Subsequently, in letters dated January 3, 2013 through March 20, 2013, twenty one (21) additional participants filed Direct Add Requests that were from NPRs that were issued after the effective date of the Ruling. Because the Ruling affected the published SSI Percentages, the issue in dispute for the Providers that appealed prior to the Ruling are subject to remand to the Medicare Administrative Contractor (MAC) for a recalculated SSI ratio pursuant to the Ruling. However, the participants with appeals filed post-Ruling have received the updated SSI ratios and are not subject to a remand. Therefore, the pre-Ruling SSI issue is different than the SSI issue currently being raised in the post-Ruling cases.

Consequently, the Board is bifurcating case no. 09-0032GC to separate the final determinations in dispute. Enclosed, please find a Notification of Bifurcated CIRP Group assigning case no. 14-3321GC to the post-Ruling participants.[5] Case no. 09-0032GC will remain pending for participants that received NPRs prior to the issuance of the Ruling.

Direct Add Requests:

The Board will allow the following providers that filed Direct Add Requests which describe the issue as "Inclusion of correct DSH SSI Proxy on Cost Report " to the post-Ruling group, case no. 14-3321GC: Northshore Regional Medical Center (19-0204); Nacogdoches Medical Center (45-0656); Cyprus Fairbanks Hospital (45-0716), Hahnemann University Hospital (39-0290); St. Louis University Hospital (26-0105); Irvine Medical Center (05-0693); Coral Gables Hospital (10-0183); Graduate Hospital (39-0285); Spalding Regional Medical Center (11-0031); North Fulton Medical Center (11-0198); Centennial Medical Center (45-0885); Lake Pointe Medical Center (45-0742); East Cooper Medical Center (42-0089); West Boca Medical Center (10-0268); Florida Medical Center (10-0210); Park Plaza Hospital (45-0659); Encino Tarzana Medical Center (05-0158); Trinity Medical Center (45-0730)

---

[5] Novitas Solutions, Inc. (Novitas) has been entered as the lead MAC for the newly established Post-Ruling SSI case based on the Schedules attached to the direct add requests. Providers formerly serviced by TrailBlazer Health Enterprises, LLC (TBHE) are now the responsibility of Novitas.

As noted in footnote 4 above, the Direct Add Request dated August 27, 2013 listed the issue in dispute as Inclusion of correct DSH SSI Proxy on Cost Report " but the attached Schedule of Providers is titled "Inclusion of correct SSI Percentage, including the proper treatment of *Medicare Part C Days.*"(emphasis added) The Board is also transferring these three participants listed on this Schedule of Providers to the post-1498R SSI group, case no. 14-3321GC.

Transfer Requests:

With regard to the Transfer Requests received January 27, 2014 for Metro West Medical Center (case no. 13-0645); St. Vincent Hospital (case no. 13-0746) and West Valley Hospital (case no. 13-0647), the Board finds that the SSI issue raised in the individual appeal request pertains specifically to the inclusion of Medicare Advantage Part C Days in the SSI ratio and includes a companion argument related to the treatment of Medicare Advantage days in the Medicaid Fraction. Specifically, the Providers are appealing the treatment of Medicare Part C Days within the SSI ratio, in addition to the accuracy of the data matching process used to calculate the SSI ratio. The Providers also contend that once a patient elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH percentage, but rather included in the numerator of the Medicaid ratio.

Neither of these issues are the same as that in case no. 09-0032GC, or the newly created post-Ruling SSI Percentage group, case no. 14-3321GC, which both involve the published SSI ratio used in the DSH calculation relating to the data matching process and the availability of data used to calculate the ratio. The Board finds that separate groups must be established for Medicaid-eligible and Medicare Part C patient days since the treatment of these days in the distinct Medicare and Medicaid fractions raises separate questions of fact and interpretation of law, regulations, or CMS Rulings for each fraction with respect to data sources, the timing and validity of CMS' policies, etc. While there may be overlap in the arguments, the exclusion of days from the Medicare fraction may not necessarily translate to an automatic inclusion in the Medicaid fraction.[6] Therefore, the Board is establishing separate group appeals for the Medicare Fraction Part C Days issue to which it has assigned case no. 14-3342GC and the Medicaid Fraction Part C Days issue, to which it has assigned case no. 14-3343GC.[7] Enclosed please find acknowledgment letters for the new groups which include the following participants:
Metro West Medical Center (22-0175); St. Vincent Hospital (22-0176) and West Valley Hospital (03-0642).

---

[6] *See e.g., Metropolitan Hospital v. HHS*, 2013 WL 1223307 (6th Cir. 2013) at 22 ("The exclusion of at least some dual-eligible patient days thus appears to be inevitable based on how Congress has structured the DPP. Because of this inevitability, no explanation was necessary for why the HHS regulation fails to account for all such days, and the lack of such explanation does not render the rulemaking process arbitrary.").

[7] WPS has been entered as the lead MAC for these new group appeals because it was the MAC on the three individual appeals from which the issue was transferred/bifurcated.

Since there are no remaining issues in the individual appeals after the transfers, the Board hereby closes case numbers 13-0645, 13-0647 and 13-0746.

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.

The Parties will receive correspondence regarding the applicability of CMS Ruling 1498-R in case no. 09-0032GC under separate cover shortly.

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

For the Board:

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and .1877
Pre-Ruling Schedules of Providers in Groups
Post 1498-R Schedules of Providers in Groups
Notification of Bifurcated SSI CIRP Group (case nos. 09-0032GC & 14-3321GC)
Group Acknowledgement for Medicare Fraction Part C Days CIRP (14-3342GC)
Group Acknowledgement for Medicaid Fraction Part C Days CIRP (14-3343GC)

cc: Timothy LeJeune, Novitas Solutions, Inc. (lead MAC for 09-0032GC, 14-3321GC)
Byron Lamprecht, Wisconsin Physicians Service (lead MAC for 14-3342GC, 14-3343GC)
Kevin D. Shanklin, Executive Director, BC BS Association

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

FAX: 410-786-5298
Phone: 410-786-2671

Internet: www.cms.gov/PRRBReview

Refer to: 10-0986GC

MAY 06 2014

CERTIFIED MAIL

National Government Services, Inc.
Kyle Browning
Appeals Lead
MP: INA102 - AF42
P. O. Box 6474
Indianapolis, IN 46206-6474

McKay Consulting, Inc.
Michael K. McKay
President
8590 Business Park Drive
Shreveport, LA 71105

RE: Jurisdictional Determination – Forest Hills Hospital, as a member of North Shore LIJ 2005 DSH Labor & Delivery Day CIRP Group
Provider No.: 33-0353
FYE: 12/31/2005
PRRB Case No.: 10-0986GC

Dear Kyle Browning and Michael K. McKay:

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

Forest Hills Hospital received an original Notice of Program Reimbursement (NPR) for FYE 12/31/2005 on November 3, 2009. On April 29, 2010, the Board received the Provider's appeal request to form a mandatory group appeal in which it challenged one issue: whether the labor and delivery days are properly included in the disproportionate share calculation. The Provider appealed directly into this group, in which it is currently the only Provider in the group. On February 14, 2013, the Board received the request for a standard remand of the LDR days issue pursuant to CMS Ruling 1498-R.

Intermediary's Contentions

The Intermediary filed a jurisdictional challenge on March 15, 2013, contending that the Board lacks jurisdiction over the LDR days issue because the Provider is appealing from an NPR in which neither the relevant issue nor total Medicaid days were specifically revised. The Intermediary contends that 42 C.F.R. §§ 405.1801 and 405.1803 require an "identifiable adverse finding," with a corresponding reduction in reimbursement, in order to request a Board hearing under § 405.1841(a). Specifically, because no adjustment was made to LDR days, the Intermediary contends that the LDR issue was not part of its final determination as required by 42 C.F.R. §§ 405.1811, 405.1835, and Section C.VI of Part 1 of the PRRB Instructions.

Provider's Contentions

The Provider filed a response to the Intermediary's jurisdictional challenge on April 15, 2013, contending that:

1. The Board has jurisdiction over the LDR issue because the Provider has met the statutory requirements for a Board hearing: specifically, the Provider self-disallowed LDR days in its amended cost report pursuant to the DSH regulation in effect at the time of the cost reporting period, granting the Board jurisdiction under *Bethesda*;[1]
2. The Intermediary's adjustment of other aspects of the DSH calculation entitles the Provider to a hearing as to the entire DSH issue;
3. The Provider submitted a claim in writing to the Intermediary for the LDR issue prior to the issuance of the NPR, preserving its right to appeal under the holding in *Athens II*;[2] and
4. Once the Board has jurisdiction over one issue pursuant to Section 1878(a) of the Act, Section 1878(d) provides the Board with discretionary jurisdiction.

The Provider maintains that it has met the jurisdictional prerequisites in 42 U.S.C. § 1395oo(a) as the appeal was filed on April 29, 2010, which was within 180 days of receipt of the revised NPR; the estimated amount in controversy exceeds $10,000; and it expressed dissatisfaction with the Intermediary's exclusion of LDR days in its group appeal request.[3] The Provider maintains that it was prohibited from claiming LDR days on its 2005 cost report under the CMS regulations in effect at the time, and that its self-disallowance of the item in its amended cost report was sufficient to establish its dissatisfaction with the Intermediary's exclusion of LDR days.[4]

The Provider further contends that, even if the regulation in effect in 2005 did not require it to exclude LDR days, the Board would still have jurisdiction because the Board and the Administrator have long ruled that when any component of a determination or issue is adjusted, there is jurisdiction over the entire issue including any component of the calculation that was not adjusted.[5] The Provider contends that the Board has jurisdiction over CMS' calculation of the SSI fraction because the Intermediary adjusted that fraction. In any event, according to the Provider, this aspect of the DSH issue falls within the scope of the self-disallowance doctrine under *Bethesda* because the DSH regulation requires the Intermediary to apply the SSI fraction computed by CMS, leaving the Provider without the option to claim any other SSI fraction on its cost report. The Provider argues that, as a result, it may challenge the DSH determination in any respect, including aspects of the calculation that were not considered by the Intermediary in the NPR.[6]

---

[1] *Bethesda Hospital Association v. Bowen*, 485 U.S. 399 (1988).
[2] *Athens Comm. Hosp. et al. v. Schweiker*, 743 F.2d 21 (D.C. Cir 1984) (on rehearing).
[3] Provider's Reply to Intermediary's Jurisdictional Challenge at 4.
[4] *Id.* at 9-10.
[5] *Id.* at 10.
[6] *Id.* at 11.

The Provider also argues that the Board has jurisdiction under the D.C. Circuit's decision in *Athens II* because even though the item was not claimed in the Provider's as-filed cost report, it claimed the item prior to the Intermediary's issuance of the NPR, preserving its right to appeal the issue.[7] The Provider noted that the Court opinion in *Athens II* stated, in pertinent part:

> [W]e hold that the PRRB has jurisdiction over costs that are specifically claimed—meaning that the provider requested reimbursement in a timely manner—as well as those cost issues raised by a provider prior to the intermediary's issuance of the NPR.

The provider notes that it submitted its listing of labor and delivery room days in 2008, nearly a year prior to the issuance of the NPR.[8]

Finally, the Provider notes that, under Section 1878(d), the Board has discretionary jurisdiction to review and revise the cost report even with respect to matters not considered by the Intermediary so long as it has jurisdiction over one issue pursuant to Section 1878(a).[9]

Board's Decision

The Board finds that it has jurisdiction over Forest Hills Hospital's appeal from an original NPR pursuant to the rationale in *Bethesda*.[10]

A Provider has a right to a hearing before the Board, as a single Provider appeal, with respect to a cost claimed on a timely filed cost report if it is dissatisfied with the final determination of the Intermediary, the amount in controversy is $10,000 or more, and the request for a hearing is filed within 180 days of the NPR.[11] The Board has *discretionary power* under 42 U.S.C. § 1395oo(d) after jurisdiction is established under 42 U.S.C. § 1395oo(a) to make a determination over all matters covered by the cost report. The Board can affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and make any other revisions on matters covered by the cost report even though such matters were not considered by the Intermediary in making its final determination.

Before December 1991, an inpatient day for a labor and delivery room (LDR) patient admitted at the census-taking hour was counted for purposes of both the DSH payment adjustment and for allocating costs on a provider's cost report.[12] In response to judicial precedent, CMS later revised both its DSH policy and its cost allocation policy by counting LDR inpatient days only if the patient occupied a routine care bed prior to occupying an ancillary LDR bed before the census-taking hour.[13] Therefore, during the period of time in question for this appeal (FYE 2005) the

---

[7] *Id.* at 14.
[8] *Id.* at 15.
[9] *Id.* at 15-16 (*citing HCA Health Servs. Of Oklahoma v. Shalala*, 27 F.3d 614, 617 (D.C. Cir. 1994); *UMDNJ Univ. Hosp. v. Leavitt*, 2008 WL 613164, at *71 (D.D.C. 2008).).
[10] *Bethesda Hospital Association v. Bowen*, 485 U.S. 399 (1988).
[11] 42 U.S.C. § 1395oo(a) (2012); 42 C.F.R. §§ 405.1835-1841 (2012).
[12] *See* 74 Fed. Reg. 43754, 43899 (Aug. 27, 2009) ("FY2010 IPPS final rule").
[13] *Id.* at 43899-900; *see also* 68 Fed. Reg. 45346, 45419-20, 45490 (Aug. 1, 2003) (final rule) (amending 42 C.F.R. § 412.106(a)(1)(ii)(B)).

Provider was barred from including patient days for LDR patients that occupied an ancillary LDR bed at the census-taking hour, but had not yet occupied a routine care bed. *Bethesda Hospital Association v. Bowen* dealt with the Board's authority to hear appeals of matters without their having been included in the cost report or having an adverse intermediary determination.[14] In *Bethesda*, the provider failed to claim a cost because a regulation dictated that it would be disallowed. In those circumstances, the Court found the plain meaning of section 1395oo(a) to resolve the question of whether the Board had jurisdiction. It stated:

> [U]nder subsection (a)(1)(A)(i), a provider's dissatisfaction with the amount of its total reimbursement is a condition to the Board's jurisdiction. It is clear, however, that the *submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations*. No statute or regulation expressly mandates that *a challenge to the validity of a regulation* be submitted first to the fiscal intermediary. Providers know that, under the statutory scheme, the fiscal intermediary is confined to the mere application of the Secretary's regulations, that the intermediary is without power to award reimbursement except as the regulations provide, and that any attempt to persuade the intermediary to do otherwise would be futile.[15]

As in *Bethesda*, this Provider was barred by regulation from including specific LDR days in Medicaid days or total days. The Board does not need to address the Provider's argument that it could take jurisdiction under 42 U.S.C. § 1395oo(d) discretionary power because it has jurisdiction under § 1395oo(a). Here, the Provider had no discretion in excluding these days from the DSH computation. The Board finds that the appeal satisfies the applicable jurisdictional and procedural requirements of 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-1840, as there was no regulatory requirement to protest a self-disallowed cost prior to August 2, 2008.[16]

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

Board Member

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

cc: Kevin D. Shanklin, BCBSA

---

[14] *Bethesda Hospital Association v. Bowen*, 485 U.S. 399 (1988).
[15] *Id.* at 404 (emphasis added; footnotes omitted).
[16] 42 C.F.R § 405.1835(a)(1)(ii).

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

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

Refer to: 08-2494GC

CERTIFIED MAIL MAY 06 2014

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: Jurisdiction Decision – Sutter Solano Medical Center as part of Sutter Health 2000 DSH SSI Ratio CIRP Group
Provider No.: 05-0101
FYE: 12/31/2000
PRRB Case No.: 08-2494GC

Dear Mr. Bunting and Ms. Kalafut,

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

Background

Sutter Solano Medical Center was issued a revised Notice of Program Reimbursement (NPR) for FYE 12/31/2000 on September 30, 2003. On March 8, 2004, the Provider filed an appeal request with the Board appealing the following issue: accuracy of the Supplemental Security Income (SSI) percentage provided by CMS and used by the Intermediary for calculating the Disproportionate Share Hospital (DSH) amounts. On October 13, 2004, the Provider requested to transfer the SSI% issue to the group appeal in case number 05-0027G. This case was closed on April 16, 2013. The Provider was thereafter included on the Schedule of Providers for group appeal number 08-2494GC without having ever requested to transfer the SSI% issue to case number 08-2494GC.

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.

42 C.F.R. § 405.1837(e)(5) provides for an opportunity to transfer an issue from a group appeal to a different group. That regulation provides, in relevant part:

> (5)(i) Except as specified in paragraph (ii) of this paragraph, when a provider has appealed an issue through electing to form, or joining, a group appeal under the procedures set forth in this section, it may not subsequently request that the Board transfer that issue to a single provider appeal brought in accordance with § 405.1811 or § 405.1835 of this subpart.
>
> (ii) Exception. When the Board determines that the requirements for a group appeal are not met (that is, when there has been a failure to meet the amount in controversy or the common issue requirement), it transfers the issue that was the subject of the group appeal to a single provider appeal (or appeals) for the provider (or providers) that meets (or meet) the requirements for a single provider appeal.

Pursuant to this regulation, PRRB Rule 17 establishes the requirements for a request to transfer from a group appeal into other appeals. It states:

> The Board will not grant a request to transfer from a group case to another case except upon written motion demonstrating that the group failed to meet the amount in controversy upon full formation or common issue requirements. The motion must also include a fully executed Model Form D (Transfer Form) and Model Form A as appropriate. No transfer from a group to another case is effective unless the transfer request is approved by the Board.1

In the case at hand, Provider Sutter Solano Medical Center had properly requested to transfer the SSI% issue from its individual appeal (case number 04-0956) to group appeal number 05-0027G. However, the Group Representative in case number 08-2494GC did not submit any evidence indicating that the Provider properly requested to transfer the SSI% from case number 05-0027G to group appeal number 08-2494GC. Because case number 05-0027G was closed by the Board on April 16, 2013 without the Provider having requested to transfer the issue, the Board finds that it does not have jurisdiction over Provider Sutter Solano Medical Center's appeal. The Provider is hereby dismissed 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
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

[1] PRRB Rule 17 (March 1, 2013).

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

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

Refer to: 08-2494GC

MAY 06 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: Jurisdiction Decision – California Pacific Medical Center as part of Sutter Health 2000 DSH
SSI Ratio CIRP Group
Provider No.: 05-0047
FYE: 12/31/2000
PRRB Case No.: 08-2494GC

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

California Pacific Medical Center was issued a Notice of Program Reimbursement (NPR) for FYE 12/31/2000 on December 17, 2003. On June 15, 2004, the Provider filed an appeal request with the Board appealing, amongst other issues, the following adjustment: allowable Disproportionate Share Hospital (DSH) percentage. The Provider did not specifically include the Supplemental Security Income (SSI) Ratio issue in its original appeal. On November 25, 2008, without having added the SSI percentage issue to its individual appeal, the Provider requested to transfer the DSH SSI Percentage issue to group appeal number 08-2494GC.

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.

Effective August 21, 2008, new Board regulations went into effect that limited the addition of issues to appeals. 42 C.F.R. § 405.1835(c) (2011) provides in relevant part:

(c) Adding issues to the hearing request.

After filing a hearing request in accordance with paragraphs (a) and (b) of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if the following requirements are met: [...]

(3) The Board receives the request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) of this section.

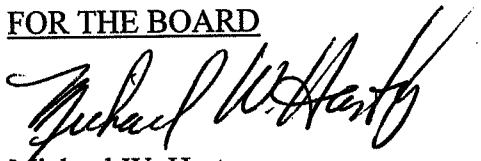
For appeals already pending when this regulations was promulgated providers were given 60 days from the date the new regulation took effect, August 21, 2008, to add issues to their appeals. In practice this means that issues had to be added to pending appeals by October 20, 2008. *See* FR 30236 (May 23, 2008).

In the case at hand, Provider California Pacific Medical Center did not include the SSI percentage issue in its original individual appeal (case number 04-1802). The Provider subsequently requested to transfer the issue to case number 08-2494GC without ever having added the issue to its individual appeal. Because the transfer request was received by the Board on December 2, 2008, after the October 20, 2008 deadline to transfer issues, the Board finds that it does not have jurisdiction over the Provider, California Medical Center's appeal. The Provider is hereby dismissed 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
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD



Michael W. Harty
Chairman

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

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

FAX: 410-786-5298
Phone: 410-786-2671

Internet: www.cms.gov/PRRBReview

Refer to: 08-0134

MAY 08 2014

CERTIFIED MAIL

Blumberg Ribner, Inc.
Isaac Blumberg
Chief Operating Officer
315 South Beverly Drive, Suite 505
Beverly Hills, CA 90212-1929

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

RE: Jurisdictional Review – Los Angeles Community Hospital
Provider No.: 05-0663
FYE: 12/31/2002
PRRB Case No.: 08-0134

Dear Mr. Blumberg and Ms. Kalafut,

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

Background

The above-captioned appeal was submitted on October 24, 2007 from a Revised Notice of Program Reimbursement ("RNPR") dated May 16, 2007. This filing was within the 180 day jurisdictional filing requirement from the RNPR. However, it was beyond the 180 day jurisdictional filing requirement from the Provider's original Notice of Program Reimbursement ("NPR") dated October 25, 2005. The issue appealed in the original appeal request was the DSH dual-eligible days. On August 6, 2008, the Provider added the SSI percentage and SSI realignment issues.

On July 15, 2013, the Board sent a letter to the Provider's representative requesting additional documentation pertaining to its appeal from the RNPR. On August 14, 2013, the Provider submitted a response to the Board's request for additional information. However, the Provider did not submit all requested documentation. Specifically, the Provider did not submit the reopening request pertaining to the RNPR under appeal nor did it submit the reopening workpapers.

Board's Decision

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

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 (2002)[1] explains the effect of a cost report revision:

> Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in § 405.1885, such revision shall be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1835, 405.1875 and 405.1877 are applicable.

In HCA Health Services v. Shalala, 27 F.3d 614 (D.C. Cir. 1994), the court held that when a Fiscal Intermediary reopens its original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening.

The Board finds that it does not have jurisdiction over the DSH Dual-Eligible Days issue because there was no documentation submitted to establish that DSH Dual-Eligible Days were reviewed or adjusted as part of the Intermediary's review of other Medicaid eligible days. Therefore, the DSH Dual-Eligible Days issue is beyond the scope of an appeal of the revised determination per 42 C.F.R. § 405.1889.

A byproduct of the Board finding that there is no jurisdiction over the sole issue in the appeal request, DSH dual-eligible days, is the status of the two supplemental issues that were later added to the current appeal. Since the jurisdictional requirements for a valid appeal (i.e., dissatisfaction with the final determination of the intermediary under 42 U.S.C. § 1395oo(a)) was not met when the case was filed, there was not a valid appeal to which to add the remaining two issues. Consequently, the Board dismisses these additional issues as invalid.

---

[1] This version of the CFR was effective from 1974 through 2008.

Since the Provider has not presented any issues with which to establish the gateway to Board jurisdiction under subsection (a), the Board cannot exercise its discretion under subsection (d) to make any other revisions on matters covered by the cost report. Since no issues remain open, the Board dismisses the Provider's appeal and closes Case No. 08-0134.

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

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

FOR THE BOARD

Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, BCBSA

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

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

Refer to: 14-3273
Certified Mail

MAY 12 2014

Don Trimble, Esq.
1124 Dr. Martin Luther King, Jr. Drive
Little Rock, Arkansas, 72202-4742

RE: Southeast Arkansas Hospice
Provider No. 04-1570
Cap Year November 1, 2011 through October 31, 2012
PRRB Case No. 14-3273

Dear Mr. Trimble:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's April 16, 2014 requests for hearing and expedited judicial review (EJR) (the request for hearing was received on April 22, 2014, the request for EJR was received on April 21, 2014). The Board determination with respect to the request for EJR is set forth below.

Background

The Provider's request for hearing and EJR stated that it is challenging the overpayment of $323,104and the hearing requests asks that its hospice cap be recalculated using the patient-by-patient proportional methodology found in 42 C.F.R. § 418.309(c),(d). The Provider goes on to allege that if the calculation had been done under the proportional methodology, rather than the streamlined methodology the facility would not have an overpayment.

In both its hearing request and request for EJR, the Provider asserts that the agreement between it and the Medicare program constitutes a regulatory taking because it cannot discharge a patient when the patient has exhausted in hospice benefits. The regulations 42 C.F.R. §§ 418.26, 418.100(d), 418.309(b)(1), as well as, 42 U.S.C. § 1395k (dd)(2)(d),[1] are cited to support this contention.

The Provider also claims that the contract between it and the Medicare program is an unconscionable contract because it is a vehicle for regulatory taking. The regulations: 42 C.F.R. §§ 418.2, 418.100(d), 418.309(b)(1), as well as 42 U.S.C. § 1395k(dd)(2)(D) are cited in defense of this assertion.

[1] 42 C.F.R. § 418.26 deals with the criteria for discharging hospice patients; § 418.100(d) contains conditions of participation in the Medicare program for hospices; § 418.309(b) deals with Medicare reimbursement under the streamlined methodology. 42 U.S.C. § 1395k(dd)(2) does not exist.

Statutory and Regulatory Background

Hospice Reimbursement under Medicare

Coverage for hospice care was provided through the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Pub. L. No. 97-248. It was designed to provide terminally ill patients with palliative care rather than curative care with individuals waiving all rights to Medicare payments for treatment underlying their terminal illnesses. 42 U.S.C. § 1395d(d)(2)(A).

Pursuant to 42 U.S.C. § 1395f(i), Medicare pays hospice providers on a per diem basis. *See* 42 C.F.R. § 418.302. The total payment to a hospice in an accounting year known as a cap year runs from November 1 through October 31 and is limited by a statutory cap. *See* 42 U.S.C. § 1395f(i)(2)(A). Payments in excess of the statutory cap are considered overpayments and must be refunded to the Medicare program by the hospice. *See* 42 C.F.R. § 418.308.

In 1983, the Secretary adopted a rule that allocates hospice care on an aggregate basis by allocating each beneficiary entirely to the cap year in which he or she would be likely to receive the preponderance of his or her care. 48 Fed. Reg. 56,0008, 56,022 (December 16, 1983). Once a beneficiary is counted for a given hospice, the beneficiary is not counted in the cap in subsequent years if services continue into more than one cap year.[2]

Hospice Payment Litigation and CMS Ruling CMS-1355-R (Ruling 1355-R)

In 2006, Providers began filing appeals objecting to the current counting methodology used in calculating hospice reimbursement, seeking to have the overpayment determination calculated under the methodology described above invalidated. The Federal district courts and courts of appeals that ruled on the question have issued decisions concluding that the methodology is inconsistent with the plain language of the Medicare statute and set aside the overpayment determinations.[3]

As a result of the outcome of the litigation, the Centers for Medicare & Medicaid Services (CMS) issued Ruling 1355-R which allowed certain providers to have their reimbursement determined using a patient-by-patient proportional methodology and, subsequently, issued a revised regulation implementing this elective methodology in future years. Under the ruling, hospice providers which had timely appeals pending under 42 U.S.C. § 1395oo could request that their reimbursement be recalculated using the proportional methodology. Under this methodology each Medicare beneficiary who received hospice care in a cap year is allocated to that hospice provider's cap year on the basis of a fraction. The numerator of the fraction is the number of patient days for that beneficiary in that hospice for that cap year and the denominator will be the total number of patient days for that beneficiary in all cap years in which the beneficiary received hospice services. The individual beneficiary counts for a given cap year will then be summed to compute the hospice's total aggregate beneficiary count (number of Medicare beneficiaries) for that cap year. A new payment cap would be calculated and a notice of overpayment determination would be issued.

---

[2] Ruling 1355-R at 3-5.

[3] *See e.g. Lion Head Health Services v. Sebelius*, 689 F. Supp. 2d 849 (N.D. Tex. 2010); Los Angeles Haven Hospice, 2009 WL 5868513 (C.D. Cal.); *Hospice of New Mexico v. Sebelius*, 691 F. Supp. 2d 1275 (D.N.M. 2010); *IHG Healthcare, Inc. v. Sebelius, 717 F. Supp. 2d 696 (S.D. Tex. 2010).*

CMS recognized that, at the time of recalculation using the patient-by-patient proportional methodology, a hospice beneficiary could still be receiving services resulting in an overstatement of a fractional allocation. Consequently, these providers' cap determinations would be subject to reopening under the reopening regulations and the reimbursement adjusted. Some portion of the hospice beneficiary's patient days will be counted toward the hospice cap in each cap year in which services were received.

Under the Ruling intermediaries and Medicare Administrative Contractors (MACs) were to identify properly pending appeals and recalculate the aggregate cap using the patient-by-patient proportional methodology using the best available data. For hospices which had not filed appeals challenging the cap, the intermediaries and MACs were to use the reimbursement methodology that appeared in the regulation at 42 C.F.R. § 418.309(b)(1) for any cap year ending on or before October 31, 2011, unless CMS adopted a rule providing otherwise.[4]

Changes to the Aggregate Cap Calculation Methodology Effective October 1, 2011

In the August 4, 2011 Federal Register[5] the Secretary announced changes to calculations of hospice cap calculation for cap years before October 31, 2011 and on or after October 31, 2012. This notice included a change in the hospice payment regulation, 42 C.F.R. § 418.309, allowing providers reimbursement to be calculated under either the new patient-by-patient proportional methodology or the streamlined methodology (the existing methodology). These changes were made as a result of the litigation resulting in Ruling 1355-R, described above, and the Secretary's requests for comments on potential modernization of the hospice cap calculation.[6]

The Secretary noted that there were hospices that had not filed appeals of overpayments determinations challenging the validity of 42 C.F.R. § 418.309 and which were awaiting cap determinations for cap years ending on or before October 31, 2011. As of October 1, 2011, those hospices could elect to have their final cap determination for those cap year(s), and all subsequent years calculated using the patient-by-patient methodology. A hospice that did not challenge the methodology used for determining the number of beneficiaries used in the cap calculation could continue to have the streamlined methodology used to calculate their reimbursement. Those hospices not seeking a change were not required to take any action.

With respect to changing hospice reimbursement methodologies, the Secretary noted in relevant part that:

> (4) Hospices which elected to have their cap determination calculated using the streamlined methodology could later elect to have their cap determinations calculated pursuant to the patient-by-patient proportional methodology by either:

---

[4] Ruling at 9-11.
[5] 76 Fed. Reg. 47302, 47308 (August 4, 2011).
[6] *See* note 5.

a. Electing to change to the patient-by-patient proportional methodology; or
b. Appealing a cap determination calculation using the streamlined methodology to determine the number of Medicare beneficiaries.

76 Fed. Reg. 47302, 47310 (August 4, 2011).

Decision of the Board

Payment under the Patient-by-Patient Proportional Methodology

In its hearing request the Provider asks that its hospice cap calculation be redone using the patient-by-patient proportional methodology set forth in 42 C.F.R. § 418.309(c). Included with the request for hearing was the Provider's "Notice of Effect of Inpatient Day Limitation and Hospice Cap Amount"[7] for the cap period ending October 31, 2012. In that document, the Medicare Administrative Contractor stated that "[w]e have completed our review of the hospice cap amount for your agency using the Patient by Patient Proportional methodology." Since the Provider was reimbursed using the method it requested, the Board finds the request for reimbursement under the proportional methodology is moot and hereby dismisses the issue from the appeal.

Regulatory Taking and Unconscionable Contract

In its request for EJR, the Provider requests that the Board grant its request for EJR over various regulations that it believes create instances of regulatory taking and create unconscionable contracts. The Provider asserts that the agreement between it and Medicare program constitutes a regulatory taking because it cannot discharge a patient when the patient has exhausted its hospice benefits based on 42 C.F.R. §§ 418.26, 418.100(d), 418.309(b)(1) and 42 U.S.C. § 1395k (dd)(2)(d). It also asserts that the contract between it and the Medicare program is an unconscionable contract because it is a vehicle for regulatory taking. The following provisions are cited to support this contention: 42 C.F.R. §§ 418.2, 418.100(d), 418.309(b)(1) and 42 U.S.C. § 1395k(dd)(2)(D).

The Board concludes that it lacks jurisdiction over the challenge to the validity of 42 C.F.R § 418.2, 418.26, 418.100(d) and 42 U.S.C. § 1395k(dd)(2)(D) and the questions of regulatory taking and unconscionable contracts. These legislative provisions and the legal questions do not involve a reimbursement matters governed by the provisions of 42 C.F.R. § 418.311. Section 418.311 permits appeals of hospice cap payments where a provider believes that its payments were not made in accordance with the regulations found in Subpart G of Part 418 of Title 42 of the Code of Federal Regulations. The provider agreement is a contract between the Provider and CMS and is not governed by Subpart G nor is the Provider's alleged inability to discharge patients from its hospice program a reimbursement matter within the scope of 42 C.F.R. § 418.311 which permits appeals of questions related to whether a hospice payments are properly determined.

[7] Provider's April 16, 2014 Hearing Request, Tab 1

With respect to 42 C.F.R. § 418.309(b)(1), this section of the regulation deals with hospice cap calculation made using the streamline methodology and for which the Provider contends is a regulation that supports its position with regard to regulatory taking and unconscionable contracts. Because the Provider was not reimbursed under 42 U.S.C. § 418.309(b)(1), nor can it have its cap calculation made using the streamline methodology once it has elected to be paid under the proportional methodology,[8] any question related to the application of this regulation is moot.[9] Since the question is moot, the Board concludes that it lacks jurisdiction over the questions of regulatory taking and unconscionable taking as it relates to this regulation.

The Board concludes that lacks jurisdiction over the issues for which EJR was requested (regulatory taking and unconscionable contracts), as well as the Provider's request to be paid under the proportional methodology and hereby denies the Provider's request for EJR in the above-referenced appeal. *See* 42 C.F.R. § 405.1842 (jurisdiction over an issue is a prerequisite to granting a request for EJR). Since there are no other matters under dispute the case is closed.

Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f)(1) 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)(1) and 42 C.F.R. §§ 405.1875 and 405.1877.

cc: Cecile Huggins, Palmetto GBA
Kevin Shanklin, BCBSA

---

[8] 42 C.F.R. § 418.309(d)(2)(i) states that "a hospice that has had its cap calculated using the patient-by-patient proportional methodology for any cap years prior to the 2012 cap year is not eligible to elect the streamline methodology, and must continue to have the patient-by-patient proportional methodology used to determine the number of Medicare beneficiaries in a given cap year."

[9] *See Princeton University v. Schmid,* 435 U.S. 100, 103 (1982) (when a challenge regulation has been superseded by a new regulation, "the issue of validity of the old regulation is moot, for this case has lost its character as a present, live controversy . . . ."

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

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

Refer to: 14-3274
Certified Mail

MAY 12 2014

Don Trimble, Esq.
1124 Dr. Martin Luther King, Jr. Drive
Little Rock, Arkansas, 72202-4742

RE: Southeast Arkansas Hospice
Provider No. 04-1566
Cap Year November 1, 2011 through October 31, 2012
PRRB Case No. 14-3274

Dear Mr. Trimble:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's April 16, 2014 requests for hearing and expedited judicial review (EJR) (the request for hearing was received on April 22, 2014, the request for EJR was received on April 21, 2014). The Board determination with respect to the request for EJR is set forth below.

Background

The Provider's request for hearing and EJR stated that it is challenging the overpayment of $117,580 and the hearing requests asks that its hospice cap be recalculated using the patient-by-patient proportional methodology found in 42 C.F.R. § 418.309(c),(d). The Provider goes on to allege that if the calculation had been done under the proportional methodology, rather than the streamlined methodology the facility would not have an overpayment.

In both its hearing request and request for EJR, the Provider asserts that the agreement between it and the Medicare program constitutes a regulatory taking because it cannot discharge a patient when the patient has exhausted in hospice benefits. The regulations 42 C.F.R. §§ 418.26, 418.100(d), 418.309(b)(1), as well as, 42 U.S.C. § 1395k (dd)(2)(d),[1] are cited to support this contention.

The Provider also claims that the contract between it and the Medicare program is an unconscionable contract because it is a vehicle for regulatory taking. The regulations: 42 C.F.R. §§ 418.2, 418.100(d), 418.309(b)(1), as well as 42 U.S.C. § 1395k(dd)(2)(D) are cited in defense of this assertion.

[1] 42 C.F.R. § 418.26 deals with the criteria for discharging hospice patients; § 418.100(d) contains conditions of participation in the Medicare program for hospices; § 418.309(b) deals with Medicare reimbursement under the streamlined methodology. 42 U.S.C. § 1395k(dd)(2) does not exist.

Statutory and Regulatory Background

Hospice Reimbursement under Medicare

Coverage for hospice care was provided through the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Pub. L. No. 97-248. It was designed to provide terminally ill patients with palliative care rather than curative care with individuals waiving all rights to Medicare payments for treatment underlying their terminal illnesses. 42 U.S.C. § 1395d(d)(2)(A).

Pursuant to 42 U.S.C. § 1395f(i), Medicare pays hospice providers on a per diem basis. *See* 42 C.F.R. § 418.302. The total payment to a hospice in an accounting year known as a cap year runs from November 1 through October 31 and is limited by a statutory cap. *See* 42 U.S.C. § 1395f(i)(2)(A). Payments in excess of the statutory cap are considered overpayments and must be refunded to the Medicare program by the hospice. *See* 42 C.F.R. § 418.308.

In 1983, the Secretary adopted a rule that allocates hospice care on an aggregate basis by allocating each beneficiary entirely to the cap year in which he or she would be likely to receive the preponderance of his or her care. 48 Fed. Reg. 56,0008, 56,022 (December 16, 1983). Once a beneficiary is counted for a given hospice, the beneficiary is not counted in the cap in subsequent years if services continue into more than one cap year.[2]

Hospice Payment Litigation and CMS Ruling CMS-1355-R (Ruling 1355-R)

In 2006, Providers began filing appeals objecting to the current counting methodology used in calculating hospice reimbursement, seeking to have the overpayment determination calculated under the methodology described above invalidated. The Federal district courts and courts of appeals that ruled on the question have issued decisions concluding that the methodology is inconsistent with the plain language of the Medicare statute and set aside the overpayment determinations.[3]

As a result of the outcome of the litigation, the Centers for Medicare & Medicaid Services (CMS) issued Ruling 1355-R which allowed certain providers to have their reimbursement determined using a patient-by-patient proportional methodology and, subsequently, issued a revised regulation implementing this elective methodology in future years. Under the ruling, hospice providers which had timely appeals pending under 42 U.S.C. § 1395oo could request that their reimbursement be recalculated using the proportional methodology. Under this methodology each Medicare beneficiary who received hospice care in a cap year is allocated to that hospice provider's cap year on the basis of a fraction. The numerator of the fraction is the number of patient days for that beneficiary in that hospice for that cap year and the denominator will be the total number of patient days for that beneficiary in all cap years in which the beneficiary received hospice services. The individual beneficiary counts for a given cap year will then be summed to compute the hospice's total aggregate beneficiary count (number of Medicare beneficiaries) for that cap year. A new payment cap would be calculated and a notice of overpayment determination would be issued.

---

[2] Ruling 1355-R at 3-5.

[3] *See e.g. Lion Head Health Services v. Sebelius*, 689 F. Supp. 2d 849 (N.D. Tex. 2010); Los Angeles Haven Hospice, 2009 WL 5868513 (C.D. Cal.); *Hospice of New Mexico v. Sebelius*, 691 F. Supp. 2d 1275 (D.N.M. 2010); *IHG Healthcare, Inc. v. Sebelius, 717 F. Supp. 2d 696 (S.D. Tex. 2010).*

CMS recognized that, at the time of recalculation using the patient-by-patient proportional methodology, a hospice beneficiary could still be receiving services resulting in an overstatement of a fractional allocation. Consequently, these providers' cap determinations would be subject to reopening under the reopening regulations and the reimbursement adjusted. Some portion of the hospice beneficiary's patient days will be counted toward the hospice cap in each cap year in which services were received.

Under the Ruling intermediaries and Medicare Administrative Contractors (MACs) were to identify properly pending appeals and recalculate the aggregate cap using the patient-by-patient proportional methodology using the best available data. For hospices which had not filed appeals challenging the cap, the intermediaries and MACs were to use the reimbursement methodology that appeared in the regulation at 42 C.F.R. § 418.309(b)(1) for any cap year ending on or before October 31, 2011, unless CMS adopted a rule providing otherwise.[4]

Changes to the Aggregate Cap Calculation Methodology Effective October 1, 2011

In the August 4, 2011 Federal Register[5] the Secretary announced changes to calculations of hospice cap calculation for cap years before October 31, 2011 and on or after October 31, 2012. This notice included a change in the hospice payment regulation, 42 C.F.R. § 418.309, allowing providers reimbursement to be calculated under either the new patient-by-patient proportional methodology or the streamlined methodology (the existing methodology). These changes were made as a result of the litigation resulting in Ruling 1355-R, described above, and the Secretary's requests for comments on potential modernization of the hospice cap calculation.[6]

The Secretary noted that there were hospices that had not filed appeals of overpayments determinations challenging the validity of 42 C.F.R. § 418.309 and which were awaiting cap determinations for cap years ending on or before October 31, 2011. As of October 1, 2011, those hospices could elect to have their final cap determination for those cap year(s), and all subsequent years calculated using the patient-by-patient methodology. A hospice that did not challenge the methodology used for determining the number of beneficiaries used in the cap calculation could continue to have the streamlined methodology used to calculate their reimbursement. Those hospices not seeking a change were not required to take any action.

With respect to changing hospice reimbursement methodologies, the Secretary noted in relevant part that:

> (4) Hospices which elected to have their cap determination calculated using the streamlined methodology could later elect to have their cap determinations calculated pursuant to the patient-by-patient proportional methodology by either:

[4] Ruling at 9-11.
[5] 76 Fed. Reg. 47302, 47308 (August 4, 2011).
[6] *See* note 5.

a. Electing to change to the patient-by-patient proportional methodology; or
b. Appealing a cap determination calculation using the streamlined methodology to determine the number of Medicare beneficiaries.

76 Fed. Reg. 47302, 47310 (August 4, 2011).

Decision of the Board

Payment under the Patient-by-Patient Proportional Methodology

In its hearing request the Provider asks that its hospice cap calculation be redone using the patient-by-patient proportional methodology set forth in 42 C.F.R. § 418.309(c). Included with the request for hearing was the Provider's "Notice of Effect of Inpatient Day Limitation and Hospice Cap Amount"[7] for the cap period ending October 31, 2012. In that document, the Medicare Administrative Contractor stated that "[w]e have completed our review of the hospice cap amount for your agency using the Patient by Patient Proportional methodology." Since the Provider was reimbursed using the method it requested, the Board finds the request for reimbursement under the proportional methodology is moot and hereby dismisses the issue from the appeal.

Regulatory Taking and Unconscionable Contract

In its request for EJR, the Provider requests that the Board grant its request for EJR over various regulations that it believes create instances of regulatory taking and create unconscionable contracts. The Provider asserts that the agreement between it and Medicare program constitutes a regulatory taking because it cannot discharge a patient when the patient has exhausted its hospice benefits based on 42 C.F.R. §§ 418.26, 418.100(d), 418.309(b)(1) and 42 U.S.C. § 1395k (dd)(2)(d). It also asserts that the contract between it and the Medicare program is an unconscionable contract because it is a vehicle for regulatory taking. The following provisions are cited to support this contention: 42 C.F.R. §§ 418.2, 418.100(d), 418.309(b)(1) and 42 U.S.C. § 1395k(dd)(2)(D).

The Board concludes that it lacks jurisdiction over the challenge to the validity of 42 C.F.R § 418.2, 418.26, 418.100(d) and 42 U.S.C. § 1395k(dd)(2)(D) and the questions of regulatory taking and unconscionable contracts. These legislative provisions and the legal questions do not involve a reimbursement matters governed by the provisions of 42 C.F.R. § 418.311. Section 418.311 permits appeals of hospice cap payments where a provider believes that its payments were not made in accordance with the regulations found in Subpart G of Part 418 of Title 42 of the Code of Federal Regulations. The provider agreement is a contract between the Provider and CMS and is not governed by Subpart G nor is the Provider's alleged inability to discharge patients from its hospice program a reimbursement matter within the scope of 42 C.F.R. § 418.311 which permits appeals of questions related to whether a hospice payments are properly determined.

[7] Provider's April 16, 2014 Hearing Request, Tab 1

With respect to 42 C.F.R. § 418.309(b)(1), this section of the regulation deals with hospice cap calculation made using the streamline methodology and for which the Provider contends is a regulation that supports its position with regard to regulatory taking and unconscionable contracts. Because the Provider was not reimbursed under 42 U.S.C. § 418.309(b)(1), nor can it have its cap calculation made using the streamline methodology once it has elected to be paid under the proportional methodology,[8] any question related to the application of this regulation is moot.[9] Since the question is moot, the Board concludes that it lacks jurisdiction over the questions of regulatory taking and unconscionable taking as it relates to this regulation.

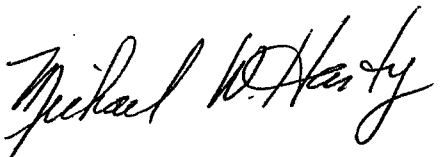
The Board concludes that lacks jurisdiction over the issues for which EJR was requested (regulatory taking and unconscionable contracts), as well as the Provider's request to be paid under the proportional methodology and hereby denies the Provider's request for EJR in the above-referenced appeal. *See* 42 C.F.R. § 405.1842 (jurisdiction over an issue is a prerequisite to granting a request for EJR). Since there are no other matters under dispute the case is closed.

Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f)(1) 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)(1) and 42 C.F.R. §§ 405.1875 and 405.1877.

cc: Cecile Huggins, Palmetto GBA
Kevin Shanklin, BCBSA

---

[8] 42 C.F.R. § 418.309(d)(2)(i) states that "a hospice that has had its cap calculated using the patient-by-patient proportional methodology for any cap years prior to the 2012 cap year is not eligible to elect the streamline methodology, and must continue to have the patient-by-patient proportional methodology used to determine the number of Medicare beneficiaries in a given cap year."

[9] *See Princeton University v. Schmid,* 435 U.S. 100, 103 (1982) (when a challenge regulation has been superseded by a new regulation, "the issue of validity of the old regulation is moot, for this case has lost its character as a present, live controversy . . . ."

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

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

Refer to:

MAY 12 2014

CERTIFIED MAIL

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

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

RE: Jurisdiction Determination for:
Mercy Hospital (34-0098), FYE 09/25/1993, participant #4
Cleveland Regional Medical Center (34-0021), FYE 9/30/1995, participant #2 and
University Hospital (34-0166), FYE 12/31/1995, participant #10

As participants in the Carolinas HealthCare System 1991-1995 SSI Percentage Group, PRRB Case No.: 09-2312GC

Dear Mr. Blumberg & Ms. Huggins:

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

Background

The Providers filed an initial request for a common issue related party (CIRP) group appeal on September 25, 2009 based on the transfer of Carolinas HealthCare System facilities that had preserved their appeal rights in previously established non-CIRP group appeals. The sole issue in the group is the SSI Percentage which is covered under CMS Ruling 1498-R. On October 17, 2013 the Group Representative filed the Schedule of Providers with supporting jurisdictional documentation.

Board Determination

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

The Board finds that it does not have jurisdiction over Mercy Hospital (participant #4), Cleveland Regional Medical Center (participant #2) and University Hospital (participant #10).

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).

The version of 42 C.F.R. § 405.1889 in effect prior to the August 2008 rule change explains the effect of a cost report revision:

> Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in §405.1885, such revision shall be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. §§ 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.

With regard to Mercy Hospital (participant #4), the Provider appealed from a revised NPR but did not supply a copy of the request to reopen, the notice of reopening, the audit workpapers or an adjustment page demonstrating that the SSI percentage was adjusted. Although the Provider did supply worksheet S-3, Pt 1 and worksheet E, Pt A, there is not enough evidence to show an adjustment to SSI on the revised NPR. Therefore, the Board finds that it does not have jurisdiction over this Provider and hereby dismisses this participant from the group appeal.

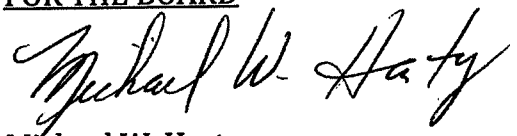
Cleveland Regional Medical Center (participant #2) and University Hospital (participant #10), did not submit copies of their initial appeal requests, NPRs, or audit adjustment pages. Although both Providers submitted letters requesting to add the SSI to the individual appeal and transfer it to the group, there is not enough evidence to determine whether the cases were filed from original or revised NPRs, or whether the SSI percentage was specifically adjusted. Because the Provider has not supplied the required documentation to support a jurisdictionally valid appeal, the Board finds that it does not have jurisdiction over these two participants and dismisses them from the group.

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.

The remaining participants in the group appeal are subject to remand pursuant to CMS Ruling 1498-R. Enclosed, please find the Board's remand under the standard procedure.

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

FOR THE BOARD



Michael W. Harty
Chairman

Enclosures: Standard Remand of the SSI fraction under CMS Ruling CMS-1498-R
Schedule of Providers
42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin D. Shanklin, Executive Director, BC BS Association (w/enclosures)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2670
Phone: 410-786-2671
Internet: www.cms.gov/PRRBReview FAX: 410-786-5298

Refer to:

CERTIFIED MAIL MAY 12 2014

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

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

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeal in response to your January 2, 2014 request for reinstatement. The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

The subject group appeal was filed on September 10, 2008, after the issuance of the August 2008 Board Rules.[1] The issue in the group is whether the Intermediary failed to include as Medicaid eligible days, Medicaid maternity patients who received care in the Labor Room and similar units, in the second computation of the DSH percentage.

On November 12, 2013, the Board found that, based on the documentation submitted in the Schedule of Providers and associated jurisdictional documentation, none of the participants included the Labor Room Days issue in their individual appeal requests. Further, the Board found no evidence that the issue had been separately added to their individual appeal requests prior to the request to form/transfer to the subject group. Therefore, the appeal was dismissed.

By letter dated January 2, 2014, the Representative requested reinstatement of the appeal. In its correspondence the Representative argues that the Providers added the Medicaid Eligible Labor Room Days issue by letter dated September 5, 2008 (a copy of which it provided) and immediately transferred the issue to the subject group.

[1] The Board Rules, effective on August 21, 2008, limited the ability to add issues to appeals. After this date, the Providers must have specifically added the issue to its individual appeal prior to requesting a transfer to a group appeal.

The September 5, 2008 letter provided in the request for reinstatement is not the letter that was initially submitted as an exhibit for any of the participants in the group at their respective tab G. The document originally supplied in the associated jurisdictional documentation that accompanied the Schedule of Providers (at tab G) was the request to form the group, which also happened to be dated September 5, 2008.

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 Notice of Program Reimbursement (NPR). After reviewing the facts in this case and the additional documentation supplied with the request for reinstatement, the Board agrees to reinstate the group appeal.

Enclosed, please find a letter remanding the case pursuant to CMS Ruling 1498-R under the standard procedure. Since there are no remaining matters to be adjudicated, the group appeal is hereby closed.

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: Standard Remand of Labor/Delivery Room Inpatient Days Under CMS Ruling CMS 1498-R
Schedule of Providers

cc: Quality Reimbursement Services, Inc.
Kristin L. DeGroat
Senior Legal Counsel
3421 E. Hunter Bend Court
Mansfield, TX 76063

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

BC BS Association
Kevin D. Shanklin, Executive Director
Senior Government Initiatives
225 N. Michigan Avenue
Chicago, IL 606011

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

MAY 13 2014

Michael T. Grady
President
Sunshine Behavioral Health Services
3530 Oak Street Northeast
St. Petersburg, FL 33704

RE: Jurisdictional Challenge
Provider: Sunshine Behavioral Health Services
Provider No: 10-4726
FYE: 12/31/1997
PRRB Case No.: 08-1121

Dear Mr. Grady:

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

Background

On February 15, 1999, a Notice of Program Reimbursement (NPR) was issued to the Provider for the fiscal year ending (FYE) December 31, 1997. On May 19, 2005, a revised NPR was issued for FYE December 31, 1997, based on an administrative resolution in PRRB case number 01-0804. On August 9, 2007, a second revised NPR was issued for FYE December 31, 1997, based on another administrative resolution in case number 01-0804. On December 28, 2007, the Provider filed an appeal of the second revised NPR challenging whether the Intermediary is required to pay the Provider certain unpaid remittance advice amounts as interim payments.

The Board assigned case number 08-1121 to the case. On September 22, 2008, the Provider requested to withdraw the appeal. On October 10, 2008, the Board granted the Provider's request for withdrawal and closed the case. On October 31, 2008, the Provider requested reinstatement of case number 08-1121 and as a reason for its request stated that it had mistakenly requested the withdrawal. Provider submitted its final position paper. On November 13, 2008, the Board approved the Provider's request for reinstatement and reinstated the case. On August 28, 2012, the Intermediary submitted its final position paper and filed a jurisdictional challenge regarding the remittance advice interim payments issue alleging no final determination/no adjustment was made and that the issue was added to the appeal untimely. On October 9, 2012, the Provider submitted a response to the Intermediary's jurisdictional challenge.

Intermediary's Position

The Intermediary contends that the Board does not have jurisdiction over Sunshine Behavioral Health Services' individual appeal because there was no adjustment made to remittance advice (RA) interim payments in the revised NPR. The Intermediary states that when it reopened the cost report, it only adjusted Medicare bad debts and issued a second revised NPR dated August 9, 2007. The Intermediary maintains that although it issued two revised NPRs dated May 19, 2005, and August 9, 2007, respectively, neither case contained an issue relating to specific RAs and neither revised NPR contained an adjustment for RA interim payments.[1] Thus, the Intermediary argues that it has not made a determination on the contended issue of specific RAs in the revised NPR under appeal and notes that the Provider has not timely appealed this issue from the original NPR dated February 15, 1999. The Intermediary requests that the Board deny jurisdiction over the appeal.[2]

Provider's Position

The Provider contends this appeal involves the Intermediary's re-opened cost report in which it recalculated the amount due to the Provider and shows interim payments paid to the Provider of $421,897. The Provider maintains that it has documented three interim payments that were not paid, totaling $20,490.[3] The Provider maintains that the entire NPR was used in calculating the amount due Provider.

The Provider acknowledges the Board's ability to limit the appeal to what was "revised" but points out that the costs, offset by reimbursements, was part of the issue with the Intermediary and therefore, necessary in calculating a bottom line amount due to the Provider, which is challenged by this appeal. The Provider contends that both the NPR and 42 C.F.R. § 405.1803 *et seq*. allows the Provider to appeal any items making up the calculations set out in the NPR.[4]

Decision of the Board

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 and the request for a hearing is filed within 180 days of the NPR.[5]

Jurisdiction for reopening a determination rests exclusively with the administrative body that rendered the last determination.[6] A determination or decision to reopen or not to reopen a

[1] Intermediary's Final Position Paper at 2.
[2] Intermediary's Jurisdictional Challenge at 2.
[3] Provider's Final Position Paper at 1.
[4] Provider's Response to Intermediary's Jurisdictional Challenge at 2.
[5] 42 U.S.C. § 1395oo(a)(2007) and 42 C.F.R. §§ 405.1835-1841(2007).
[6] 42 C.F.R. §405.1885(c) (2007).

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.[7] A revised NPR is considered a separate and distinct determination from which the provider may appeal.[8] A Provider's appeal of a revised NPR is limited to the specific issues revised on reopening and does not extend further to all determinations underlying the original NPR.[9] The effect of a revised NPR on a provider's right to a Board hearing is addressed in 42 C.F.R. § 405.1889 (2007). This 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[right to intermediary hearing], 405.1835 [right to Board hearing], 405.1875 [CMS Administrator's review] and 405.1877 [judicial review] are applicable.

In the instant case, the sole adjustment in the second revised NPR dated August 9, 2007, was an adjustment to increase reimbursable bad debts by $99,235.[10] There were no adjustments regarding RA interim payments. The first revised NPR dated May 19, 2005, shows that the intermediary reported an audited interim payment amount of $421,897,[11] which is the same amount in the second revised NPR currently under appeal.[12] As the Provider appealed from a revised NPR and there was no specific adjustment to interim payments, the Board finds that it lacks jurisdiction over the RA interim payments issue and dismisses the issue from the appeal. As the RA interim payments issue is the sole issue in this appeal, the Board hereby closes case number 08-1121.

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.

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

For the Board:

Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, Blue Cross & Blue Shield Association
Geoff Pike, First Coast Service Options, Inc.

---

[7] See, Your Home Visiting Nurse Services, Inc. v. Shalala, 525 U.S. 449 (1999).
[8] 42 C.F.R. §405.1889 (2007).
[9] See, HCA Health Services of Oklahoma, Inc. v. Shalala, 27 F.3d 614 (D.C. Cir 1994).
[10] *See* Intermediary's Jurisdictional Challenge, Attachment 3 at 7.
[11] *See* Intermediary's Jurisdictional Challenge, Attachment 2 at 6.
[12] *See* Provider's Final Position Paper, Ex. P-1 at 7-8.

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

Internet: www.cms.gov/PRRBReview

FAX: 410-786-5298
Phone: 410-786-2671

Refer to: 09-0542GC

CERTIFIED MAIL

MAY 14 2014

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

RE: Request for Reopening
Include and Remand Providers
QRS BHCS 1997-2003 DSH LDR Days Group,
Specifically, Baylor University Medical Center
Provider No.: 45-0021
FYE: 6/30/1997 & 6/30/1998
PRRB Case No.: 09-0542GC

Dear Mr. Ravindran,

The Provider Reimbursement Review Board (Board) has reviewed the Request for Reopening and to Include Provider (Baylor University Medical Center, FYEs 6/30/1997 & 1998) in remand. The Board's decision is set forth below.

Background

The hearing request for the establishment of the group appeal was filed with the Board on December 24, 2008. This was a group appeal with one issue, labor and delivery room days, covered under CMS Ruling 1498-R. On June 21, 2013, the Board sent a letter to the Providers' representative, Quality Reimbursement Services, Inc. (QRS), requesting additional jurisdictional documentation for Providers that appealed from revised Notices of Program Reimbursement (NPR). The letter also requested the letters in which Baylor University Medical Center added the labor room days issue to its individual appeals for FYEs 6/30/1997 & 6/30/1998. QRS responded to this request on July 22, 2013, and indicated that it was unable to locate the "add" letters requested for Baylor University Medical Center.

On August 13, 2013, the Board issued a jurisdictional determination in which it denied jurisdiction over Baylor University Medical Center for FYs 1997 and 1998 because there was not sufficient documentation to determine that the Provider added the issue to its individual appeals prior to transferring the issue to this group. The Board remanded the remaining Providers on the same date. On October 25, 2013, QRS submitted a "Request for Reopening" and to "Include and Remand Providers."

Provider's Position

QRS requests that the Board reopen its August 13, 2013 jurisdictional determination in which it found that it lacked jurisdiction over Baylor for FYs 1997 and 1998. QRS explains that at the time it responded to the Board's June 21, 2013 request for additional information, it was not able to obtain the documentation establishing that the labor room days issue had been added to the Provider's individual appeals for 1997 and 1998. However, QRS was subsequently able to locate those two add letters, and has submitted them along with its request to reopen the appeal to include these two fiscal year ends in the remand of the labor room days issue.

Intermediary's Position

The Intermediary did not file a brief in response to the Provider's request for reopening.

Board's Decision

The Board hereby grants QRS' request to reopen case number 09-0542GC in order to remand Baylor University Medical Center for FYEs 6/30/1997 and 6/30/1998. The Board has determined that the "add" letters QRS submitted subsequent to dismissal of those FYEs are sufficient as proof that the labor and delivery room days issue was added and transferred to this group appeal. The letters establish that Baylor University Medical Center added the labor room days issue to its FYE 6/30/1997 appeal on October 13, 2008 and to its FYE 6/30/1998 appeal on Ocotber 13, 2008. With the submission of these letters, the Board has been able to determine that the labor room days issue for Baylor University Medical Center FYEs 6/30/1997 and 6/30/1998 were properly added and transferred to this group appeal. The Board therefore grants the request to reopen case number 09-0542GC.

The remand of the two FYEs pursuant to CMS Ruling 1498-R will be addressed under separate cover.

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

FOR THE BOARD

Michael W. Harty
Chairman

cc: Novitas Solutions, Inc.
Timothy LeJeune
JH Provider Audit & Reimbursement
Union Trust Building
501 Grant Street, Suite 600
Pittsburgh, PA 15219

Kevin D. Shanklin
Executive Director
Senior Government Initiatives
Blue Cross and Blue Shield Association
225 N. Michigan Ave.
Chicago, IL 60601-7680

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

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

Refer to:

13-0649GC
CERTIFIED MAIL

MAY 14 2014

Stephen P. Nash, Esq.
Patton Boggs, LLP
1801 California Street
Suite 4900
Denver, CO 80202

RE: # 10 Banner Del E. Webb Medical Center, Provider No. 03-0093,
FYE 1/1/2008-8/31/2008
11 Banner Boswell Medical Center, Provider No. 03-0061,
FYE 1/1/2008-8/31/2008
as participants in the Patton Boggs/Banner 2008 Medicare Outlier Group
PRRB Case No. 13-0649

Dear Mr. Nash:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' March 21, 2014 request for expedited judicial review (EJR) (received March 13, 2014) and the additional information regarding jurisdiction received on April 17, 2014, in the above-referenced appeal. The Board finds that EJR is appropriate for these Providers and cost reporting period.

Issue

The Providers in this case assert that they have not been paid the full amount of supplemental Medicare outlier payments to which they are entitled under 42 U.S.C. § 1395ww(d)(5)(A)(i)-(iv) and (d)(3)(B). The Providers request that the Board grant their request for EJR with respect to the following legal question:

> Whether the specific regulations governing Outlier Case Payments as set forth in the two regulatory sources—the Outlier Payment Regulations[1] and the fixed loss threshold ("FLT") regulations[2] (collectively, the "Medicare Outlier Regulations")—as promulgated by the Secretary of Health and Human Services ("HHS") and the Centers for Medicare [&] Medicaid Services ("CMS"), and as in effect for the appealed years, are contrary to the Outlier Statute and/or are otherwise substantively or procedurally invalid?

[1] See Providers' March 6, 2014 EJR request, Page 2, n. 2
[2] *Id. at n. 3.*

Providers' Request for EJR

The Providers explain that hospitals are paid for services to Medicare patients under the inpatient prospective payment system (IPPS)[3] under which inpatient operating costs are reimbursed based on a prospectively determined formula. The IPPS legislation contains a number of provisions that provide for additional payment based on specific factors. This case involve one of those factors: outlier payments. Outlier payments are made for patients whose hospitalization is either extraordinarily costly or lengthy.[4] Outlier payments are made from the "outlier pool," which is a regulatory set-aside or subset of the Medicare Part A Trust Fund, maintained by the government to pay for outlier cases. The outlier pool is, in effect, funded by a 5-6 percent reduction in IPPS payments to acute care hospitals.[5] Prior to the start of each fiscal year, the Secretary establishes a FLT beyond which hospitals will qualify for outlier payments at levels that are between 5-6 percent of DRG[6] payments.[7]

The Providers note that beginning in 1997 through 2003, a number of hospitals were reported to have inflated their charge masters an action which the Department of Justice (DOJ) termed "turbo-charging." This practice greatly inflated cost to charge ratios which greatly increased the cost per case. DOJ termed this action a false claim and this also resulted in the Secretary greatly increasing the FLT so that payments for outliers would remain at 5-6 percent of DRG payments. More specifically, beginning in or around Federal fiscal year (FFY) 1998, the Secretary began making upward adjustments to the FLTs which were in excess of the rate of inflationary indices routinely used such as the CPI-Medical Index or the Medicare Market Basket.

In 2002, the Secretary disclosed that he was aware of "turbo-charging" and that would be amending the outlier regulations to fix "vulnerabilities" in the regulations. In the March 5[8] and June 9, 2003[9] Federal Registers, the Secretary acknowledged three flaws in the outlier payment regulations and stated that the vulnerabilities would be fixed. The Providers maintain that the data used to correct the vulnerabilities had always been available and should have been used to calculate outlier reimbursement. The Providers noted that the Secretary stated that he believed that there was the authority to revise the outlier threshold given the manipulation of the outlier policy. However, he elected not to exercise this authority because of the short amount of time remaining in the FFY. The Providers allege that the Secretary was aware of the problem months before the

---

[3] *See* U.S.C. 42 § 1395ww(d)(5).
[4] Providers' March 6, 2014 EJR request at 3.
[5] *Id.* at 4 n. 9, 42 U.S.C. § 1395ww(d)(3)(B) (Reducing for the Value of Outlier Payments).
[6] Diagnostic Related Group.
[7] Providers' March 6, 2014 EJR request at 4.
[8] 68 Fed. Reg. 10,420, 10,423 (March 5, 2003) (Recent analysis indicates that some hospitals have taken advantage of two vulnerabilities in our methodology to maximize their outlier payments . . . [1] the time lag between the current charges on a submitted bill and the cost–to-charge ratio taken from the most recently settled cost report and [2] in some cases hospitals may increase their charges far above cost that their cost-to-charge ratios fall below 3 standard deviations from the geometric mean of cost-to-charge ratios and a higher statewide average cost-to-charge ratio is applied.)
[9] 68 Fed. Reg. 34,494,34,501 (June 9, 2003) ([3] even though final payment would reflect a hospital's true cost experience, there would still be the opportunity for a hospital to manipulate its outlier payments by dramatically increasing charges during the year in the discharge occurs. Here, the hospital would receive excessive outlier payments, which, although the hospital would incur an overpayment and have to refund the money when the cost report is settled, this would allow the hospital to obtain excess payments from the Medicare Trust fund on a short-term basis.)

final rule was published as demonstrated by Provider Exhibit 9, a copy of an Interim Final Rule submitted to the Office of Management and Budget on February 13, 2003.[10] As noted by the Providers[11] the D.C. District Court in *Banner Health v. Sebelius*, 2013 U.S. Dist. Lexis 69889 (D.D.C. May 16, 2013) noted that the February 13, 2013 proposed rule was virtually identical to the final proposed rule with the exception that the later proposed rule published on March 5, 2013 did not recommend reduction of the FLT and the supporting analysis.

The Providers state that they did not learn of the February 13, 2003 unpublished, interim final rule until their counsel obtained it through a Freedom of Information Act request made to the Office of Management and Budget in 2012. They believe the document is still relevant because the Secretary has not accounted for the impact of the "turbo charging" data, and is, allegedly, still relying on inflated data to calculate outlier reimbursement. As a result, the Providers do not receive the full amount of outlier reimbursement to which they are entitled. Further, in the June 12, 2012 Office of Inspector General report, the Inspector General noted that seven years after the 2003 publication of the regulation requiring reconciliation of outlier payments, CMS had not reconciled any of the cost reports screened and reported by Medicare Administrative Contractors (MACs).[12] In a later, 2013 report,[13] OIG noted that although nearly all hospitals receive outlier payments, a small percentage of hospitals receive a significantly higher proportion of payments. The hospitals receiving this higher portion of payments charged Medicare more for the same Medical Severity-Diagnostic Related Groups (MS-DRGs), yet had similar lengths of stay and cost-to-charge ratios. The Providers contend that this is another example of CMS' failure to correct the distribution of outlier payments.[14]

The Providers assert that the FLT, established by the FLT regulations, are invalid for numerous reasons including, but not limited to:

1) The FLTs, established by the FLT regulations, are substantively invalid because, both as written and implemented, they represent agency action that exceeded statutory authority and frustrated the intent of Congress as reflected in the Outlier Statute.

2) Further, under well-settled principles of judicial review of agency action, an agency action is arbitrary and capricious if it:

---

[10] The Providers furnished no evidence that this document was ever published in the Federal Register.
[11] Providers' March 6, 2014 EJR request at 7, n. 15.
[12] *Id.* Ex. 10, OIG Report: The Centers for Medicare & Medicaid Services Did Not Reconcile Medicare Outlier Payments in Accordance with Federal Regulations and Guidance, Report A-07-10-02764 at 7-9 (June 2012).
[13] *Id.* Ex. 11 Medicare Hospital Outlier Payments Warrant Increased Scrutiny, Report OEI-06-10-00520 (November 2013). (incomplete document)
[14] *Id. at 13.*

a) fails to use the best data available for its action and/or does not adequately explain why it is not using such data;
b) fails to consider one or more important aspects of the problems(s); and/or

c) offers explanations for its decisions that run counter to the evidence.[15]

Decision of the Board

The Board has reviewed the submissions of the Providers pertaining to the requests for hearing and expedited judicial review. 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permit 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 Providers are challenging the validity of the outlier regulations, 42 C.F.R. §§ 412.80 through 412.86.[16] The Intermediary did not oppose the request for EJR. The documentation shows that in each case the estimated amount in controversy exceeds $50,000 threshold for Board jurisdiction over group appeals and the appeal was timely filed.

The Board finds that:

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

2) based upon the Providers' assertions regarding the outlier regulations, 42 C.F.R. §§ 412.80-412.86, there are no findings of fact for resolution by the Board;

3) it is bound by the regulations; and

4) it is without the authority to decide the legal question of whether the outlier regulations, are valid.

Accordingly, the Board finds that the outlier issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for expedited judicial review

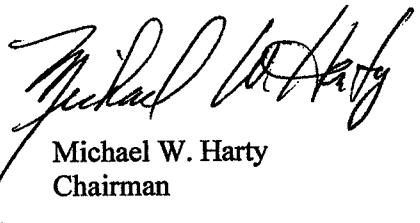
[15] *Id.* at 15-24.
[16] *Id. at 2 n.* 2 (The Outlier Payment Regulations are the base regulations that establish the method for calculating a hospital's imputed costs for a patient case, which are set forth at 42 C.F.R. §§ 412.80 through 412.86. The Payment Regulations were first enacted in 1985 and have been revised periodically over the years . . . .)

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 Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo (f)(1), Schedules of Providers

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

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

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

Refer to: 06-0105

CERTIFIED MAIL MAY 14 2014

KPMG LLP
Bill Hannah
Principal
Healthcare Advisory Services
303 Peachtree Street NE, Suite 2000
Atlanta, GA 30308

Novitas Solutions, Inc.
Timothy LeJeune
JH Provider Audit & Reimbursement
Union Trust Building
501 Grant Street, Suite 600
Pittsburgh, PA 15219

RE: Jurisdictional Determination – Singing River Hospital Systems
Provider No.: 25-0400
FYE: 9/30/2000
PRRB Case No.: 06-0105

Dear Mr. Hannah and Mr. LeJeune,

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

Singing River Hospital Systems was issued a revised Notice of Program Reimbursement (NPR) for FYE 9/30/2000 on September 22, 2005. On October 24, 2005, the Board received the Provider's appeal request in which it appealed one issue: the Supplemental Security Income (SSI) percentage used by the Intermediary in calculating the Provider's Disproportionate Share Hospital (DSH) adjustment. On November 28, 2005, the Intermediary filed a jurisdictional challenge.

Intermediary's Position

The Intermediary contended that the Board does not have jurisdiction over the Provider's appeal from a revised NPR because the issue being appealed was not adjusted in the revised NPR. The Intermediary argued that the subject of the cost report reopening was the adjustment of Medicaid eligible days. The revised NPR adjusted the operating and capital Disproportionate Share Hospital (DSH) adjustment based solely on the changes to include additional Medicaid Days. The Intermediary stated that there was no specific adjustment to the SSI percentage on the revised NPR. Because the Board does not have jurisdiction over appeals from revised NPR that did not adjust the issue being appealed, the Intermediary asked the Board to deny jurisdiction and dismiss the case.

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 of receipt of the Intermediary's final determination.

The Board finds that it does not have jurisdiction over the Provider's appeal from a revised NPR because the only issue on appeal, the SSI percentage, was not adjusted. The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2004) provides in relevant part:

> 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 (2004), a revised NPR is considered a separate and distinct determination from which the provider may appeal. The regulation provides, in part:

> 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.

In appeals from revised NPRs, the Board's jurisdiction is limited to those matters that were specifically revised in the revised NPR. This regulation was 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.

Here, the Notice of Cost Report Reopening dated August 9, 2005 states that the cost report was reopened as a result of the proposed changes to "Medicaid eligible days." The workpapers and the audit adjustment report associated with the September 22, 2005 revised NPR show that the general DSH calculation was adjusted to include additional Medicaid days, but there was no adjustment made specifically to the SSI percentage. Therefore the appeal does not meet the specificity requirements for a revised NPR appeal. The Board does not have jurisdiction over the SSI percentage issue and dismisses it from the appeal. Because SSI was the sole issue in dispute, the Board hereby closes case number 06-0105.

Review of this determination is available under the provisions of 42 U.S.C. § 395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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

FOR THE BOARD

Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, BCBSA

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

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

Refer to: 13-0135

MAY 14 2014

CERTIFIED MAIL

HCA, Inc.
H. Anne Browne
Senior Appeals Analyst
One Park Plaza, MOD 13
Nashville, TN 37203

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

RE: Jurisdictional Decision – Sunrise Hospital and Medical Center
Provider No.: 29-0003
FYE: 1/31/2005
PRRB Case No.: 13-0135

Dear Ms. Browne 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

Sunrise Hospital and Medical Center was issued a revised Notice of Program Reimbursement (NPR) for FYE 1/31/2005 on July 12, 2012. On December 4, 2012, the Provider filed an appeal request with the Board appealing the following issue: bad debt expense.

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 of receipt of the intermediary's final determination. 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 appeal because the Provider appealed from a revised NPR in which the only issue on appeal, the bad debt expense, 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.

In its individual appeal request, Sunrise Hospital and Medical Center characterized the adjustments in dispute (numbers 4-6) as "improperly omit[ting] some Medicare bad debts that were written off during 2005." The Provider indicated that it received detailed listings regarding the date collection activities ceased at the secondary collection agency to determine in which year to claim the regular bad debt. Subsequent to filing its reopening request for payment of bad debts, the Provider learned that there was a contract terminated on January 1, 2014 ["851 bad debts"] with another secondary agency. The Provider conceded that the 851 bad debts were not included in the bad debt information reported to staff and, therefore, were not included in the reopening request to the MAC for payments of bad debts and are not on the Provider's January 31, 2005 revised NPR.

Although the Intermediary made an adjustment to allowable bad debts expense in the revised NPR (adjustments 4-6), the Provider's appeal rights are limited to the specific determination or decision made as part of the revision. Adjustments 4 and 6 on the audit adjustment report show the inclusion of previously unreported bad debts in the amount of $176,741 for Part A and $23,360 for Part B. Adjustment 5 shows a reduction to the Part A bad debts to reflect the MAC's audit findings in the amount of $22,635. However, since the Provider conceded that the 851 bad debts were not presented to the MAC for consideration, there is no overlap between the bad debt expenses adjusted through the revised NPR and the newly identified bad debt claims raised in the appeal.

Because the 851 bad debt claims at issue in this appeal were not specifically adjusted in the revised NPR, the Board finds that it does not have jurisdiction over Sunrise Hospital and Medical Center's appeal as it lacks the specificity required for the Board to find jurisdiction over a revised NPR appeal. As the bad debts issue was the only issue on appeal, case number 13-0135 is hereby dismissed.

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.

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

FOR THE BOARD

Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, BCBSA

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

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

Refer to: 13-0182GC, 13-0188GC,
13-0255GC, 13-2514GC, 13-0201GC
CERTIFIED MAIL

MAY 14 2014

Stephen P. Nash, Esq.
Patton Boggs, LLP
1801 California Street
Suite 4900
Denver, CO 80202

RE: Patton Boggs/Banner Health 2007 Medicare Outlier Group, FYE 12/31/2007, PRRB Case No. 13-0182GC
Patton Boggs/Allina Health 2007 Medicare Outlier Group, FYE 12/31/2007, PRRB Case No. 13-0188GC
Patton Boggs/Lee Memorial 2007 Medicare Outlier Group, FYE 09/30/2007, PRRB Case No. 13-0255GC
Patton Boggs/Lee Memorial 2008 Medicare Outlier Group, FYE 9/30/2008 PRRB Case No. 13-2514GC
Patton Boggs 2007 Medicare Outlier Group, FYE 2007, PRRB Case No. 13-0201G

Dear Mr. Nash:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' March 12, 2014 request for expedited judicial review (EJR) (received March 13, 2014) and the additional information regarding jurisdiction received on April 17, 2014, in the above-referenced appeals. The Board finds that EJR is appropriate.

Issue

The Providers in these cases assert that they have not been paid the full amount of supplemental Medicare outlier payments to which they are entitled under 42 U.S.C. § 1395ww(d)(5)(A)(i)-(iv) and (d)(3)(B). The Providers request that the Board grant their request for EJR with respect to the following legal question:

> Whether the specific regulations governing Outlier Case Payments as set forth in the two regulatory sources—the Outlier Payment Regulations[1] and the fixed loss threshold ("FLT") regulations[2] (collectively, the "Medicare Outlier

[1] See Providers' March 6, 2014 EJR request, Page 2, n. 2
[2] *Id.* at n. 3.

> Regulations")—as promulgated by the Secretary of Health and Human Services ("HHS") and the Centers for Medicare [&] Medicaid Services ("CMS"), and as in effect for the appealed years, are contrary to the Outlier Statute and/or are otherwise substantively or procedurally invalid?

Providers' Request for EJR

The Providers explain that hospitals are paid for services to Medicare patients under the inpatient prospective payment system (IPPS)[3] under which inpatient operating costs are reimbursed based on a prospectively determined formula. The IPPS legislation contains a number of provisions that provide for additional payment based on specific factors. These cases involve one of those factors: outlier payments. Outlier payments are made for patients whose hospitalization is either extraordinarily costly or lengthy.[4] Outlier payments are made from the "outlier pool," which is a regulatory set-aside or subset of the Medicare Part A Trust Fund, maintained by the government to pay for outlier cases. The outlier pool is, in effect, funded by a 5-6 percent reduction in IPPS payments to acute care hospitals.[5] Prior to the start of each fiscal year, the Secretary establishes a FLT beyond which hospitals will qualify for outlier payments at levels that are between 5-6 percent of DRG[6] payments.[7]

The Providers note that beginning in 1997 through 2003, a number of hospitals were reported to have inflated their charge masters an action which the Department of Justice (DOJ) termed "turbo-charging." This practice greatly inflated cost to charge ratios which greatly increased the cost per case. DOJ termed this action a false claim and this also resulted in the Secretary greatly increasing the FLT so that payments for outliers would remain at 5-6 percent of DRG payments. More specifically, beginning in or around Federal fiscal year (FFY) 1998, the Secretary began making upward adjustments to the FLTs which were in excess of the rate of inflationary indices routinely used such as the CPI-Medical Index or the Medicare Market Basket.

In 2002, the Secretary disclosed that he was aware of "turbo-charging" and that would be amending the outlier regulations to fix "vulnerabilities" in the regulations. In the March 5[8] and June 9, 2003[9] Federal Registers, the Secretary acknowledged three flaws

---

[3] *See* U.S.C. 42 § 1395ww(d)(5).
[4] Providers' March 6, 2014 EJR request at 3.
[5] *Id.* at 4 n. 9, 42 U.S.C. § 1395ww(d)(3)(B) (Reducing for the Value of Outlier Payments).
[6] Diagnostic Related Group.
[7] Providers' March 6, 2014 EJR request at 4.
[8] 68 Fed. Reg. 10,420, 10,423 (March 5, 2003) (Recent analysis indicates that some hospitals have taken advantage of two vulnerabilities in our methodology to maximize their outlier payments . . . [1] the time lag between the current charges on a submitted bill and the cost–to-charge ratio taken from the most recently settled cost report and [2] in some cases hospitals may increase their charges far above cost that their cost-to-charge ratios fall below 3 standard deviations from the geometric mean of cost-to-charge ratios and a higher statewide average cost-to-charge ratio is applied.)
[9] 68 Fed. Reg. 34,494,34,501 (June 9, 2003) ([3] even though final payment would reflect a hospital's true cost experience, there would still be the opportunity for a hospital to manipulate its outlier payments by dramatically increasing charges during the year in the discharge occurs. Here, the hospital would

in the outlier payment regulations and stated that the vulnerabilities would be fixed. The Providers maintain that the data used to correct the vulnerabilities had always been available and should have been used to calculate outlier reimbursement. The Providers noted that the Secretary stated that he believed that there was the authority to revise the outlier threshold given the manipulation of the outlier policy. However, he elected not to exercise this authority because of the short amount of time remaining in the FFY. The Providers allege that the Secretary was aware of the problem months before the final rule was published as demonstrated by Provider Exhibit 9, a copy of an Interim Final Rule submitted to the Office of Management and Budget on February 13, 2003.[10] As noted by the Providers[11] the D.C. District Court in *Banner Health v. Sebelius*, 2013 U.S. Dist. Lexis 69889 (D.D.C. May 16, 2013) noted that the February 13, 2013 proposed rule was virtually identical to the final proposed rule with the exception that the later proposed rule published on March 5, 2013 did not recommend reduction of the FLT and the supporting analysis.

The Providers state that they did not learn of the February 13, 2003 unpublished, interim final rule until their counsel obtained it through a Freedom of Information Act request made to the Office of Management and Budget in 2012. They believe the document is still relevant because the Secretary has not accounted for the impact of the "turbo charging" data, and is, allegedly, still relying on inflated data to calculate outlier reimbursement. As a result, the Providers do not receive the full amount of outlier reimbursement to which they are entitled. Further, in the June 12, 2012 Office of Inspector General report, the Inspector General noted that seven years after the 2003 publication of the regulation requiring reconciliation of outlier payments, CMS had not reconciled any of the cost reports screened and reported by Medicare Administrative Contractors (MACs).[12] In a later, 2013 report,[13] OIG noted that although nearly all hospitals receive outlier payments, a small percentage of hospitals receive a significantly higher proportion of payments. The hospitals receiving this higher portion of payments charged Medicare more for the same Medical Severity-Diagnostic Related Groups (MS-DRGs), yet had similar lengths of stay and cost-to-charge ratios. The Providers contend that this is another example of CMS' failure to correct the distribution of outlier payments.[14]

The Providers assert that the FLT, established by the FLT regulations, are invalid for numerous reasons including, but not limited to:

1) The FLTs, established by the FLT regulations, are substantively invalid because, both as written and implemented, they represent agency action that exceeded statutory authority and

---

receive excessive outlier payments, which, although the hospital would incur an overpayment and have to refund the money when the cost report is settled, this would allow the hospital to obtain excess payments from the Medicare Trust fund on a short-term basis.)

[10] The Providers furnished no evidence that this document was ever published in the Federal Register.

[11] Providers' March 6, 2014 EJR request at 7, n. 15.

[12] *Id.* Ex. 10, OIG Report: The Centers for Medicare & Medicaid Services Did Not Reconcile Medicare Outlier Payments in Accordance with Federal Regulations and Guidance, Report A-07-10-02764 at 7-9 (June 2012).

[13] *Id.* Ex. 11 Medicare Hospital Outlier Payments Warrant Increased Scrutiny, Report OEI-06-10-00520 (November 2013). (incomplete document)

[14] *Id. at 13.*

frustrated the intent of Congress as reflected in the Outlier Statute.

2) Further, under well-settled principles of judicial review of agency action, an agency action is arbitrary and capricious if it:

   a) fails to use the best data available for its action and/or does not adequately explain why it is not using such data;
   b) fails to consider one or more important aspects of the problems(s); and/or

   c) offers explanations for its decisions that run counter to the evidence.[15]

Decision of the Board

The Board has reviewed the submissions of the Providers pertaining to the requests for hearing and expedited judicial review. 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permit 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 these cases, the Providers are challenging the validity of the outlier regulations, 42 C.F.R. §§ 412.80 through 412.86.[16] The Intermediaries did not oppose the request for EJR. The documentation shows that in each case the estimated amount in controversy exceeds $50,000 threshold for Board jurisdiction over group appeals and the appeals were timely filed.

The Board finds that:

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

2) based upon the Providers' assertions regarding the outlier regulations, 42 C.F.R. §§ 412.80-412.86, there are no findings of fact for resolution by the Board;

3) it is bound by the regulations; and

4) it is without the authority to decide the legal question of whether the outlier regulations, are valid.

---

[15] *Id.* at 15-24.

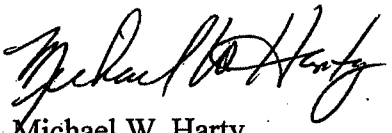
[16] *Id. at 2 n.* 2 (The Outlier Payment Regulations are the base regulations that establish the method for calculating a hospital's imputed costs for a patient case, which are set forth at 42 C.F.R. §§ 412.80 through 412.86. The Payment Regulations were first enacted in 1985 and have been revised periodically over the years . . . .)

Accordingly, the Board finds that the outlier 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 years. 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 Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo (f)(1), Schedules of Providers

cc: Danene Hartley, NGS (w/Schedules of Providers)
Byron Lamprecht, WPS (w/Schedules of Providers)
Geoff Pike, First Coast Services Options (w/Schedules of Providers)
Timothy LeJeune, Novitas (w/Schedules of Providers)
Kevin Shanklin, BCBSA (w/Schedules of Providers)

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

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

Refer to: 13-0649GC
Certified Mail

MAY 14 2014

Stephen P. Nash, Esq.
Patton Boggs LLP
1801 California Street
Suite 4900
Denver, CO 80202

RE: Patton Boggs/Banner 2008 Medicare Outlier Group
(Providers on the Enclosed Schedule of Providers)
Provider Nos. Various
FYE 2008
PRRB Case No. 13-0649GC

Dear Mr. Nash:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' March 21, 2014 request for expedited judicial review (EJR) (received March 24, 2013) and the additional information regarding jurisdiction received April 17, 2014. The Board decision with respect to the request for EJR and jurisdiction for the Providers on the enclosed Schedule of Providers is set forth below.

Background

The Providers are all subsection (d)[1] hospitals and receive reimbursement for inpatient services under the inpatient prospective payment system for inpatient operating and capital costs (IPPS). The Providers allege that the calculation of the outlier payments under IPPS is incorrect because the Secretary[2] improperly established the "fixed loss thresholds" (FLT) used to calculate the number of cases that qualify for and the amount of outlier payments. In Federal fiscal year 2003, the regulations establishing the method of calculating were amended to correct what the Secretary described a number of vulnerabilities in the payment system that made is susceptible to manipulation.[3] Analysis revealed that hospitals had taken advantage of the three vulnerabilities to maximize their outlier payments.[4] The Providers contend that the FFY 2004 FLT used data that was from the period in which certain hospitals had manipulated their data to increase outlier reimbursement resulting in inaccurate, inflated and overstated charge data be being using in the compilation of the FLT. This resulted in outlier payments being less than the 5-6 percent of the actual DRG payments as required by 42 U.S.C. § 1395ww(d)(5)(A)(i)-(iv).

[1] 42 U.S.C. § 1395ww(d).
[2] of the Department of Health and Human Services.
[3] *See* 68 Fed. Reg. 10,420, 10,423 (March 5, 2003) and 68 Fed. Reg. 34,494, 34,501 (June 9, 2003).
[4] 68 Fed. Reg. 34494, 34496 (June 9, 2003).

The Providers were asked brief the basis for the Board's jurisdiction over the their appeals in light of the regulation, 42 C.F.R. § 405.1835(a)(1)(ii) which requires providers preserve their right to claim dissatisfaction with the amount of payments for specific items by protesting them on their cost report. In response, the Providers admitted that the additional outlier costs had not been protested on their respective cost reports. They note that there are numerous appeals of this issue pending in Federal court in which the validity of § 405.1835(a)(1)(ii) is being challenged and they intend to challenge the validity of the regulation in this case, as well.[5]

Decision of the Board

The Board concludes that it lacks jurisdiction over the appeals of the Providers on the enclosed Schedule of Providers and hereby dismisses the Providers from this case. Since jurisdiction is a prerequisite to granting a request for EJR, the Board hereby denies the Providers request for EJR. *See* 42 C.F.R. § 405.1842(a).

This appeal was filed based on the provisions of 42 U.S.C. § 1395oo(a) and 42 C.F.R. § 405.1835(a) which permit a provider to file an appeal within 180 days of receipt by the Providers of the final determinations (Notices of Program Reimbursement (NPRs)). In this regard, 42 U.S.C. § 1395oo(a) states in relevant part:

> (a) [ ] any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1886[6] and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may *obtain a hearing* with respect to such payment by the Board, if—
>
> (1) such provider—
>
> (A)(ii) is dissatisfied with the final determination of the Secretary as to the amount of payment under subsection (b) or (d) of section 1886,
>
> *********
>
> (2) such provider files a request for hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(ii) . . .
>
> (b) The provisions of subsection (a) shall apply to any group of providers of services if each provider of services in such group would upon the filing of an appeal (but without regard to the $10,000 limitation), be entitled to such a hearing, but only if the matters in controversy involve a common question of fact

[5] Providers' April 16, 2014 Response to the Board's Request for Information at 2.
[6] Codified as 42 U.S.C. § 1395ww.

> or interpretation of law or regulations and the amount in controversy is, in the aggregate, $50,000 or more.[7]

Similarly, 42 C.F.R. § 405.1835(a) (2008) states in pertinent part:

> (a) **Criteria.** A provider . . . has a *right to a Board hearing*, as a single provider appeal, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination, *only if*—
>
> *(1) The provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for specific item(s) at issue, by* either—
>
> (i) Including a claim for specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or
>
> (ii) Effective with cost reporting periods that end on or after December 31, 2008, *self-disallowing the specific item(s) by following the applicable procedures for filing a cost report under protest*, where the provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy (for example, if the intermediary lacks discretion to award the reimbursement the provider seeks for the item(s)).

This confirms that the general right to hearing at the beginning of the new subsection (a) necessarily encompasses claims for both reasonable cost reimbursement and reimbursement under IPPS. Significantly, the general right to hearing in the new subsection (a) relates to "an intermediary or Secretary *determination.*"[8] The definition of "determination" as used therein is defined in 42 C.F.R. § 405.1801. Significantly, the § 405.1801 definition of "determination" has included determinations for both reasonable cost reimbursement and reimbursement under IPPS since September 1983 when CMS revised its regulations to implement IPPS.[9] Indeed, the Board's review of the regulatory history of § 405.1835 suggests that the May 23, 2008 changes simply update and expand the § 405.1835 right to hearing to include any IPPS reimbursement issues that are part of the normal cost report audit, settlement and appeals process as reflected by the historical application of such process.

At the outset, the Board notes that providers subject to IPPS ("IPPS providers") are required to file cost reports on an annual basis pursuant to 42 C.F.R. §§ 412.40 and 412.52. Further, in defining "determination" for purposes of appeal rights under 42 U.S.C. § 1395oo(a), CMS has

---

[7] *See also* 42 C.F.R. § 405.1837(a)(3) (the amount in controversy for a group appeal must be $50,000 or more).
[8] (Emphasis added.)
[9] *See* 42 C.F.R. § 405.1835 (editions dated Oct. 1, 1983, Oct. 1, 2007, Oct. 1, 2010).

specified in 42 C.F.R. § 405.1803 that the appeal rights of an IPPS provider flow from the intermediary's issuance of the NPR that is based upon the cost report filed by that provider. Thus, the Board concludes that the "report" discussed in § 1395oo(a)(1)(B) is the cost report.

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

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

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

> 115.1 **Provider Disclosure of Protest**.--When you file a cost report under protest, the disputed item and amount *for each issue* must be specifically identified in footnotes to the settlement worksheet and the fact that the cost report is filed under protest must be disclosed.
>
> 115.2 **Method for Establishing Protested Amounts**.-- The effect of *each nonallowable cost report item is estimated* by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. In addition, *you must submit*, with the cost report, *copies of the working papers used to develop the estimated adjustments* in order for the contractor/contractor to evaluate the reasonableness of the methodology for purposes of establishing whether the cost report is acceptable. The cumulative effect on reimbursement for all disputed issues is shown as an adjustment to balance due to the program (provider) in the reimbursement settlement computation. The actual effect on reimbursable cost(s) is determined after final adjudication of the issue(s).[10]

Effective with cost report periods that end on or after December 31, 2008, CMS amended the regulations governing cost report appeals to incorporate PRM 15-2 § 115 *et seq.* into the regulations at 42 C.F.R. § 405.1835(a)(1)(ii) (2008) by specifying that, where a provider seeks

[10] (emphasis added.)

payments that it believes may not be allowable or may not be in accordance with Medicare policy, the provider must claim the items as self-disallowed costs "by following the applicable procedures for filing a cost report under protest."

In the preamble to the final rule published on May 23, 2008 ("2008 Final Rule")[11], the Secretary explained that he believed that requirement to follow the procedures for filing cost reports under protest was appropriate under the decision in *Bethesda Hospital Association v. Bowen.*[12] In *Bethesda*, the providers were dissatisfied with malpractice reimbursement and did not file a claim for the additional reimbursement on their cost report nor did they file a statement with the cost report challenging the validity of the regulation. Hence, there was no final determination with respect to malpractice costs. The Court rejected the Secretary's argument that 42 U.S.C. § 1395oo(a)(1)(A)(i), which requires dissatisfaction with a final determination of the intermediary, "necessarily incorporates an exhaustion requirement." The Court found that this "strained interpretation" of the statutory dissatisfaction requirement was inconsistent with the express language of the statute.[13] However, the Court agreed, that under § 1395oo(a)(1)(A)(i), a provider's dissatisfaction with the amount of its total reimbursement is a condition of the Board's jurisdiction, but held that "it is clear, however, that the submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations. No statute or regulation expressly mandates that a challenge to the validity of a regulation be submitted first to the intermediary. . . . Thus, [the providers in *Bethesda]* stand on different ground that do providers who bypass clearly prescribed exhaustion requirements or who fail to request from the intermediary reimbursement for costs to which they are entitled under the applicable rules. While such defaults might well establish that a provider was satisfied with the amounts requested in its cost report and awarded by the intermediary, those circumstances are not presented here."[14] The Secretary noted that the Court recognized that an exhaustion requirement could be imposed by regulation, and that a provider who fails to claim all costs to which it is entitled may fail to meet the jurisdictional prerequisite of dissatisfaction.[15] In light of the ability to enact such regulations, 42 C.F.R. § 405.1835(a)(1)(ii) was promulgated, requiring providers to claim all items for which they seek additional reimbursement.

The Secretary when on to state that "although there may be nothing in the statue indicating that dissatisfaction with final determination must be expressed on the cost report with respect to "each claim." There is nothing in the statute indicating that the Secretary cannot interpret the dissatisfaction requirement in this manner.[16] The final determination, which here is the NPR, is not just the total amount of program reimbursement. Rather it is composed of many individual calculations representing the various items for which a provider seeks payment. Providers generally challenge discrete reimbursement items. Thus, dissatisfaction with total reimbursement is based on dissatisfaction with items that result in total reimbursement. Consequently the Secretary believes it is reasonable under 42 U.S.C. § 1395oo(a) to require dissatisfaction be shown with respect to each issue being appealed.[17] In light of this and the

---

[11] 73 Fed. Reg. 30190 (May 23, 2008).
[12] 485 U.S. 399 (1988)
[13] 73 Fed. Reg. at 30196 citing *Bethesda* at 404.
[14] *Id.* at 404-405.
[15] *Id.*
[16] 73 Fed. Reg. at 30197.
[17] *Id.*

challenge to the outlier regulations must be claimed as a protested item and the Providers failed to comply with this requirement.

In the preamble, the Secretary also confirmed that this regulation codified the PRM rules governing cost reports filed under protest:

> **Comment**: One commenter recommended that the text of section 115 *et seq.* of the PRM, Part II, be placed in the regulations. The commenter noted that these sections of the PRM have not changed since 1980. . . .
>
> **Response**: We are adopting the proposal, which is essentially a codification of the protested amount line procedures set forth in section 115 *et seq.* of the PRM, Part II.[18]

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

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

The Board notes that 42 C.F.R. § 405.1804(d) (2008) provides further evidence that the "rules and regulations governing [cost] reports" are, in part, located in 42 C.F.R. Part 405, Subpart R. This regulation governs implementation of decisions to award, part or in full, self-disallowed items filed under protest:

> (d) **Effect of certain final agency decisions and final court judgments: audits of self-disallowed and other items**. . . .
>
> (2) CMS may require the intermediary to audit any item, including any self-disallowed item, at issue in an appeal or a civil action, before any revised intermediary determination or additional Medicare payment,

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

> recoupment, or offset may be determined for an item under paragraph (d)(2) of this section.

In the preamble to the 2008 Final Rule, CMS stated the following regarding the purpose of this regulatory provision:

> The final decision awarding reimbursement for a self-disallowed item may come from the Board, the Administrator, or a court. Although we believe that, in most instances, the administrative or judicial body that issues a decision would not specify a dollar figure for reimbursement, the proposal was intended to ensure that intermediaries, in fact, have the opportunity to determine the correct amount of reimbursement after an award is made. We believe that it would be inappropriate for the administrative or judicial body to award a specific amount for reimbursement without the benefit of an audit by the intermediary.[19]

Thus, the procedures and documentation required for filing an item under protest and the audit of such items when they are awarded (in part or in full) following a successful appeal as codified at 42 C.F.R. §§ 405.1835(a)(1)(ii) and 405.1804(d) respectively, are an integral part of the cost reporting process established under 42 U.S.C. § 1395g(a) that the provider must "furnish[ ] such information as the Secretary may request in order to determine the amounts due such provider."

For the Providers on the attached Schedule of Providers, there is no amount claimed on Worksheet E, Part A, Line 30 of the cost reports at issue as required to protest the amount of outlier reimbursement pursuant to § 405.1835(a)(1)(ii).[20] As these cost reports involve a fiscal year that end on or after December 31, 2008, self-disallowed items such as the outlier reimbursement at issue must have been filed under protest in order to have "complied with the rules and regulations of the Secretary relating to such [cost] report" and, thereby, established one of the elements for Board jurisdiction under 42 U.S.C. § 1395oo(a)(1). Thus, as the Providers failed to protest the outlier reimbursement at issue and that is the sole issue involved in these appeals, the Board lacks jurisdiction over the appeals of the Providers on the attached Schedule of Providers and hereby dismisses the Providers from case. In a separate decision the Board granted the request for EJR for the two Providers' cost reporting periods which are not subject to the requirement to protest. Since there are no remaining Providers in the appeal, the case is hereby closed.

---

[19] 73 Fed. Reg. at 30199.

[20] *See Providers' April 16,2014 Response to the Board's Request for Information at 2 (the Provider have demonstrated that the protested amount was zero for the fiscal year at issue(.*

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,
Schedule of Providers

cc: Byron Lamprecht, WPS
Kevin Shanklin, BCBSA

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

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

Refer to: 14-0590

MAY 16 2014

CERTIFIED MAIL

Paul Holden
Moss Adams LLP
805 SW Broadway
Suite 1200
Portland, OR 97205

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

RE: Jurisdictional Decision – Renown Regional Medical Center
Provider No.: 29-0001
FYE: 6/30/2009
PRRB Case No.: 14-0590

Dear Mr. Holden 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

Renown Regional Medical Center was issued an original Notice of Program Reimbursement (NPR) for FYE 6/30/2009 on May 29, 2013. On December 5, 2013, the Provider filed an appeal request with the Board appealing four issues: DSH – SSI% (Provider Specific); DSH – SSI% (Systemic Errors); Medicare Advantage, Medicare Managed Care, Medicare + Choice, and/or Part C Days; and Rural Floor Budget Neutrality.

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 of receipt of the final the 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 challenge jurisdiction over the issues appealed, the Board nonetheless finds that it does not have jurisdiction over this appeal because it was not timely filed. Pursuant to 42 C.F.R. § 405.1835(a)(3)(i) and PRRB rules, an appeal must be filed with the Board no later than 180 days after the provider has received its final determination.

42 C.F.R. § 405.1835(a)(3)(i) states,

> (3) Unless the provider qualifies for a good cause extension[...], the date of the receipt by the Board of the provider's hearing request is-
>
> (i) No later than 180 days after the date of receipt by the provider of the intermediary or Secretary determination.

For mailing purposes, pursuant to 42 C.F.R. § 405.1801(a)(1)(iii) and PRRB Rule 4.3, the date of receipt of a NPR is presumed to be five days after the date of issuance, unless established by a preponderance of the evidence that it was actually received on a later date. Furthermore, 42 C.F.R. § 405.1801(a)(2) establishes that the date of receipt by the Board is the date of delivery where the document is transmitted by a nationally-recognized next-day courier or, alternatively, the date stamped "received" by the reviewing entity where a nationally-recognized next-day courier is not used.

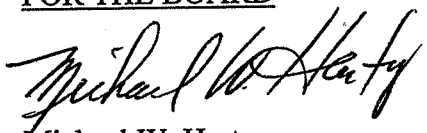
Renown Regional Medical Center was issued its NPR on May 29, 2013, and is presumed to have received it on June 3, 2013. The Provider did not present evidence that the NPR was received later than the five day presumption. An appeal request from this original NPR was delivered by FedEx and received by the Board on December 5, 2013. Thus, the date of filing was 185 days after the presumed date of receipt of the determination from the Intermediary.

Because the appeal request was not received by the Board within 180 days as required by 42 C.F.R. § 405.1835, the Board finds that it was not timely filed. The Board hereby dismisses the appeal and case number 14-0590 is closed.

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.

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

FOR THE BOARD



Michael W. Harty
Chairman

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

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

Refer to:

CERTIFIED MAIL

MAY 22 2014

Hooper, Lundy & Bookman, P.C.
Laurence D. Getzoff, Esq.
Watt Plaza, Suite 1600
1875 Century Park East
Los Angeles, CA 90067 2799

RE: Tenet 2007 DSH SSI Fraction Part C Days CIRP Group, PRRB Case No. 10-0290GC

Dear Mr. Getzoff:

The Provider Reimbursement Review Board (the Board) has reviewed the subject group appeal on its own motion and has noted a jurisdictional impediment. The pertinent facts with regard to this case and the Board's jurisdictional determination are set forth below.

Pertinent Facts:

The Providers filed this appeal through a letter dated December 17, 2009.[1] The hearing request stated that the basis for the appeal was the issuance of the 2007 SSI data on June 24, 2009.[2]

The Providers contend that Medicare Part C days should not be included in either the numerator or denominator of the SSI fraction, which is part of the DSH calculation. In accordance with 42 U.S.C. §1395ww(d)(5)(F)(vi)(I), hospital inpatients who are "entitled to benefits under [P]art A" are to be included in the SSI fraction. The denominator includes all Part A days, whereas the numerator includes only Part A days for patients who are also entitled to SSI under Title XVI. The Providers maintain that patients who have enrolled in Medicare HMOs [health maintenance organizations] under Medicare Part C may be "eligible" for Part A, but are not "entitled" to Part A during the months when they have given up their Part A entitlement to enroll in Part C. The Providers assert that the CMS has improperly included Part C days in the SSI percentages that were released on June 24, 2009 to be used to calculate the DSH SSI fraction for hospital cost reporting years beginning in Federal Fiscal Year 2007 (the 2007 SSI data) resulting in an improper reduction in the DSH percentage for the Providers. The Providers contend that all Part C days should be removed from the SSI fraction.[3]

[1] The Hearing Request was received on December 18, 2009.
[2] The Providers asserted they were appealing from a June 24, 2009 notice. The only documentation demonstrating that the SSI percentages were updated is CMS Transmittal 1774 (Change Request 6530) (CMS Pub. 100-04, Chapter 3 § 20.3) issued on July 24, 2009 which instructed intermediaries that the updated SSI percentages for FFY 2007 were on the CMS website and to use them.
[3] Providers' appeal request at page 2.

Board Determination:

The Board finds that the publication of the 2007 SSI ratios on the CMS website is not a final determination of reimbursement, which is a prerequisite for Board jurisdiction under 42 U.S.C. §1395oo(a) and 42 C.F.R. §§405.1835-405.1840.

On July 24, 2009, CMS issued Transmittal 1744[4] (Change Request 6530) which provided updates for the DSH adjustment for the FY 2007 final determinations. This transmittal notified the providers and the intermediaries of the updated SSI/Medicare Beneficiary data for hospitals. However, on July 31, 2009, CMS reversed its prior notice and instructed intermediaries that they were not to issue final settlements for the fiscal year 2007 using the 2007 SSI ratios.[5] Then, in the May 4, 2010 Federal Register the Secretary issued the Proposed Changes to the Inpatient Prospective Payment Systems (IPPS).[6] In this proposed rule, the Secretary announced that, as a result of the litigation in Baystate Medical Center v. Leavitt, 545 F. Supp.2d 20, as amended 587 F.Supp.2d 37 and 44 (D.D.C. 2008), the calculation of the SSI percentages were being changed based on new data matches. The Secretary also noted the CMS Administrator had prepared a ruling[7] which provided for qualifying appeals and for cost reports not yet finally settled to be revised or settled using the new data match adopted in the forthcoming FY 2011 IPPS final rule for cost report periods prior to October 1, 2010 (Federal fiscal year 2011).[8] Because the cost reports for the Providers in this case have not been settled, they will be subject to this ruling and the new matching process for the SSI data.

In summary, whether the June 24, 2009 publication of the SSI percentage could have been considered a final determination is now moot in that subsequent publications that provide those figures are no longer considered final and will be revised. There being no other final determination (such as an NPR) from which the Providers can appeal, the Board concludes that the appeal is premature and hereby dismisses the case.

Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 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 .1877

cc: Timothy LeJeune, Novitas Solutions, Inc.
Kevin D. Shanklin, BCBSA

---

[4] CMS Pub. 100-04 Claims Processing (July 24, 2009).
[5] See http://www.wpsic.com/medicare/j5macparta/departments/audit_reimbursement/2009_081.
[6] 75 Fed. Reg. 23852 (May 4, 2010).
[7] Centers for Medicare and Medicare Ruling CMS-1498-R issued April 28, 2010.
[8] 75 Fed. Reg. at 24006.

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

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

Refer to:

CERTIFIED MAIL

MAY 22 2014

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

RE: LaPalma Intercommunity Hospital, Provider No. 05-0580, FYE 12/31/2006
PRRB Case No. 13-2302

Dear Ms. Goron:

The Provider Reimbursement Review Board (the Board) has begun an own-motion review of the above-captioned individual appeal. The pertinent facts of the case and the Board's jurisdictional determination are set forth below.

Pertinent Facts:

Healthcare Reimbursement Services, Inc. (HRS) filed an individual appeal on May 28, 2013 from a revised Notice of Program Reimbursement (NPR) dated November 28, 2012. The appeal included the following issues:

- SSI Systemic Errors
- DSH SSI Percentage (Provider Specific) -realignment
- DSH Medicaid Eligible Days
- DSH Medicare Managed Care Part C Days
- DSH Dual Eligible Days (including Exhausted Benefit, Secondary Payor and No-Pay Part A Days
- Rural Floor Budget Neutrality Adjustment

The request for appeal included two authorization letters appointing HRS as the designated representative. The first was dated September 11, 2101 and authorized HRS to handle the Medicare DSH SSI & Part C Payment issues. The second letter was dated February 22, 2012 and authorized HRS to handle the Rural Floor Budget Neutrality Adjustment.

The Board acknowledged the appeal and assigned case no. 13-2302 in an email to HRS dated June 7, 2013.

On November 22, 2013, HRS requested the transfer of the Rural Floor Budget Neutrality issue to a common issue related party (CIRP) group case no. 13-3616GC, the HRS 2006 Prime Healthcare RFBNA CIRP Group.

On January 9, 2014, HRS requested the transfer of the Managed Care Part C Days issue to the HRS 2006 Prime Healthcare DSH Medicare Managed Care Part C Days CIRP, case no. 14-0155GC and the SSI Percentage issue to case no. 14-0148GC, the HRS 2006 Prime Healthcare DSH SSI Percentage CIRP.

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.

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 explains the effect of a cost report revision:

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

The Provider referenced audit adjustment numbers 4, 5, 15 and S/D (self-disallowed) for all issues in the appeal request. Upon review, the Board finds that adjustments 4, 5 and 15 on the adjustment report all relate to the SSI Percentage. Adjustment 4 states it is to "update the SSI ratio." Adjustment 5 states it is to "adjust allowable DSH Percentage due to update on SSI ratio" and adjustment 15 states it is "to update SSI ratio – recipient patient days to Medicare Part A patient days." Because appeals from revised NPRs are limited to the specific matters revised in the revised determination the Board finds that it does not have jurisdiction over the following issues: DSH Medicaid Eligible Days, DSH Medicare Managed Care Part C Days, DSH Dual Eligible Days (including Exhausted Benefit, Secondary Payor & No-Pay Part A Days) and Rural Floor Budget Neutrality. The Board finds no evidence that these issues were adjusted on the revised NPR. Although HRS indicated in the appeal request that the Provider 'self-disallowed' these issues, there is not an opportunity for 'self-disallowance' on a Revised NPR as only adjustments specifically adjusted are appealable.

Further, the Board finds that HRS was not authorized to handle the DSH Medicaid Eligible Days and DSH Dual Eligible Days issues (which included Exhausted Benefit, Secondary Payor & No-Pay Part A Days).

Finally, the Board notes that the Provider is appealing the SSI Provider Specific issue (SSI Realignment). This issue was also not adjusted on the revised NPR. Further, the Provider indicates that it is seeking data from CMS in order to reconcile its records and has not yet decided whether to request realignment (based upon the Provider's cost reporting period.) Because there is no final determination and the Provider has not yet requested realignment, the Board finds this issue to be prematurely appealed. Realignment is a remedy the Provider may pursue if it is dissatisfied with MEDPAR SSI data.

The Board, therefore, dismisses the DSH SSI Percentage (Provider Specific) Realignment, DSH Medicaid Eligible Days, DSH Medicare Managed Care Part C Days, DSH Dual Eligible Days (including Exhausted Benefit, Secondary Payor & No-Pay Part A Days) and the Rural Floor Budget Neutrality Adjustment issues. Since there are no remaining issues, case no. 13-2302 is closed. Furthermore, as the Board has found that it lacks jurisdiction over the Managed Care Part C Days and Rural Floor Budget Neutrality issues, the Board denies the Representative's requests to transfer the DSH Medicare Managed Care Part C Days to case no. 14-0155GC and the Rural Floor Budget Neutrality Adjustment to case no. 13-3616GC.

Because the SSI Percentage (systemic errors) issue was adjusted in the revised NPR, the Board grants the Provider's earlier request to be transferred from case no. 13-2302 to the HRS 2006 Prime Healthcare DSH/SSI Percentage CIRP group, case no. 14-0148GC. Since there are no remaining issues in the individual appeal, the Board hereby closes case no. 13-2302.

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.

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

FOR THE BOARD

Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, Executive Director, BCBSA
Donna Kalafut, Noridian Healthcare Solutions, LLC

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

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

Refer to: 09-1552GC
Certified Mail

MAY 23 2014

J.C. Ravindrin
Quality Reimbursement Services, Inc.
150 N. Santa Anita Ave.
Suite 570A
Arcadia, CA 91006

RE: # 13 Mercy Medical Center of North Merced
as a participant in QRS/CHW 2005 Medicare L/D Group
Provider No. 05-0444
FYE 6/30/2005
PRRB Case No. 09-1552GC

Dear Mr. Ravindrin:

The Provider Reimbursement Review Board (Board) has reviewed the Schedule of Providers and associated jurisdictional documents, as well as supplemental submissions related to jurisdiction requested by the Board. Through correspondence dated December 20, 2012 the Providers requested the labor/delivery room issue be remanded under the Centers for Medicare & Medicaid Services (CMS) Ruling CMS -1498-R. The Board's jurisdictional determination with respect to Mercy Medical Center of North Merced for the fiscal year June 30, 2005 is set forth below.

Background

On March 11, 2008, the Provider filed an appeal of its October 5, 2007 revised Notice of Program Reimbursement (NPR). The Provider was seeking reimbursement for labor/delivery room days in the disproportionate share (DSH) adjustment. The revised NPR stated that:

> Provider initiated request for reopening dated July 10, 2007. Request to reopen cost report to amend the Disproportionate Share (DSH) reimbursement.

The Provider's March 11th hearing request include a number of issues, the only one relevant in this case is the labor/delivery room issue. The audit adjustments the Provider identified as giving rise to the issue were R1-006, R1-007, R1-008 and R1-009. Adjustments R1-006, R1-007 and R1-008 each adjusted Medicaid eligible days on Worksheet S-3 and adjustment R1-009 increased the DSH percentage.[1]

[1] *See* Jurisdictional Documents, Tab 13.D.

The Provider was asked to furnish additional documentation to establish that labor/delivery room days were adjusted through the revised NPR. In correspondence dated July 12, 2013, the Provider illustrated the number of Medicaid days that had been adjusted and stated that it was reviewing the audit and revised Medicaid days to determine if labor/delivery days had been adjusted. In a July 19, 2013 letter to the Board, the Provider submitted a copy of its July 10, 2007 request to reopen the cost report. The request to reopen dealt with the Medicaid eligible days allowable under the Health Care Financing Administration Ruling 97-2. Page 3 of the reopening request discusses labor/delivery room days and states that labor/delivery room days had been reviewed in keeping with the policy to exclude the labor/delivery room days for additional Medi-Cal eligible patients and found no changes to audited labor room days was required. The undated workpapers which were furnished do not show any review or revision to the labor/delivery room count.

Decision of the Board

The Board concludes that it lacks jurisdiction over the Mercy Medical Center of North Merced's appeal of the labor/delivery room issue because there was no adjustment to the issue in the revised NPR as required by 42 C.F.R. § 405.1889.

Pursuant to 42 U.S.C. § 1395oo (a) and 42 C.F.R. §§ 405.1835-.1841, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $50,000 or more for a group appeal, and the request for hearing is filed within 180 days of the date of the final determination.

The effect of a revised NPR on a provider's right to a Board hearing is addressed in 42 C.F.R. § 405.1889. This regulation provides that "such revision shall be considered a separate and distinct determination" for the purposes of the appeal. A revised NPR does not reopen the entire cost report to appeal nor does it extend the 180 day appeal period for any earlier NPR(s). It merely reopens those parts of the cost report adjusted by the revised NPR and only those adjustments may be appealed. [2]

In this case, the Provider filed a timely request for a hearing within 180 days of the revised NPR, but the revised NPR did not adjust labor/delivery room days. Therefore, the Board finds that it lacks jurisdiction over is issue for Mercy Medical Center of North Merced and hereby dismisses the Provider from the appeal. Since this Provider does not have a jurisdictionally proper appeal pending with the Board, the Provider's request for remand under CMS Ruling 1498-R is hereby denied.

---

[2] *See also HCA Health Services of Oklahoma v. Shalala*, 27 Fed. 3d 614 (D.C. Cir. 1994) (hearing rights before the Board challenging an intermediary's decision on a reopening are issue specific: The separate and distinct determination gives a right to hearing on the matters corrected by [the revised NPR]. Thus a revised NPR does not reopen the entire cost report to appeal. It merely reopens those matters adjusted by the revised NPR).

Review of this decision is available under the provisions of 42 U.S.C. § 1395oo (f) (1) 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) (1) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Donna Kalafut, Noridian Healthcare Solutions
Kevin 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

Refer to: 09-1552GC

Certified Mail

MAY 23 2014

J.C. Ravindrin
Quality Reimbursement Services, Inc.
150 N. Santa Anita Ave.
Suite 570A
Arcadia, CA 91006

RE: # 9 Sierra Nevada Memorial Hospital
as a participant in QRS/CHW 2005 Medicare L/D Group
Provider No. 05-0150
FYE 12/31/2005
PRRB Case No. 09-1552GC

Dear Mr. Ravindrin:

The Provider Reimbursement Review Board (Board) has reviewed the Schedule of Providers and associated jurisdictional documents, as well as supplemental submissions related to jurisdiction requested by the Board. Through correspondence dated December 20, 2012 the Providers requested the labor/delivery room issue be remanded under the Centers for Medicare & Medicaid Services (CMS) Ruling CMS -1498-R. The Board's jurisdictional determination with respect to Sierra Nevada Memorial Hospital for the fiscal year December 31, 2005 is set forth below.

Background

On September 4, 2007, this Provider filed an appeal of its revised Notice of Program Reimbursement (NPR) dated July 12, 2007. On May 24, 2013, after reviewing the jurisdictional documents furnished in the Provider's December 2012 submission of jurisdiction documents, the Board asked the Group Representative to establish that labor/delivery room days had been adjusted by the revised NPR that was the subject of this appeal.

In correspondence dated July 12, 2013, the Group Representative stated:

> The Provider had appealed the revised NPR issued on 7/12/2007. There was no settlement for DSH [disproportionate share adjustment]. The revised settlement did not include any DSH payments and there were no adjustments for Labor Room days in the Revised NPR.

Decision of the Board

The Board concludes that it lacks jurisdiction over Sierra Nevada Memorial Hospital's appeal of the labor/delivery room issue because there was no adjustment to the issue in the revised NPR as required by 42 C.F.R. § 405.1889.

Pursuant to 42 U.S.C. § 1395oo (a) and 42 C.F.R. §§ 405.1835-.1841, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $50,000 or more for a group appeal, and the request for hearing is filed within 180 days of the date of the final determination.

The effect of a revised NPR on a provider's right to a Board hearing is addressed in 42 C.F.R. § 405.1889. This regulation provides that "such revision shall be considered a separate and distinct determination" for the purposes of the appeal. A revised NPR does not reopen the entire cost report to appeal nor does it extend the 180 day appeal period for any earlier NPR(s). It merely reopens those parts of the cost report adjusted by the revised NPR and only those adjustments may be appealed. [1]

In this case, the Provider filed a timely request for a hearing within 180 days of the revised NPR, but the revised NPR did not adjust labor/delivery room days. Therefore, the Board finds that it lacks jurisdiction over this issue for Sierra Nevada Memorial Hospital and hereby dismisses the Provider from the appeal. Since this Provider does not have a jurisdictionally proper appeal pending with the Board, the Provider's request for remand under CMS Ruling 1498-R is hereby denied.

Review of this decision is available under the provisions of 42 U.S.C. § 1395oo (f) (1) 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) (1) and 42 C.F.R. §§ 405.1875 and 405.1877.

cc: Donna Kalafut, Noridian Healthcare Solutions
Kevin Shanklin, BCBSA

[1] *See also HCA Health Services of Oklahoma v. Shalala*, 27 Fed. 3d 614 (D.C. Cir. 1994) (hearing rights before the Board challenging an intermediary's decision on a reopening are issue specific: The separate and distinct determination gives a right to hearing on the matters corrected by [the revised NPR]. Thus a revised NPR does not reopen the entire cost report to appeal. It merely reopens those matters adjusted by the revised NPR).

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

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

Refer to: 07-1801GC

MAY 23 2014

CERTIFIED MAIL

Stephanie A. Webster
Akin, Gump, Strauss, Hauer & Feld, LLP
1333 New Hampshire Ave, NW
Suite 400
Washington, DC 20036-1532

Timothy LeJeune
JH Provider Audit & Reimbursement
Novitas Solutions, LLC
Union Trust Building
501 Grant Street, Suite 600
Pittsburgh, PA 15219

RE: Jurisdictional Decision – St. Joseph Hospital East, *as a participant in* CHI 2005 DSH Labor & Delivery Days Group
Provider No.: 18-0143
FYE: 6/30/2005
PRRB Case No.: 07-1801GC

Dear Ms. Webster and Mr. LeJeune,

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. Joseph Hospital East was issued a revised Notice of Program Reimbursement (NPR) for FYE 6/30/2005 on August 13, 2008. On January 23, 2009, the Provider requested to be directly added to this labor and delivery days group appeal, case number 07-1801GC.

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 of receipt of the intermediary's final determination. 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 St. Joseph Hospital East (FYE 6/30/2005) because the Provider appealed from a revised NPR in which the issue on appeal, labor and delivery days, was not adjusted. 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).

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:

> (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.

The Board finds that it does not have jurisdiction over St. Joseph Hospital East because the documentation submitted does not establish that there was an adjustment to labor and delivery days. In the Provider's reopening request it acknowledges that some issues will not be settled during review and removes $16,184 from the amount to be considered.[1] A workpaper submitted shows that dual eligible days were removed, but not labor and delivery days, and that the new total of 4,546 ties to worksheet S-3.[2] Based on the submitted documentation, the Board has concluded that labor and delivery days were not adjusted in St. Joseph East's (FYE 6/30/2005) revised NPR, therefore it does not have jurisdiction over the Provider. St. Joseph Hospital East is hereby dismissed from case number 07-1801GC.

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.

---

[1] Additional documentation submitted to the Board on November 16, 2010 at Tab 2B.
[2] *Id.* at Tab 1A.

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

FOR THE BOARD

Michael W. Harty
Chairman

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

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

Refer to: 07-0155

MAY 23 2014

CERTIFIED MAIL

Crouse Hospital
Molly Galvin
736 Irving Avenue
Syracuse, NY 13210

National Government Services, Inc.
Kyle Browning
Appeals Lead
MP:INA101-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

RE: Crouse Hospital
Provider No. 33-0203
FYE December 31, 2002
PRRB Case No. 07-0155

Dear Ms. Galvin and Mr. Browning:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal in response to the Intermediary's challenge to the Board's jurisdiction to the Direct Graduate Medical Education ("DGME") Omitted rotations issue. The pertinent facts of the case, the Parties' positions and the Board's jurisdictional determination are set forth below.

PERTINENT FACTS:

The Provider filed its initial appeal on October 24, 2006, for its cost reporting period ending December 31, 2002, from a notice of program reimbursement ("NPR") dated May 5, 2006. The Provider initially sought to appeal the (1) Medicare SSI percentage, (2) DSH Dual Eligible days, and (3) Direct Graduate Medical Education ("DGME") and Indirect Medical Education ("IME") Full time equivalent ("FTEs") count. On June 7, 2007, the Provider transferred the DSH Dual Eligible Days issue to group appeal 07-0420G and the SSI % issue to group appeal 95-2120G. The Provider subsequently added another SSI issue based on a revised NPR and also transferred that issue to case no. 95-2120G.

On February 26, 2013, the Intermediary filed a Jurisdictional Challenge for issue 3, DGME/IME FTE count. The Provider did not file a responsive brief to the Intermediary's challenge.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Board does not have jurisdiction over the issue raised in this appeal because it did not make a final determination concerning the Provider's GME/IME FTEs that were inadvertently omitted by the Provider from the as filed cost report and IRIS report used by the Intermediary.

At audit the Intermediary disallowed 9.09 Internal Medicine Resident FTEs as the rotation schedules submitted by the provider showed that the residents had completed the claimed rotations at other facilities.[1] The provider is not contesting these disallowed rotations, but has instead submitted an entirely revised IRIS[2] report which includes 226 rotations from 88 Internal Medicine Residents that were not included on the as filed IRIS[3] report used to settle the cost report.

The Intermediary argues that it did not make an adjustment on the cost report for this issue and therefore, the Provider is unable to demonstrate that it satisfies 42 CFR § 405.1835.[4]

In sum, the Intermediary argues that the Provider never claimed the DGME/IME FTEs that it omitted from the cost report. Therefore, the Intermediary did not make an adjustment to the cost report and as such these FTEs are unclaimed costs.

Provider's Contentions:

The Provider did not submit a responsive brief to the Intermediary's jurisdictional challenge.

BOARD'S DECISION:

The Board has considered the Medicare law, program instructions, the evidence presented and the parties' contentions. Set forth below are the Board's findings and conclusions.

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

The Board finds that the Provider does not have a right under 42 U.S.C. § 1395oo(a) to a hearing on the omitted rotations. The Provider received reimbursement for the items and services claimed on its as filed cost report and, therefore, is not dissatisfied under § 1395oo(a). Also, the Board declines to hear this matter under its discretionary powers of review pursuant to 42 U.S.C. § 1395oo(d).

The crux of this dispute centers around the gateway to Board jurisdiction under 42 U.S.C. § 1395oo(a), which provides in relevant part:

> "Any provider of services which has filed a required cost report within the time specified in the regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board . . . if –
>
> (1) such provider

---

[1] *See* Intermediary jurisdictional challenge at I-2
[2] *See* Intermediary jurisdictional challenge at I-3
[3] *See* Intermediary jurisdictional challenge at I-4
[4] 42 CFR § 405.1835 states: "The Provider…has the right to a hearing before the Board about any matter designated in 42 CFR § 405.1801(a)(1), if…[a] Intermediary determination has been made with respect to the provider."

> (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by this report . . .

After jurisdiction is established under 42 U.S.C. § 1395oo(a) the Board has the discretionary power to make a determination over all matters covered by the cost report under 42 U.S.C. § 1395oo(d) which states in relevant part:

> The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

In *Bethesda Hospital Association v. Bowen*,[5] the provider failed to claim a cost because a regulation dictated that it would have been disallowed. In that situation, the Supreme Court found section 1395oo(a) permitted jurisdiction over the "self-disallowed" claim. The Court wrote:

> [U]nder subsection (a)(1)(A)(i), a provider's dissatisfaction with the amount of its total reimbursement is a condition to the Board's jurisdiction. It is clear, however, that the *submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations.*[6]

The Court recognized that a situation where a regulation pre-determines a disallowance is distinct from those in which a provider simply neglects to include an item on the cost report for which it would be due reimbursement:

> Thus, petitioners stand on different ground than do providers who bypass a clearly prescribed exhaustion requirement or *who fail to request from the intermediary reimbursement for all costs to which they are entitled under applicable rules.* While such defaults might well establish that a provider was satisfied with the amounts requested in its cost report and awarded by the fiscal intermediary, those circumstances are not presented here.[7]

In the subject case, the Board has precisely the situation described by the Supreme Court as being "on different ground."[8] While the Supreme Court has not had an opportunity to squarely address whether the Board must take jurisdiction of an appeal of a cost unclaimed through inadvertence rather than futility, other appellate courts have. However, there is a split among the circuit courts that have addressed the issue of unclaimed or self-disallowed costs since the *Bethesda* decision was issued.

The Seventh Circuit has adopted an interpretation of *Bethesda* that precludes Board jurisdiction where the provider's request would not have been clearly futile. Specifically, in 1994 in *Little Co. of Mary*

---

[5] 485 U.S. 405(1988) Hereinafter *Bethesda*.
[6] *Bethesda* at 1258, 1259. (Emphasis added).
[7] *Id.* at 1259. (Emphasis added).
[8] Emphasis added.

Hosp. v. Shalala ("*Little Co. I*"),[9] the Seventh Circuit relied on the *Bethesda* dicta, noting that a provider's failure to claim all the reimbursement to which it is entitled under program policies is tantamount to a "failure to exhaust" administrative remedies before the fiscal intermediary, which establishes that the provider is not "dissatisfied" with the intermediary's final reimbursement determination.[10]

Subsequently, in 1999, the Seventh Circuit addressed the same issue in a case involving the same provider ("*Little Co. II*").[11] In *Little Co.II*, the Seventh Circuit held that the Board lacked jurisdiction over an appeal of an issue that the Intermediary had not considered, and distinguished *Bethesda* on the grounds that the cost issue on appeal in *Little Co. II* did not involve an "issue of policy" like the *Bethesda* plaintiffs' challenge to the malpractice regulations.[12] The Seventh Circuit noted:

> But while the statute is curiously worded, the intent is plain that the provider must give the intermediary a first shot at the issue, provided the issue is within the intermediary's competence...[13]

Citing *Little Co. II,* the preamble to the 2008 final rule (while not controlling for this cost reporting year under appeal) states that it has been the agency's "longstanding view that providers that fail to claim on their cost reports costs that are allowable under Medicare law and regulations cannot meet the 'dissatisfaction' requirement" of subsection (a).[14] The Agency policy of presentment aims to prevent an end-run around the Intermediary. The Agency further states that it "interpret[s] section 1878(d) of the Act as permitting the Board to make revisions to cost report items that directly flow from the determination with which the Provider has expressed dissatisfaction and from which the provider has filed a jurisdictionally proper appeal under section 1878(a) of the Act."[15]

In contrast, the First and Ninth Circuits have determined that the language of the Medicare statute provides for Board jurisdiction over claims not included in the initial cost report, whether they have been inadvertently omitted or "self-disallowed."[16] Both circuits rejected the Seventh Circuit's interpretation of the statute, finding it contained neither an exhaustion requirement to obtain a hearing before the fiscal intermediary, nor a limitation on the Board's scope of review once its jurisdiction was invoked. The progeny of decisions in these circuits have generally regarded subsection (a) to be read in conjunction with subsection (d) and supports the discretionary nature of subsection (d).

The seminal case in the 9th Circuit is the 2007 decision in *Loma Linda Univ. Med. Ctr. v. Leavitt* ("*Loma Linda*").[17] In *Loma Linda,* the provider had inadvertently zeroed out reimbursable interest expense in the cost report and filed it without any claim for reimbursement. The intermediary issued its NPR without any adjustments for interest expense. The provider then appealed to the Board and

---

[9] 24 F.3d 984 (7th Cir. 1994).
[10] *Little Co. I,* 24 F.3d at 992.
[11] *Little Co. of Mary Hosp. v. Shalala,* 165 F.3d 1162 (7th Cir. 1999).
[12] *Little Co. II,* 165 F.3d at 1165.
[13] *Id.*
[14] 73 Fed. Reg. at 30196.
[15] 73 Fed. Reg. at 30203.
[16] *See Loma Linda Univ. Med. Ctr. v. Leavitt,* 492 F.3d at 1065 (9th Cir. 2007); *MaineGeneral Med. Ctr. v. Shalala,* 205 F.3d 493 (1st Cir. 2000).
[17] 492 F.3d 1065 (9th Cir. 2007).

identified six aspects of the Intermediary's final determination with which it was dissatisfied (not including the zeroed out interest expense). When it later discovered its interest error, the provider added the interest expense issue to its pending appeal. The Ninth Circuit Court stated:

> We conclude that once the Board acquires jurisdiction pursuant to 42 U.S.C. § 1395oo(a) over a dissatisfied provider's cost report on appeal from the intermediary's final determination of total reimbursement due for a covered year, it has *discretion under § 1395oo(d) to decide whether to order reimbursement of a cost or expense ... even though that particular expense was not expressly claimed or explicitly considered by the intermediary.*[18]

This holding suggests that the "dissatisfaction" requirement to exercise a right to appeal under § 1395oo(a) applies only to the total amount of program reimbursement reflected on the NPR and that "dissatisfaction" does not need to be tied to a specific gateway claim or issue under § 1395oo(a) before the Board can exercise discretion under § 1395oo(d) to hear a claim or issue not raised with the intermediary (*e.g.*, unclaimed costs).[19] Further, the Ninth Circuit stated it was joining the First Circuit's view as expressed in *MaineGeneral Med. Ctr. v. Shalala* ("*MaineGeneral*")[20] and *St. Luke's Hosp. v. Secretary* ("*St. Luke's*")[21] which were decisions issued in 2000 and 1987 respectively.[22]

MaineGeneral involved hospitals that listed zero for reimbursable bad debts on their cost reports. The providers did not discover mistakes in their as-filed cost reports until after the NPRs had been issued. The providers appealed several items adjusted by the NPRs, but also appealed certain previously unclaimed bad debts (*i.e.*, costs not claimed due to inadvertence rather than futility). The Board dismissed the bad debt claims for lack of jurisdiction because the claims had not been disclosed on the as-filed cost reports, despite there being no legal impediment. The First Circuit in *MaineGeneral* relied on its prior pre-*Bethesda* decision in *St. Luke's* in which costs were self-disallowed, not inadvertently omitted. However, that First Circuit found the *St. Luke's* decision nevertheless addressed the question of whether the Board has the power to decide an issue that was not first raised by the intermediary, holding the Board does have the power, but that the power is discretionary. In *St. Luke's*, the First Circuit expressly rejected the provider's assertion that the court should order the Board to hear the case even though it found the hospital had a strong equitable argument favoring review under the particular circumstances.[23] Specifically, the First Circuit wrote: "The statute [*i.e.*, § 1395oo(d)] does not say that the Board *must* consider matters not considered by the intermediary. But, it does say the Board may, it can, it has the 'power' to do so."[24]

The First Circuit in *MaineGeneral* then found that the Board could adopt a policy of hearing such claims or refusing to hear them, or it could opt to decide on a case-by-case basis. The First Circuit further noted that "a rule of consistently refusing to hear inadvertently omitted claims would be rational, given the ability of providers to request the intermediary to reopen an NPR up to three years after it has been

---

[18] *Id.* at 1068 (emphasis added).
[19] *See* 73 Fed. Reg. at 30197.
[20] 205 F.3d 493 (1st Cir. 2000).
[21] *St. Luke's Hosp. v. Secretary*, 810 F.2d 325 (1st Cir. 1987).
[22] *See Loma Linda*, 492 F.3d at 1068.
[23] *St. Luke's*, 810 F.2d at 332.
[24] *Id.* at 327-328 (emphasis in original).

issued."[25] Similarly, in *St. Luke's*, the First Circuit opined that, even though the Board has legal power to consider matters not specifically raised before the intermediary, whether to exercise that power is for the Board to decide and, like many similar powers of courts and agencies, should be exercised only sparingly.[26] Although the First Circuit in *MaineGeneral* analyzed appeal rights on a "claim" or issue specific basis, the First Circuit included the following dicta:

> That a cost is listed in a cost report says nothing about whether the provider is "dissatisfied" with the later decision by the intermediary to reimburse or not reimburse costs. . . . [N]othing in St. Luke's suggests that the hospital would not have been "dissatisfied" if it omitted to list the cost on a worksheet in the cost report (whether through inadvertence or in reliance on the agency's earlier determination that the costs were not recoverable). ...Under *St. Lukes's*, the statutory word '"dissatisfied"' is not limited to situations in which reimbursement was sought by the hospital from the intermediary."[27]

This dicta suggests that, similar to the Ninth Circuit in *Loma Linda*, the First Circuit would interpret § 1395oo(a) as not requiring that a specific gateway issue or claim be established under § 1395oo(a) before the Board could exercise discretion under 1395oo(d) to hear an issue or claim not considered by the intermediary (*e.g.*, unclaimed cost). Rather, the First Circuit appears to decouple the listing of costs claimed in the cost report from the ability of the provider to be "dissatisfied" with the later decision by the intermediary to reimburse or not reimburse.

This application of § 1395oo(d) is further supported by the D.C. District Court in the 2008 case of *UMDNJ-University Hospital v. Leavitt*.[28] As in *MaineGeneral* and *Loma Linda*, the provider filed its appeal based on several intermediary adjustments to its cost report claims with which it was dissatisfied, but it also included an appeal of costs for its clinical medical education programs that were omitted entirely from the cost report. That court wrote:

> The Board may adopt a policy of hearing claims not initially presented to the fiscal intermediary or of refusing to hear them, or it may decide on a case by case basis. This conclusion comports with the plain language of subsection (d), ...[29]

Similar to the Ninth Circuit in *Loma Linda*, the D.C. District Court interpreted § 1395oo(a) as requiring only general dissatisfaction with the amount of total reimbursement on the NPR in order to establish Board jurisdiction under § 1395oo(a).[30]

In the aggregate, the case law of the First and Ninth Circuits and the D.C. District Court consistently conforms to the notion that § 1395oo(d) bestows the Board with a limited discretion, which is preconditioned on first establishing jurisdiction under § 1395oo(a). The case law does not stand for the proposition that § 1395oo(d) is a grant of "alternate" jurisdiction, but instead, these decisions make it clear that, once the Board acquires jurisdiction over a cost report itself pursuant to 42 U.S.C.

---

[25] *MaineGeneral*, 205 F.3d at 501.
[26] *St. Luke's*, 810 F.2d at 327.
[27] *MaineGeneral*, 205 F.3d at 501.
[28] *UMDNJ Univ. Hosp. v. Leavitt*, 539 F.Supp.2d. 70 (D.D.C. 2008) [hereinafter "*UMDNJ*"].
[29] *Id.* at 79.
[30] *Id.*at 77.

§ 1395oo(a), the Board has the discretionary power under § 1395oo(d) to hear any discrete items and services on the cost report. The Board *may* then hear the appeals of claims inadvertently omitted or mistakenly reported on the cost report, but the Board is *not required* to hear those claims.

Historically, the Board's interpretation of §§ 1395oo(a) and (d) has generally been more closely aligned with the interpretation of the First Circuit rather than arguably broader interpretation of the Ninth Circuit or the more narrow interpretation of the Seventh Circuit. Specifically, the Board has generally interpreted § 1395oo(a) as: (1) the gateway to establishing Board jurisdiction to hear an appeal; and (2) contrary to *Loma Linda* and *UMDNJ*, requiring that dissatisfaction be expressed with respect to the total reimbursement for "each claim" (as opposed to a general dissatisfaction to the total reimbursement on the NPR) because the Board has viewed the NPR as being comprised of many individual determinations on various items for which the provider has sought payment in the as-filed cost report.[31]

42 U.S.C. § 1395oo(a) dictates that, to obtain jurisdiction, a provider must be "dissatisfied" with a "final determination" of the intermediary. Thus, it follows that a provider must have claimed reimbursement for items and services for the intermediary to make a "final determination" regarding such items and services.

The Provider failed to claim all of the DGME/IME FTEs on its cost report as filed with the Intermediary. The Board is not persuaded by the Provider's argument that a change in methodology for determining the number of FTEs it should claim resulted in these FTEs not being claimed on its submitted IRIS report or as filed cost report.[32] The Board finds that these FTEs are unclaimed costs as the Provider is not asserting futility (*e.g.*, a law, regulation, CMS Ruling, or manual provision actually precludes reimbursement) but rather ignorance on the methodology to calculate rotations and documentation required.

The Board finds the errors and omissions for the unclaimed rotations raised in the appeal were due solely to the Provider's negligence in understanding the Medicare regulations governing the reimbursement of such items on the Medicare cost report. Only in hindsight did the Provider determine that it could (and should) have reported these items differently, thereby potentially increasing the amount of reimbursement. However, uncertainty as to the interpretation of a regulation does not necessarily make a claim for reimbursement futile. Rather, this case is precisely the situation described by the Supreme Court as being "on different ground" because the Provider "fail[ed] to request from the intermediary reimbursement for all costs to which [it was] entitled under applicable rules."[33]

While the Provider is located in the Second Circuit, the Board reaches the same result as the Seventh Circuit decisions in *Little Co. I* and *Little Co. II*. As previously noted, the Board generally has interpreted 42 U.S.C. § 1395oo(a) as the gateway to establishing Board jurisdiction to hear an appeal and requiring a provider to establish a right to appeal on a claim-by-claim or issue-specific basis. Accordingly, the Board finds that only when the provider has established jurisdiction under § 1395oo(a) with respect to one or more of such claims/issues can the Board then exercise discretion to hear other

---

[31] *See, e.g., Affinity Med. Ctr. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2010-D15 (Mar. 11, 2010), *declined review*, CMS Administrator (May 3, 2010) ("*Affinity*") (analyzing a provider's right to a hearing on an issue-specific basis rather than a general basis). *See also* Board Rule 7; 73 Fed. Reg. at 30197.
[32] *See* Provider's appeal request dated October 24, 2006, issue 3.
[33] *Bethesda*, 485 U.S. at 404-405.

claims not considered by the intermediary (*e.g.*, unclaimed costs).[34] Further, the Board again notes that it has consistently declined to exercise discretion under 42 U.S.C. § 1395oo(d) to hear appeal of other issues involving unclaimed costs when reimbursement of those costs was not precluded by a specific law, regulation, CMS Ruling or manual instruction and has dismissed those appeals when the sole issue(s) in the case involves unclaimed costs.[35]

Therefore, the Board dismisses the DGME/IME omitted rotations issue as the Board does not have jurisdiction under 42 U.S.C. § 1395oo(a) or § 1395oo(d) to address items and services not claimed or not properly reported on the cost report where the failure to claim was due to inadvertence rather than futility. Since this is the sole issue remaining in the appeal, the Board hereby closes case no. 07-0155.

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 .1877

cc: Kevin Shanklin, Managing Director, BCBSA

[34] *See supra* note 57 and accompanying text.
[35] *See, e.g., Affinity Med. Ctr. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2010-D15 (Mar. 11, 2010), *declined review*, CMS Administrator (May 3, 2010). This would not be a case in which the Board would deviate from this practice.

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

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

Refer to: 07-1472 CERTIFIED MAIL MAY 30 2014

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

CGS Administrators
Judith E. Cummings
Accounting Manager
CGS Audit & Reimbursement
P.O. Box 20020
Nashville, TN 37202

Re: St. Claire Regional Medical Center
Provider No. 18-0018
FYE 06/30/2005
PRRB Case No. 07-1472

Dear Mr. Rotella and Ms. Cummings:

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

Background

This appeal was filed on March 22, 2007, from the Notice of Program Reimbursement (NPR) dated September 27, 2006. The Provider filed the appeal with the three issues: DSH Calculation-Title XIX KHCP Charity Care Days, which was withdrawn on March 13, 2014; DSH Calculation, Medicare/Medicaid Dual Eligible Patient Days, which was transferred on March 24, 2014 to case number 13-0603G; and DSH Calculation SSI days, which is pending a remand under the CMS1498-R. The Provider also briefed the Observation Bed Days issue as Issue #2 in its Final Position Paper dated December 3, 2007. The Intermediary also presented an argument on the Observation Bed Days issues on its Final Position Paper submitted on November 9, 2007.

On March 13, 2014 the Provider submitted a request to transfer the Provider's Observation Bed Days issue for the 2005 cost year to the pending Reed Smith 2002-2006 Observation Bed Days Group, Case No. 09-1091G.[1] In connection with this request, the Provider submitted the Model *Form D- Request to Transfer Issue to Group Appeal.*

In its letter to the PRRB the Provider stated "we understand that the Provider added the Observation Bed Days issue to its 2005 cost year appeal by separate correspondence, a so-

[1] *See,* Request of Appeal Hearing dated March 22, 2007 and Reed Smith Letter (Request to Transfer and Withdraw Issue) received March 13, 2014.

called "add letter". While we were unable to locate a copy of that formal letter and include it with the enclosed Form D, we note that both the Provider and the Intermediary acknowledged the existence of the issue in the appeal by presenting arguments on Observation Bed Days in their respective Preliminary and Final Position Papers."

The Provider recognizes that the group to which they are seeking to make this transfer was closed to new providers on April 1, 2010. The Provider also stated that they have no other observation bed days group open, and don't anticipate forming any new such group since they do not meet the requisite amount in controversy to do so. The Provider elaborated that, the PRRB has not yet set a hearing date for the Reed Smith 2002-2006 Observation Bed Days Group and the transfer would not require any special consideration.[2]

Provider's Contentions:

In the Final Position Paper, the Provider contends the Intermediary improperly included observation Bed days, swing bed days, outpatient days, and similar days of service in the denominator of the IME ratio and in the denominator of the Medicaid proxy of the Medicare DSH calculation.

The Provider states in *Clark Regional Medical center V United States Department of Health and Human Services 314F.3d 241 (6th Cir. 2002)("Clark Regional"),* the Intermediary sought to count beds fractionally that were occasionally used for observation or other non-acute purpose. However the United States Court of Appeals for the sixth circuit rejected this approach and ruled in favor of the hospitals, holding that so long as the patient bed was in an acute care unit, it counted toward the 100 bed threshold. The Provider contends that court in ruling in favor of the hospitals and against the fractional approach, did nothing more than hold fast to the text of CMS's own regulation regarding the beds. The Provider further contends that, nevertheless, CMS then used the *Clark Regional* decision as a basis to proclaim on August 25, 2004(memorandum) that it would be appropriate for intermediaries in the sixth Circuit to include non-acute care days in the DSH calculation. The Provider is adamant that the "bed threshold" and "patient day" are separate issues, and the memorandum reflects that the issue of counting days was not considered by the Sixth Circuit in Clark Regional case.

The Provider contends accordingly, the Intermediary should be instructed to reopen the Provider's cost report, and to exclude observation days, swing bed days, outpatient days, and similar days of service, from the denominator of the IME ratio and from the denominator of the Medicaid proxy of the Medicare DSH calculation.[3]

Intermediary's Contentions:

As per the Final Position Paper, the Intermediary contends that in a CMS memorandum dated August 25, 2004, intermediaries with hospitals located in the Sixth Circuit were instructed on how to apply the Court of Appeals decision in *Clark Regional Medical Center v. United States Department of Health and Human Services.*

---

[2] *Id*
[3] *See,* Providers Final Position Paper at 6

The Intermediary states that the provider objects to two instructions in this CMS memorandum. First, intermediaries were instructed for all discharges occurring before October 1, 2003, to include the days associated with outpatient observation services in the denominator (available beds) of the IME ratio if the services were provided in beds generally used to provide inpatient acute care services. Secondly, intermediaries were instructed for all discharges occurring before October 1, 2003, to include the days associated with these outpatient observation services in both the numerator and denominator of the Medicaid ratio used in the DSH calculation. The Intermediary is adamant that these instructions were not implemented for any discharges after October 1, 2003. This entire (Provider) cost reporting period occurred after October 1, 2003, so the above instructions were followed on this cost report. The Intermediary requests that the provider withdraw this issue because the CMS memorandum to which it objects was not implemented on this cost report.[4]

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 Notice of Program Reimbursement (NPR).

The Board finds that the Provider does not have a right under 42 U.S.C. § 1395oo(a) to a hearing on the observation bed day issue . The Provider received reimbursement for the items and services claimed on its as-filed cost report and, therefore, is not dissatisfied under § 1395oo(a). Also, the Board declines to hear this matter under its discretionary powers of review pursuant to 42 U.S.C. § 1395oo(d).

The crux of this dispute centers around the gateway to Board jurisdiction under 42 U.S.C. § 1395oo(a), which provides in relevant part:

> Any provider of services which has filed a required cost report within the time specified in the regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board . . . if –
>
> (1) such provider
>
> (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by this report . . .

After jurisdiction is established under 42 U.S.C. § 1395oo(a) the Board has the discretionary power to make a determination over all matters covered by the cost report under 42 U.S.C. § 1395oo(d) which states in relevant part:

> The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the

[4] *See*, Intermediary's Final Position Paper at 6

intermediary in making such final determination.

In *Bethesda,* the provider failed to claim a cost because a regulation dictated that it would have been disallowed. In that situation, the Supreme Court found section 1395oo(a) permitted jurisdiction over the "self-disallowed" claim. The Court wrote:

> [U]ndcr subscction (a)(1)(A)(i), a provider's dissatisfaction with the amount of its total reimbursement is a condition to the Board's jurisdiction. It is clear, however, that the *submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations.*[5]

The Court recognized that a situation where a regulation pre-determines a disallowance is distinct from those in which a provider simply neglects to include an item on the cost report for which it would be due reimbursement:

> Thus, petitioners stand on different ground than do providers who bypass a clearly prescribed exhaustion requirement or *who fail to request from the intermediary reimbursement for all costs to which they are entitled under applicable rules.* While such defaults might well establish that a provider was satisfied with the amounts requested in its cost report and awarded by the fiscal intermediary, those circumstances are not presented here.[6]

In the subject case, the Board has precisely the type of situation described by the Supreme Court as being "on different ground.", albeit it is slightly different as the inclusion of the days in dispute actually reduces provider payment.[7] Had the Provider excluded the days on its as-filed cost report, it would have requested "full reimbursement" for the medical education and DSH costs. However, it included these days even though they were not obligated to do so by the *Clark* decision or the CMS policies. While the Supreme Court has not had an opportunity to squarely address whether the Board must take jurisdiction of an appeal of a cost unclaimed through inadvertence rather than futility, other appellate courts have. However, there is a split among the circuit courts that have addressed the issue of unclaimed or self-disallowed costs since the *Bethesda* decision was issued.

The Seventh Circuit has adopted an interpretation of *Bethesda* that precludes Board jurisdiction where the provider's request would not have been clearly futile. Specifically, in 1994 in *Little Co. of Mary Hosp. v. Shalala* ("*Little Co. I*"),[8] the Seventh Circuit relied on the *Bethesda* dicta, noting that a provider's failure to claim all the reimbursement to which it is entitled under program policies is tantamount to a "failure to exhaust" administrative remedies before the fiscal intermediary, which establishes that the provider is not "dissatisfied" with the intermediary's final reimbursement determination.[9]

Subsequently, in 1999, the Seventh Circuit addressed the same issue in a case involving the same provider ("*Little Co. II*").[10] In *Little Co.II*, the Seventh Circuit held that the Board lacked jurisdiction over an appeal of an issue that the Intermediary had not considered, and distinguished *Bethesda* on the grounds that the cost issue on appeal in *Little Co. II* did not

---

[5] *Bethesda* at 1258, 1259 (emphasis added).
[6] *Id.* at 1259 (emphasis added).
[7] Emphasis added.
[8] 24 F.3d 984 (7th Cir. 1994).
[9] *Little Co. I,* 24 F.3d at 992.
[10] *Little Co. of Mary Hosp. v. Shalala,* 165 F.3d 1162 (7th Cir. 1999).

involve an "issue of policy" like the *Bethesda* plaintiffs' challenge to the malpractice regulations.[11] The Seventh Circuit noted:

> But while the statute is curiously worded, the intent is plain that the provider must give the intermediary a first shot at the issue, provided the issue is within the intermediary's competence...[12]

Citing *Little Co. II,* the preamble to the 2008 final rule (while not controlling for this cost reporting year under appeal) states that it has been the agency's "longstanding view that providers that fail to claim on their cost reports costs that are allowable under Medicare law and regulations cannot meet the 'dissatisfaction' requirement" of subsection (a).[13] The Agency policy of presentment aims to prevent an end-run around the Intermediary. The Agency further states that it "interpret[s] section 1878(d) of the Act as permitting the Board to make revisions to cost report items that directly flow from the determination with which the Provider has expressed dissatisfaction and from which the provider has filed a jurisdictionally proper appeal under section 1878(a) of the Act."[14]

In contrast, the First and Ninth Circuits have determined that the language of the Medicare statute provides for Board jurisdiction over claims not included in the initial cost report, whether they have been inadvertently omitted or "self-disallowed."[15] Both circuits rejected the Seventh Circuit's interpretation of the statute, finding it contained neither an exhaustion requirement to obtain a hearing before the fiscal intermediary, nor a limitation on the Board's scope of review once its jurisdiction was invoked. The progeny of decisions in these circuits have generally regarded subsection (a) to be read in conjunction with subsection (d) and supports the discretionary nature of subsection (d).

The seminal case in the 9th Circuit is the 2009 decision in *Loma Linda Univ. Med. Ctr. v. Leavitt* ("*Loma Linda*").[16] In *Loma Linda,* the provider had inadvertently zeroed out reimbursable interest expense in the cost report and filed it without any claim for reimbursement. The intermediary issued its NPR without any adjustments for interest expense. The provider then appealed to the Board and identified six aspects of the Intermediary's final determination with which it was dissatisfied (not including the zeroed out interest expense). When it later discovered its interest error, the provider added the interest expense issue to its pending appeal. The Ninth Circuit Court stated:

> We conclude that once the Board acquires jurisdiction pursuant to 42 U.S.C. § 1395oo(a) over a dissatisfied provider's cost report on appeal from the intermediary's final determination of total reimbursement due for a covered year, it has *discretion under § 1395oo(d) to decide whether to order reimbursement of a cost or expense ... even though that particular expense was not expressly claimed or explicitly considered by the intermediary.*[17]

This holding suggests that the "dissatisfaction" requirement to exercise a right to appeal under

---

[11] *Little Co. II*, 165 F.3d at 1165.
[12] *Id.*
[13] 73 Fed. Reg. at 30196.
[14] 73 Fed. Reg. at 30203.
[15] *See Loma Linda Univ. Med. Ctr. v. Leavitt*, 492 F.3d at 1065; *MaineGeneral Med. Ctr. v. Shalala,* 205 F.3d 493 (1st Cir. 2000).
[16] 492 F.3d 1065 (9th Cir. 2007).
[17] *Id.* at 1068 (emphasis added).

§ 1395oo(a) applies only to the total amount of program reimbursement reflected on the NPR and that "dissatisfaction" does not need to be tied to a specific gateway claim or issue under § 1395oo(a) before the Board can exercise discretion under § 1395oo(d) to hear a claim or issue not raised with the intermediary (*e.g.*, unclaimed costs).[18] Further, the Ninth Circuit stated it was joining the First Circuit's view as expressed in *MaineGeneral Med. Ctr. v. Shalala* ("*MaineGeneral*")[19] and *St. Luke's Hosp. v. Secretary* ("*St. Luke's*")[20] which were decisions issued in 2000 and 1987 respectively.[21]

MaineGeneral involved hospitals that listed zero for reimbursable bad debts on their cost reports. The providers did not discover mistakes in their as-filed cost reports until after the NPRs had been issued. The providers appealed several items adjusted by the NPRs, but also appealed certain previously unclaimed bad debts (*i.e.*, costs not claimed due to inadvertence rather than futility). The Board dismissed the bad debt claims for lack of jurisdiction because the claims had not been disclosed on the as-filed cost reports, despite there being no legal impediment. The First Circuit in *MaineGeneral* relied on its prior pre-*Bethesda* decision in *St. Luke's* in which costs were self-disallowed, not inadvertently omitted. However, that First Circuit found the *St. Luke's* decision nevertheless addressed the question of whether the Board has the power to decide an issue that was not first raised by the intermediary, holding the Board does have the power, but that the power is discretionary. In *St. Luke's*, the First Circuit expressly rejected the provider's assertion that the court should order the Board to hear the case even though it found the hospital had a strong equitable argument favoring review under the particular circumstances.[22] Specifically, the First Circuit wrote: "The statute [*i.e.*, § 1395oo(d)] does not say that the Board *must* consider matters not considered by the intermediary. But, it does say the Board may, it can, it has the 'power' to do so."[23]

The First Circuit in *MaineGeneral* then found that the Board could adopt a policy of hearing such claims or refusing to hear them, or it could opt to decide on a case-by-case basis. The First Circuit further noted that "a rule of consistently refusing to hear inadvertently omitted claims would be rational; given the ability of providers to request the intermediary to reopen an NPR up to three years after it has been issued."[24] Similarly, in *St. Luke's*, the First Circuit opined that, even though the Board has legal power to consider matters not specifically raised before the intermediary, whether to exercise that power is for the Board to decide and, like many similar powers of courts and agencies, should be exercised only sparingly.[25] Although the First Circuit in *MaineGeneral* analyzed appeal rights on a "claim" or issue specific basis, the First Circuit included the following dicta:

> That a cost is listed in a cost report says nothing about whether the provider is "dissatisfied" with the later decision by the intermediary to reimburse or not reimburse costs. . . . [N]othing in St. Luke's suggests that the hospital would not have been "dissatisfied" if it omitted to list the cost on a worksheet in the cost report (whether through inadvertence or in reliance on the agency's earlier determination that the costs were not recoverable). ...Under *St. Lukes's*, the statutory word '"dissatisfied"' is not limited to situations in which reimbursement

---

[18] *See* 73 Fed. Reg. at 30197.
[19] 205 F.3d 493 (1st Cir. 2000).
[20] *St. Luke's Hosp. v. Secretary*, 810 F.2d 325 (1st Cir. 1987).
[21] *See Loma Linda*, 492 F.3d at 1068.
[22] *St. Luke's*, 810 F.2d at 332.
[23] *Id.* at 327-328 (emphasis in original).
[24] *MaineGeneral*, 205 F.3d at 501.
[25] *St. Luke's*, 810 F.2d at 327.

> was sought by the hospital from the intermediary."[26]

This dicta suggests that, similar to the Ninth Circuit in *Loma Linda*, the First Circuit would interpret § 1395oo(a) as not requiring that a specific gateway issue or claim be established under § 1395oo(a) before the Board could exercise discretion under 1395oo(d) to hear an issue or claim not considered by the intermediary (*e.g.*, unclaimed cost). Rather, the First Circuit appears to decouple the listing of costs claimed in the cost report from the ability of the provider to be "dissatisfied" with the later decision by the intermediary to reimburse or not reimburse.

This application of § 1395oo(d) is further supported by the D.C. District Court in the 2008 case of *UMDNJ-University Hospital v. Leavitt*.[27] As in *MaineGeneral* and *Loma Linda*, the provider filed its appeal based on several intermediary adjustments to its cost report claims with which it was dissatisfied, but it also included an appeal of costs for its clinical medical education programs that were omitted entirely from the cost report. That court wrote:

> The Board may adopt a policy of hearing claims not initially presented to the fiscal intermediary or of refusing to hear them, or it may decide on a case by case basis. This conclusion comports with the plain language of subsection (d), ...[28]

Similar to the Ninth Circuit in *Loma Linda*, the D.C. District Court interpreted § 1395oo(a) as requiring only general dissatisfaction with the amount of total reimbursement on the NPR in order to establish Board jurisdiction under § 1395oo(a).[29]

In the aggregate, the case law of the First and Ninth Circuits and the D.C. District Court consistently conforms to the notion that § 1395oo(d) bestows the Board with a limited discretion, which is preconditioned on first establishing jurisdiction under § 1395oo(a). The case law does not stand for the proposition that § 1395oo(d) is a grant of "alternate" jurisdiction, but instead, these decisions make it clear that, once the Board acquires jurisdiction over a cost report itself pursuant to 42 U.S.C. § 1395oo(a), the Board has the discretionary power under § 1395oo(d) to hear any discrete items and services on the cost report. The Board *may* then hear the appeals of claims inadvertently omitted or mistakenly reported on the cost report, but the Board is *not required* to hear those claims.

Historically, the Board's interpretation of §§ 1395oo(a) and (d) has generally been more closely aligned with the interpretation of the First Circuit rather than arguably broader interpretation of the Ninth Circuit or the more narrow interpretation of the Seventh Circuit. Specifically, the Board has generally interpreted § 1395oo(a) as: (1) the gateway to establishing Board jurisdiction to hear an appeal; and (2) contrary to *Loma Linda* and *UMDNJ*, requiring that dissatisfaction be expressed with respect to the total reimbursement for "each claim" (as opposed to a general dissatisfaction to the total reimbursement on the NPR) because the Board has viewed the NPR as being comprised of many individual determinations on various items for which the provider has sought payment in the as-filed cost report.[30]

42 U.S.C. § 1395oo(a) dictates that, to obtain jurisdiction, a provider must be "dissatisfied" with

---

[26] *MaineGeneral*, 205 F.3d at 501.
[27] *UMDNJ Univ. Hosp. v. Leavitt*, 539 F.Supp.2d. 70 (D.D.C. 2008) [hereinafter "*UMDNJ*"].
[28] *Id.* at 79.
[29] *Id.* at 77.
[30] *See, e.g., Affinity Med. Ctr. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2010-D15 (Mar. 11, 2010), *declined review*, CMS Administrator (May 3, 2010) ("*Affinity*") (analyzing a provider's right to a hearing on an issue-specific basis rather than a general basis). *See also* Board Rule 7; 73 Fed. Reg. at 30197.

a "final determination" of the intermediary. Thus, it follows that a provider must have claimed reimbursement for items and services for the intermediary to make a "final determination" regarding such items and services.

The Board notes that the Provider inadvertently failed to exclude the observation bed days from the Medicare cost report. The Provider now seeks to reopen the cost report, and to exclude observation days, swing bed days, outpatient days, and similar days of service, from the denominator of the IME ratio and from the denominator of the Medicaid proxy of the Medicare DSH calculations.

The Board finds the errors and inclusion of the observation bed days raised in this appeal were due solely to the Provider's negligence in understanding the Medicare regulations governing the reimbursement of such costs on the Medicare cost report. Only in hindsight did the Provider determine that it could (and should) have excluded these days from its bed count claimed, thereby potentially increasing the amount of reimbursement. However, uncertainty as to the interpretation of a regulation does not necessarily make a claim for reimbursement futile. Rather, this case is precisely the situation described by the Supreme Court as being "on different ground" because the Provider "fail[ed] to request from the intermediary reimbursement for all costs to which [it was] entitled under applicable rules."[31]

Therefore, the Board dismisses the Observation Bed Days issue as the Board does not have jurisdiction under 42 U.S.C. § 1395oo(a) to address items and services not claimed or properly reported on the cost report where the failure to claim or properly report was due to inadvertence rather than futility. Once jurisdiction is obtained under 42 U.S.C. §1395oo(a), over a cost report, subsection (d) gives the Board discretionary power to review additional matters not considered by the Intermediary. The Board declines to exercise its discretionary power as the Provider had ample opportunity in filing its cost report and on audit to claim proper reimbursement.

Therefore, the Board also denies the request to transfer observation bed days to PRRB Case No. 09-1091G. The case remains open pending the SSI remand.

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 this case.

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

For the Board:

Michael Harty (CJ)
Michael W. Harty,
Chairman

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

cc: Kevin D. Shanklin, Executive Director, Senior Gov. Initiatives, BCBSA

[31] *Bethesda*, 485 U.S. at 404-405.