DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
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Refer to:

CERTIFIED MAIL

JUL 02 2014

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

RE: QRS Pre-2000 SSI Proxy Group II, PRRB Case No. 14-2934G

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned group appeal which is subject to CMS Ruling 1498-R. Upon review, the Board has noted impediments to jurisdiction for some of the participants in the group. The background of the case and the Board's jurisdictional determination are set forth below.

Background:

The Board bifurcated multiple Common Issue Related Party (CIRP) participants from case no. 98-2692G to form this group on March 20, 2014. Because the issue is subject to CMS Ruling 1498-R, the group appeal is now being reviewed under the standard implementation procedure. The Board notes that a number of the participants in the group are missing pertinent documentation as noted below.

St. Joseph Mercy Hospital Oakland (23-0029)

Participant #4: (FYE 6/30/1989) The Representative does not have a copy of Provider's appeal request. Although there is proof that the Provider added the SSI Proxy issue to its individual appeal and transferred the issue to the initial group case (98-2692G), the add/transfer request is dated after the closure of the individual appeal on 11/20/1998.

Participant #5: (FYE 6/30/1990) The Representative does not have copies of the Notice of Program Reimbursement (NPR) and the appeal request for this Provider. According to the Board's database, the final determination date for case no. 93-1517+, which appears to be based on a revised NPR, is 7/30/1993.[1] The Provider's appeal date for FYE 1990, according to the Board's database, was 1/24/1994, not 3/17/1993 as indicated on the Schedule of Providers (Schedule). There is no record, in the Board's database, of an appeal filed from a final determination dated 9/20/1992 as the Representative indicated on the Schedule.

[1] When appeals were filed from the Notice of Hospital Specific Rate after an NPR based appeal was already pending, the Board assigned the case the same number with a "C" postscript and it would add a "+" postscript to the NPR based case. The only issue in the "C" case was capital.

St. Luke's Hospital of Kansas City (26-0138)

Participant #9: (FYE 12/31/1996) The Provider did not include the SSI issue in its individual appeal. Although there is proof that the Provider added the SSI Proxy issue to its individual appeal and transferred the issue to the initial group case (98-2692G) dated 5/15/2001, the add/transfer request is dated after the closure of the individual appeal on 11/22/2000.

Participant #10: (FYE 12/31/1997) The Representative does not have a copy of the NPR for this Provider. According to the Board's database, the date of the NPR for the Provider's individual appeal was 4/24/2000; not 3/6/2000 as indicated on the Schedule of Providers. The Provider does have proof that the SSI Proxy issue was added to the appeal prior to being transferred to the group case.

St. Luke's Northland Hospital (26-0062)

Participant # 13: (FYE 12/31/1999) The Representative does not have copy of the NPR or the appeal request for this Provider. According to the Board's database, the date of the NPR is 2/28/2001 and the appeal date is 8/23/2001. The Provider does have proof that the SSI Proxy issue was added to the appeal prior to being transferred to the group case.

Baylor University Medical Center (45-0021)

Participant #14: (FYE 6/30/1994) The document submitted behind tab A of the jurisdictional documentation is not a copy of the NPR. The NPR date according to the Board's database is 9/26/1996. The Representative does not have a copy of the appeal request, but does have proof that the SSI Proxy issue was added to the appeal prior to being transferred.

Participant #15: (FYE 6/30/1995) The Representative does not have a copy of the appeal request, but does have proof that the SSI Proxy issue was added to the appeal.

Participant #16: (FYE 6/30/1996) The Representative does not have a copy of the appeal request, but does have proof that the SSI Proxy issue was added to the appeal.

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, although the Representative was unable to provide copies of the Providers' appeal requests for Baylor University Medical Center, Provider No. 45-0021 (participant #s 15 and 16, respectively), both participants can establish that they appealed from original NPRs and have proof that the SSI issue was added to open appeals prior to being transferred to the group. The Board therefore, grants jurisdiction over Baylor University Medical Center (45-0021) for FYEs 6/30/1995 and 6/30/1996.

The Board dismisses St. Joseph Mercy Hospital Oakland, Provider No. 23-0029 (participant #4) for FYE 6/30/1989. The Board finds there is insufficient evidence to establish that the SSI issue was included in the individual appeal prior to transferring to the group appeal. The documentation submitted, in which the Provider requests the addition of the issue to, and the transfer of the issue from, the individual appeal is dated 6/16/1999 which is after the individual case was closed on 11/20/1998.

The Board also dismisses St. Joseph Mercy Hospital Oakland (participant #5) for FYE 6/30/1990. The Board finds there is insufficient evidence to support a proper appeal of the SSI Proxy issue. Although the Representative has proof that the SSI Proxy issue was transferred from case no. 93-1517+ to case no. 98-2692G on May 24, 2001, there is no proof that the issue was adjusted on the Revised NPR.[2] In addition, the Board notes that the Representative has indicated the Provider self-disallowed this issue. Appeals from revised NPRs are limited to the specific matters revised in the revised 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 stated 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.

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[2] The Board's database reflects that this appeal was filed from a Revised NPR.

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

The Board dismisses St. Luke's Hospital of Kansas City for FYE 1996 (participant #9). Although the Provider has established that it appealed from an original NPR, the Provider's appeal request did not include the SSI issue. The request to add and transfer the issue was filed after the case was closed on 11/22/2000.

Finally, the Board dismisses St. Luke's Hospital of Kansas City for FYE 12/31/1997 (participant #10), St. Luke's Northland Hospital for FYE 12/31/1999 (participant #13) and Baylor University Medical Center for FYE 6/30/1994 (participant #14) from the group appeal. Although the Representative was able to provide a copy of participant #10's appeal request, it did not provide a copy of the NPR or audit adjustment pages. Participant #13 and #14 do not have copies of their appeal requests. As noted in the background facts, the document supplied by participant 13 is not an NPR and the audit adjustment pages were not provided and participant 14 asserts that the issue was self-disallowed. Because the Board cannot ascertain whether the final determinations appealed were original NPRs and because there is not enough evidence to meet the RNPR standard, the Board denies jurisdiction over these three participants.

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.

Enclosed, please find a Standard Remand of the SSI fraction under CMS Ruling 1498-R for the remaining participants in the group 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 .1877
Standard Remand of the SSI fraction under CMS Ruling 1498-R
Schedule of Providers

cc: Byron Lamprecht, Wisconsin Physicians Service
Kevin D. Shanklin, Executive Director, Blue Cross Blue Shield Association

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Refer to: 09-1915G

CERTIFIED MAIL

JUL 02 2014

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

National Government Services, Inc,
Kyle Browning
Appeals Lead
MP: INA 102-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

RE: Jurisdictional Review – Millcreek Community Hospital, *as a participant in* Blumberg Ribner Independent Hospitals 2002 Dual Eligible Days Second Group Appeal
Provider No.: 39-0198
FYE: 6/30/2002
PRRB Case No.: 09-1915G

Dear Mr. Blumberg 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 for one of the participants, Millcreek Community Hospital ("Millcreek"), Provider No. 39-0198, fiscal year end ("FYE") June 30, 2002. The pertinent facts of the case, the Parties' positions and the Board's jurisdictional determination are set forth below.

Pertinent Facts:

Millcreek filed an individual appeal dated September 10, 2007, to which the Board assigned Case No. 07-2798. This filing was within the 180 day jurisdictional filing requirement from the Provider's revised notice of program reimbursement ("RNPR") dated April 2, 2007. However, it was beyond the 180 day jurisdictional filing requirement from the Provider's original notice of program reimbursement ("NPR") dated December 9, 2003.

The issues included in the original appeal request included: Medicare SSI percentage and Medicare/Medicaid Dual Eligible Patient Days. The Provider transferred the Medicare/Medicaid Dual Eligible Days issue from Case No. 07-2798 to group appeal 09-1915G on January 29, 2010. On October 23, 2012, the Board closed Case No. 07-1298.

On September 1, 2011, the Intermediary challenged jurisdiction over Millcreek in Case No. 09-1915G. On September 29, 2011, the Provider submitted its response to the Intermediary's jurisdictional challenge.

Intermediary's Contentions:

The Intermediary asserts that the Board does not have jurisdiction over the Medicare/Medicaid Dual Eligible days issue for Millcreek because the Provider appealed from a RNPR which did not review or adjust Medicare/Medicaid Dual Eligible days. Only items specifically adjusted on the RNPR are subject to appeal.

Provider's Contentions:

The Provider contends that the so-called "Dual Eligible days" are no different than other Medicaid Eligible days which were adjusted in the RNPR. The Provider argues that the Board has jurisdiction over all Medicaid Eligible days which include dual eligible days. The Provider asserts that days in dispute do not "relate to DE days at all, but rather to days which are eligible for Medicaid and, erroneously characterized by CMS as entitled to Medicare Part A…they are identical to any and all other Medicaid Eligible days…"[1]

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 receipt of a 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) 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...

42 C.F.R. § 405.1889 (2007)[2] 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.

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[1] *See* Representative jurisdictional brief at 2.
[2] This version of the CFR was effective from 1974 through 2008.

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

As the Provider did not document that this category of days was reviewed and revised in the RNPR, the Board hereby **denies** the transfer of the Medicare/Medicaid Dual-Eligible Days issue for Millcreek, FYE June 30, 2002, into the subject appeal. Therefore, the Board **dismisses** Millcreek, 06/30/2002 from Case No. 09-1915G.

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

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

FOR THE BOARD

Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, BCBSA

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CERTIFIED MAIL

JUL 10 2014

Anita Lee
Office of the County Counsel
648 Kenneth Hahn Hall of Administration
Health Services Division
500 West Temple Street, Room 602
Los Angeles, CA 90012

RE: Jurisdictional Challenge
Provider: Martin Luther King Jr./Drew Medical Center, Provider No. 05-0578
Provider No: 05-0578
FYE: 06/30/03
PRRB Case No.: 08-1657

Dear Ms. Lee:

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

Background

On September 26, 2007, a Notice of Program Reimbursement (NPR) was issued to the Provider for the cost reporting period ending June 30, 2003. On March 21, 2008, the Provider filed an appeal of the NPR challenging indirect medical education (IME) interns and residents full-time equivalent (FTE) count, graduate medical education (GME) interns and residents FTE count, new program and/or temporary residents FTE count, IME bed count, provider statistical and reimbursement report (PS&R), disproportionate share hospital (DSH) Medicaid eligible days, DSH supplemental security income (SSI) ratio, DSH HMO days and Medicare bad debts.

The Board assigned case number 08-1657 to the case. On June 30, 2008, the Provider requested to add a new issue to the appeal: transitional outpatient payments. The correspondence also requested to expand the scope of the prior IME/GME FTE issues to include a dispute over the aggregate historical FTE resident cap and rolling three year average. On July 29, 2008, the Provider requested to add relative value units (RVUs) to the appeal and to transfer the issue to a group appeal, case number 07-2338G. The Provider also requested to transfer the PS&R issue to a group appeal, case number 07-2323G.

On December 23, 2011, the Intermediary filed a jurisdictional challenge regarding the IME and GME aggregate historical FTE resident cap issue alleging that it is not an appealable issue/no adjustment was made. On January 03, 2012, the Provider filed an opposition to the Intermediary's jurisdictional challenge. On January 24, 2012, the parties reached a partial administrative resolution for all but the IME/GME historical FTE resident cap issues.

Intermediary's Position

The Intermediary contends that it made audit adjustments 28 and 29 related to IME and GME. Audit adjustment 28 was made to the current year FTE counts for IME and GME. Adjustment 29 adjusted the prior and penultimate year FTE counts for GME as well as the prior year IME FTE count and prior year resident to bed ratio for IME. The Intermediary argues that it made no adjustments to the historical resident cap for either IME or GME. The Intermediary maintains the Provider is attempting to appeal amounts that were not adjusted. The Provider was not precluded from claiming the additional payment for which it asserts the hospital is qualified based on their records. The Intermediary requests that the Board dismiss the issue.[1]

Provider's Position

The Provider contends that it filed its cost report listing 241.27 FTEs as the historical cap for GME purposes and 222.86 FTEs as the historical cap for IME purposes. These figures are consistent with the numbers identified on audit by the Intermediary in FYE June 30, 1999, but are lower than the numbers that the Provider believes to be correct. The Provider maintains it believes the actual unweighted number of residents to be used is 250.39 FTEs for GME purposes and 232.97 FTEs for IME purposes. The Provider concedes that the Intermediary made no modification to the historical caps reported by the Provider. However, the Provider contends the historical resident caps were applied to the revised number of residents for fiscal year end (FYE) June 30, 2003, and used to calculate allowable reimbursement.[2]

The Provider argues that although the Intermediary did not make an audit adjustment to the historical resident caps reported, the statute at 42 U.S.C § 1395oo(a),[3] confers jurisdiction irrespective of whether there was an audit adjustment.[4] Moreover, the Provider contends consistent with the law in the Ninth Circuit (the circuit in which the Provider is located) it has also met the dissatisfaction requirement even though it did not specifically report the higher historical caps that it now believes should have been used. The Provider cites to the cases of *Loma Linda University Medical Center v. Leavitt*, 492 F.3d 1065 (9th Cir. 2007) and *UMDNJ-University Hospital v. Leavitt*, 539 F.Supp.2d 70 (D.C.D.C. 2008), in support of its proposition.[5]

The Provider maintains in *Loma Linda*, the Ninth Circuit Court of Appeals considered the question of whether a provider can meet the "dissatisfaction" requirement in the statute when it had not included the disputed amount in the cost report. The court found that the statute itself clearly conferred jurisdiction over all matters covered by the cost report even though that particular expense was not expressly claimed or explicitly considered by the Intermediary. The

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[1] Intermediary's Jurisdictional Challenge at 2-3.
[2] Provider's Opposition to Jurisdictional Challenge at 1-2.
[3] 42 U.S.C. § 1395oo(a)(1)(A)(1) states that a provider has a right to a hearing before the PRRB if it: "is dissatisfied with a final determination of an organization serving as its fiscal intermediary pursuant to section 1816 as to the amount of total reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this title for the period covered by such report."
[4] Provider's Opposition to Jurisdictional Challenge at 2.
[5] *Id.* at 3-4.

court noted that Section 1395oo(d) allows the PRRB to make revisions on costs that were not expressly claimed.

The Provider contends that the *UMDNJ* case reached the same result in a case involving accidently omitted clinical medical education costs. Thus, the Provider concludes the fact that it did not use the correct historical caps in filing its FYE June 30, 2003 cost report does not deprive the Board of jurisdiction to hear its challenge to the historical caps, so long as the disputed items are "covered by the cost report." [6]

The Provider contends that the regulation at 42 C.F.R. § 405.1835(a)(1)(ii) permits providers to meet the dissatisfaction requirement, even though they have not directly claimed disputed amounts in the body of the cost report. The Provider maintains that the regulatory requirement to file a cost report under protest only applies to cost reporting periods ending on or after December 31, 2008, and does not apply to cost reporting periods ending before that date, like this one. The Provider contends that it did not have to use a protested item in this fiscal year to preserve its right to appeal, as it was challenging a Medicare policy, or was claiming costs that may not be allowable.

The Provider maintains that it had previously reported higher historical caps on its cost report for FYE June 30, 1999, and the Intermediary reduced the number. Thus, under these circumstances it was appropriate for the Provider to follow the Intermediary's direction and report the lower numbers for later fiscal years.[7] The Provider differentiates the circumstances in this case from those in which providers fail completely to include a particular expense. The Provider maintains both the filed and the audited cost reports include specific information regarding the historical caps.[8]

Decision of the Board

Pursuant to 42 U.S.C. §1395oo(a) (2007) and 42 C.F.R. §§ 405.1835-405.1840 (2007), 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. After jurisdiction is established under 42 U.S.C. § 1395oo(a) the Board has the discretionary power under 42 U.S.C § 1395oo(d) 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.

The operation of the jurisdictional gateway established by 42 U.S.C § 1395oo(a) was addressed by the Supreme Court in the case of *Bethesda Hospital Association v. Bowen,* 485 U.S. 399 (1988). The narrow facts of *Bethesda* dealt with the self-disallowed apportionment of

[6] *Id.*
[7] *Id.* at 5-6.
[8] *Id.* at 7-8.

malpractice insurance costs.[9] The provider failed to claim the cost because a regulation dictated it would have been disallowed. In that situation, the Supreme Court found § 1395oo(a) permitted jurisdiction over the "self-disallowed" claim. The Court stated:

> We agree that, under 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.[10]

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. The Court stated:

> 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.[11]

While the Supreme Court has not had an opportunity to squarely address whether the Board *must* take jurisdiction of an appeal of a cost that was unclaimed through inadvertence rather than futility (e.g., a law, regulation, CMS Ruling, or manual provision actually precludes reimbursement), 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.[12] 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."[13] Similarly, 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.[14]

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[9] 485 U.S. at 401-402.
[10] *Id.* at 404.
[11] *Id.* at 404-405 (emphasis added).
[12] See *Little Company of Mary Hosp. v. Shalala,* 24 F.3d 984 (7th Cir. 1994); *See also Little Co. of Mary Hosp. v. Shalala,* 165 F.3d 1162 (7th Cir. 1999) (Little Co. II).
[13] *See MaineGeneral Med. Ctr. v. Shalala,* 205 F.3d 493 (1st Cir. 2000); *Loma Linda Univ. Med. Ctr. v. Leavitt,* 492 F.3d 1065 (9th Cir. 2007).
[14] *See UMDNJ Univ. Hosp. v. Leavitt,* 539 F. Supp. 2d 70, 77 (D.D.C. 2008).

In the First Circuit case of *Maine General Med. Ctr. v. Shalala*, 205 F.3d 493 (1st Cir. 2000), this case involved hospitals that listed zero for reimbursable bad debts on their cost reports. The mistakes were not discovered until after the NPRs had been issued. The providers appealed several items adjusted by the NPRs but also included claims for the bad debts. The Board dismissed the bad debt claim for lack of jurisdiction because they had not been disclosed on the cost reports despite there being no legal impediment to doing so. The *Maine General* court relied on its prior decision in *St. Luke's Hosp. v. Secretary*, 810 F.2d 325 (1st Cir. 1987), in which costs were self-disallowed, not inadvertently omitted. However, it found that the *St. Luke's* decision had nevertheless addressed the question of whether the Board has the power to decide an issue that was not first raised before the intermediary and held that it does, but that the power is discretionary.[15]

The *St. Luke's* court 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 circumstance.[16] "The statute [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."[17] The First Circuit in *Maine General* advised 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 court 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."[18] Similarly, *St. Luke's* 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.[19]

The Ninth Circuit addressed this issue in the case of *Loma Linda Univ. Med. Ctr. v. Leavitt*, 492 F.3d 1065 (9th Cir. 2007). In this case, 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 concluded:

> 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

[15] *Maine General*, 205 F.3d at 497.
[16] *St. Luke's*, 810 F.2d at 332.
[17] *Id.* at 327-328. (Emphasis in original)
[18] *Maine General*, 205 F.3d at 501.
[19] *St. Luke's*, 810 F.2d at 327.

> expense . . . even though that particular expense was not expressly claimed or explicitly considered by the intermediary.[20]

The holding[21] suggested 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).[22] However, the court recognized "[t]here is no dispute that 1395oo(a) is the gateway provision for Board jurisdiction."[23] The case law stands for the proposition that the Board may hear the appeals of claims inadvertently omitted or mistakenly reported on the cost report but the Board is not required to hear those claims.

The D.C. District Court in *UMDNJ Univ. Hosp. v. Leavitt*, 539 F. Supp. 2d 70, 77 (D.D.C. 2008), reached the same conclusion as the First and Ninth Circuits. As in *Maine General* 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 costs for its clinical medical education programs which were omitted entirely from the cost report. The D.C. Court found guidance in the D.C. Circuit's decision in *HCA Health Services of Oklahoma Inc. v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994), that involved an appeal of a reopened intermediary decision. The D.C. District Court also refused Provider's request for it to order the Board to hear a claim inadvertently omitted, saying "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."[24]

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. 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

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[20] *Loma Linda,* 492 F.3d at 1068.

[21] The court held "that the Board had jurisdiction pursuant to § 1395oo(a) for a hearing with respect to Loma Linda's 1985 cost report because the provider was dissatisfied with a final determination by Blue Cross as to the amount of total reimbursement due and other jurisdictional prerequisites were met." *Id.* at 1073.

[22] *See* 73 Fed. Reg. 30190, 30197 (May 23, 2008).

[23] *Loma Linda*, 492 F.3d at 1070.

[24] *UMDNJ*, 539 F. Supp. 2d at 79.

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.[25]

The Board has previously held that it lacks jurisdiction where a Provider fails to claim an issue on its cost report. *See Maple Crest Care Center v. Mutual of Omaha Ins. Co.*, PRRB Decision No. 2003-D4, Case No. 01-0320 (November 7, 2002) at 3, (finding the Board lacked jurisdiction where the provider failed to claim bad debts on a cost report); *Mercy Hospital Miami FL v. BlueCross BlueShield Ass'n,* PRRB Decision No. 2010-D4 (March 11, 2010) at 10, (the Board majority concluded that in order for a provider to have a right to a hearing on a cost issue, "the expense must be in the cost report unless a predetermination has been made that the cost would be disallowed"); and *St. Vincent Hospital & Health Center vs. BlueCross BlueShield Ass'n*, PRRB Decision No. 2013-D39 (September 13, 2013) at 8 (finding the Board lacked jurisdiction over unclaimed Ambulatory Surgery Costs and Organ Acquisition Costs not claimed on the cost report). The Board in *St. Vincent* noted 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." The Board reiterated that only when the provider has established jurisdiction under 42 U.S.C. § 1395oo(a) with respect to one or more of such claims/issues can the Board then exercise discretion to hear other claims not considered by the intermediary (e.g. unclaimed costs).[26]

In the instant case, the Provider claimed 241.27 FTEs as its historical cap for GME and claimed 222.86 as its historical cap for IME on its as-filed cost report. It is undisputed that the Intermediary did not make an adjustment to either of the historical caps. The Provider admits it had previously reported higher FTE caps on its cost reports as it believed the Intermediary audited caps to be incorrect. In those years, the Intermediary adjusted those caps, which would have provided the hospital with appeal rights under 42 U.S.C § 1395oo(a). Had the Provider done the same in the current year, the Provider would have met the requirement of § 1395oo(a) for Board jurisdiction. Only in hindsight did the Provider determine that it should have reported additional FTEs, thereby increasing the amount of reimbursement. There was no statutory, regulatory or manual provision preventing the Provider from claiming the higher FTE cap as it had in other years. Since there was no adjustment proposed on the historical cap issue, the Intermediary has not made a determination. As such, the Board finds that the Provider does not have a right to appeal the IME and GME historical cap issues under 42 U.S.C § 1395oo(a) and dismisses the issues from the appeal. Since the Provider has established jurisdiction under § 1395oo(a) with respect to other issues in the appeal, the Board can hear the IME and GME historical cap issues pursuant to its discretionary power under 42 U.S.C. § 1395oo(d). The Board

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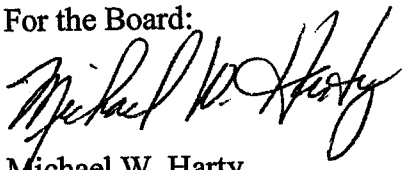
[25] *See, e.g., Affinity Med. Ctr. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2010-D15 (Mar. 11, 2010), *declined review*, CMS Administrator (May 3, 2010) ("*Affinity*") (analyzing a provider's right to a hearing on an issue-specific basis rather than a general basis). *See also* Board Rule 7; 73 Fed. Reg. at 30197.
[26] *Id.* at 15.

declines to hear the issues pursuant to its discretionary powers under § 1395oo(d), consistent with *St. Vincent,* and closes the case as this is the sole issue remaining in the case.

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
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Refer to:

CERTIFIED MAIL

JUL 11 2014

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

RE: Huntington Beach Hospital, Provider No. 05-0526, FYE 12/31/2006, Case No. 13-1499
(as a participant in group cases 14-0148GC, 14-0155GC, 13-3616GC)

Dear Ms. Goron:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned individual appeal which was closed by the Board on December 23, 2013 as a result of transferring all issues to the subject group appeals. Upon review, the Board notes jurisdictional impediments. The pertinent facts and the Board's jurisdictional determination are set forth below.

Pertinent Facts:

Healthcare Reimbursement Services, Inc. (HRS) filed an individual appeal for Huntington Beach Hospital on April 9, 2013 from a revised Notice of Program Reimbursement (RNPR) dated October 12, 2012. The appeal included the following issues:

- SSI Systemic Errors
- DSH Medicare Managed Care Part C Days
- Rural Floor Budget Neutrality Adjustment (RFBNA)

The authorization letter included with the appeal request was dated February 22, 2012 and appointed HRS as the designated representative to handle the Rural Floor Budget Neutrality Adjustment *as part of the SRS Prime Healthcare 2001-2011 RFBNA Equitable Tolling Group* (which was established by the Board in February 2012 and to which it assigned case no. 12-0227GC).

The Board acknowledged the individual appeal for Huntington Beach Hospital and assigned case number 13-1499 in an email to HRS dated April 15, 2013.

On November 22, 2013, HRS requested the transfer of the RFBNA issue to group case 13-3616GC, the HRS 2006 Prime Healthcare RFBNA CIRP Group; the transfer of the SSI Percentage issue to group case 14-0148GC, the HRS 2006 Prime Healthcare DSH/SSI Percentage group; and the transfer of the Managed Care Part C Days issue to group case 14-0155C, the HRS 2006 Prime Healthcare DSH Medicare Managed Care Part C Days group. Since these were the only issues, once the transfers were completed the individual appeal, case no. 13-1499, was closed on December 23, 2013.

Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider (but no other individual, entity, or party) 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 intermediary 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 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 Board finds that the closure of the individual appeal due to the transfers of the 3 issues identified in the initial appeal request was in error. The Board has reviewed the initial appeal request including the Representation letter that HRS filed with the appeal as support that it has the authority to act on behalf of the Provider, the Revised Notice of Program Reimbursement and its adjustments, as well as the issues appealed.

The revised NPR and the audit adjustment report clearly indicates that RNPR was issued solely for the implementation of the revised SSI%. Neither the DSH Medicare Managed Care Part C Days nor the Rural Floor Budget Neutrality Adjustment issues were considered or adjusted as part of, or on the RNPR. As the regulation requires that a revision must be considered a separate and distinct determination, and that only matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision, the Board lacks jurisdiction over the Medicare Managed Care Part C Days and the Rural Floor Budget Neutrality[1] issues from the RNPR from which it appealed.

Further, the Board finds that representation letter provided by HRS with the establishment of the individual appeal request clearly did not grant them the authorization to act on the behalf of the

---

[1] In the appeal request, the RFBNA issue was identified as self-disallowed.

provider for this issues of the SSI% or the Medicare Managed Care Part C Days issues, as the letter; signed over a year earlier, specifically only granted authorization over the issue of Rural Floor Budget Neutrality. Therefore the Board dismisses the SSI% appeal and the Medicare Managed Care days issue as the appeal of those issues, as filed by HRS, did not meet the requirements of 42 C.F.R. §§ 405.1835(a). Additionally, as the representation letter signed by the Provider was so specific as to state that HRS only had the authority to represent on the RFBNA issue *as part of the SRS Prime Healthcare 2001-2011 RFBNA Equitable Tolling Group*, which by its name is not an appeal from a timely issued final determination (as this appeal is), there is great doubt that HRS has authorization over the RFBNA issues in this appeal. However, as the RFBNA issue was dismissed above as it was not an issue covered by the RNPR, the Board does not have to reach a conclusion on 42 C.F.R. §§ 405.1835(a) here.

Consequently, the Board hereby reinstates the appeal in order to deny jurisdiction over the issues under appeal in PRRB appeal 13-1499 and denies the Representative's requests to transfer the issues from the individual appeal and dismisses Huntington Beach Hospital from the following groups:

- SSI Percentage - group case 14-0148GC
- Managed Care Part C days – group case 14-0155GC and
- Rural Floor Budget Neutrality – group case 13-3616GC

As all issues are dismissed, Case No. 13-1499 is closed. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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

For the Board:
Michael W. Harty
Chairman

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

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

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Refer to:

CERTIFIED MAIL

JUL 18 2014

CampbellWilson
Manie W. Campbell
15770 North Dallas Parkway
Suite 500
Dallas, TX 75248

RE: Adventist Health System 2005 SSI – Entitled CIRP, PRRB Case No. 10-0689GC
Standard Remand of SSI Proxy Issue

Dear Mr. Campbell:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeal which is subject to remand under CMS Ruling 1498-R. The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

The Adventist Health System 2005 SSI – Entitled CIRP group appeal was created on January 29, 2010 when the Representative requested the individual appeal for Castle Medical Center, case no. 09-1762, be converted to a group appeal for the SSI Entitled issue. Rather than converting the individual case no. 09-1762, the Board formed a new group to which it assigned case no. 10-0689GC. Subsequently, on March 2, 2010, the Board closed Castle Medical Center's individual appeal since the SSI issue had been transferred to the group.

There are 7 participants listed on the Schedule of Providers for the group appeal. Two of the participants, Glendale Adventist Medical Center and White Memorial Medical Center (#s 6 & 7) have not yet received NPRs. Three of the participants, Adventist Medical Center–Portland, Feather River Hospital and San Joaquin Community (#s 2 through 4) do not have copies of the necessary jurisdictional documentation to support proper appeals of the SSI issue. All three of these participants were in other groups that were ultimately transferred to this group. The Representative has requested that they be given an opportunity to cure any defects prior to the Board taking any adverse action on the case.

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 Adventist Medical Center – Portland, Feather River Hospital and San Joaquin Community were allegedly transferred to the subject group in 2010. According to the Schedule of Providers, Adventist Medical Center (# 2) filed directly into group case no. 08-0075G, then transferred to group case no. 07-2707G, then to group case no. 08-1189GC, before ultimately being transferred to this CIRP group. In addition, Feather River Hospital (# 3) and San Joaquin (# 4) presumably filed individual appeals from which the issue was subsequently transferred to group case no. 07-2707G, then to group case no. 08-1189GC, before ultimately being transferred to this CIRP group.

Since these Providers have been unable to furnish the documentation necessary to establish jurisdiction (i.e. NPR, copy of appeal request, proof of transfer to group, etc.) and since the group has been pending since 2010, the Board finds that the Representative has had ample time to establish jurisdiction of these participants. Based on the lack of documentation, the Board dismisses Adventist Medical Center – Portland, Feather River Hospital and San Joaquin Community from the group appeal (#s 2 through 4).

Further, because NPRs have not yet been issued for Glendale Adventist Medical Center and White Memorial Medical Center (#s 6 and 7) they are not subject to the remand as they do not have a valid appeal from a final determination.

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. Enclosed, please find the Board's Standard Remand of the SSI fraction under CMS Ruling-1498-R for the remaining participants in the group 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 .1877
Standard Remand of the SSI fraction under CMS Ruling CMS-1498-R

cc: Noridian Healthcare Solutions, LLC (w/enclosures)
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Refer to: 13-1905GC

CERTIFIED MAIL

JUL 21 2014

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Palmetto GBA
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Camden, SC 29020-1728

RE: Jurisdictional Decision – Palmetto Health 2006 DSH Observation Days
Provider No.: Various
FYE: 9/30/2006
PRRB Case No.: 13-1905GC

Dear Ms. Hulls and Ms. Huggins,

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

Background

On April 19, 2013, the Board received this mandatory Common Issue Related Group (CIRP) group appeal brought by three related providers: Palmetto Health Baptist Columbia (PN: 42-0086), Palmetto Health Richmond (PN: 42-0018), and Baptist Easley (PN: 42-0015) (the Providers). The Providers appealed their fiscal years ending (FYE) 09/30/2006 and 09/30/2007 from revised Notices of Program Reimbursement (revised NPR) issued October 25, 2012. The sole issue for the Providers disputed in this CIRP appeal was the Disproportionate Share Hospital (DSH) Observation Days.

On May 7, 2013, the Board emailed the parties, advising that pursuant to Board Rule 12, the group appeal would be bifurcated into separate group appeals. Appeals for FYE 09/30/2006 remained in this case number, while the Board transferred appeals for FYE 09/30/2007 into case number 13-1908GC.

Medicare Advantage Contractor's (MAC) Position

Pursuant to PRRB Rule 15.2, Palmetto GBA notified the Board on May 31, 2013 that jurisdiction was not met for this CIRP group appeal. While Palmetto agreed that a single common issue was established, Palmetto disputed whether the Providers preserved their right to appeal, as well as the amount in controversy requirement. Specifically, Palmetto asserts that the only issues preserved for appeal in the Providers' amended cost reports involve CMS SSI issues,

and that the cost report only reopened SSI issues. Because the Providers did not preserve the DSH Observation Days issue on appeal, the Board lacks jurisdiction over the group appeal.

Provider's Position

The Providers did not file a brief.

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 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 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.
>
> (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.

All three providers were issued their RNPRs on October 25, 2012. Each audit adjustment report indicates that adjustments were made to implement the updated SSI% on W/S E part A. None of the audit reports make any revisions to observation days, which are reported on W/S S-3.

The Board therefore finds that it does not have jurisdiction over the DSH Observation Days issue because the Providers fail to meet the requirement that the issue be specifically revised. Thus, pursuant to 42 C.F.R. § 405.1889(b)(1), such days are beyond the scope of any appeal of the revised determination.

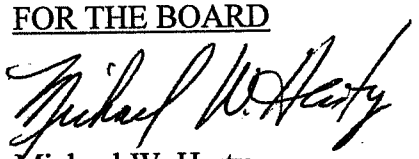
Conclusion

Pursuant to 42 C.F.R. §§ 405.1835(a) and 405.1889(b), the Board finds that it lacks jurisdiction over each of the providers in the Palmetto Health DSH Observation Days CIRP Group appeal as they each appealed from revised NPRs that did not specifically adjust the Observation Day issue. As there are no providers that remain in the appeal, case number 13-1905GC is closed.

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

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

FOR THE BOARD



Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, BCBSA

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Refer to: 14-3458

JUL 21 2014

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Larry M. Carlton, CPA
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4000 Meridian Boulevard
Franklin, TN 37067

CGS Administrators
Judith E. Cummings
Accounting Manager
CGS Audit & Reimbursement
Two Vantage Way
Nashville, TN 37228

RE: Jurisdictional Decision – Affinity Medical Center
Provider No.: 36-0151
FYE: 06/30/2011
PRRB Case No.: 14-3458

Dear Mr. Carlton and Ms. Cummings,

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

Affinity Medical Center was issued an original Notice of Program Reimbursement (NPR) for FYE 6/30/2011 on November 8, 2013. On May 13, 2014 the Provider filed an appeal request with the Board, appealing the Bed Count issue.

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. 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.

Affinity Medical Center was issued its NPR on November 8, 2013 and presumed to have received it on November 13, 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 May 13, 2013. Thus, the date of filing was 181 days after the presumed date of receipt of the determination from the Intermediary.

Additionally, the protected health information (PHI) which was submitted with this appeal will be struck from the file and returned to the Provider. Board Rule 27.6.H states, in relevant part, that:

1. Because the record in Board proceedings may be disclosed to the public, the parties must carefully review their documents to ensure that they do not contain patient names, health insurance or social security numbers, or other information that identifies individuals.
2. If the parties need to include materials with patient names, numbers, or other identifying information, they must redact (untraceably remove) the names and numbers and replace them with non-identifying sequential numbers. If the confidential information itself is necessary to support your position, submit a sealed envelope containing the confidential information with a cross reference to the non-identifying sequential numbers.

The PHI disclosed in this appeal includes patient names, gender, age, account numbers and insurance identification numbers, totaling 25 pages in total. As this information was neither redacted nor submitted in a sealed envelope as instructed per Board Rule 26, the Board is returning this information to the Provider.

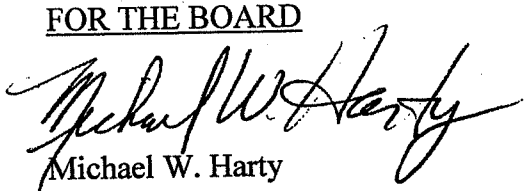
Because the appeal request was not received by the Board within 180 days as required by 42 C.F.R. § 405.1835, the Board finds that it was not timely filed. The Board hereby dismisses the appeal and case number 14-3458 is closed.

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

and 42 C.F.R. §§ 405.1875 and 405.1877.

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

FOR THE BOARD



Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, BCBSA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Internet: www.cms.gov/PRRBReview
Phone: 410-786-2671

Refer to: 13-1110

CERTIFIED MAIL

JUL 23 2014

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

Cahaba Government Benefit Administrators
Renee Rhone
Senior Auditor/Appeals Specialist
P.O. Box 1448
Birmingham, AL 35242

RE: Jurisdictional Decision – Wellmont Bristol Regional Medical Center
Provider No.: 44-0012
FYE: 06/30/2007
PRRB Case No.: 13-1110

Dear Mr. Ravindran and Ms. Rhone,

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

Background

The Intermediary issued a revised Notice of Program Reimbursement (NPR) for FYE 12/31/2001 on September 18, 2012. On March 13, 2013, the Provider submitted an Appeal Request to the Board where it appealed the following issues: SSI Realignment (Provider Specific), DSH/SSI (Systemic errors), Medicare Managed Care Part Days, Dual Eligible Days and the Exclusion of Part C Days issues. Subsequently, the Provider transferred four of the five issues to group appeals. The DSH/SSI issue was transferred to case number 14-0227GC. The Part C Days issue was transferred to case number 14-0237GC. The Dual Eligible Days issue was transferred to case number 14-0239GC, and lastly, the Exclusion of Part C Days issue was transferred to case number 14-0241GC.

After the transfers, the sole issue remaining in the appeal is the SSI Realignment issue, in which the Provider claims that it may exercise its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period once it obtains and reconciles the underlying data.

Board's Decision

The Board has chosen to review whether it has jurisdiction over the SSI realignment issue in this appeal on its own motion and finds that it does not have jurisdiction as the appeal is premature. 42 C.F.R. § 405.1835 (2005) states:

"The provider… has a right to a hearing before the Board about any matter

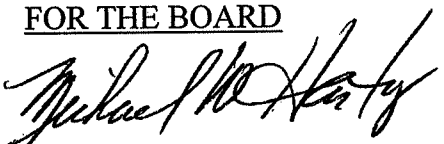
> designated in § 405.1801(a)(1), if...[a]n intermediary determination has been made with respect to the provider."

In this case, there was no final determination made by the Intermediary and the Provider has not yet decided whether it will request realignment. Realignment is a remedy the Provider may pursue if it is dissatisfied with MEDPAR SSI data. Therefore, the SSI realignment issue is hereby dismissed. Since the SSI Realignment Issue was the sole remaining issue in the appeal, case number 13-1110 is hereby 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 Participating
Michael W. Harty
L. Sue Anderson
John Gary Bowers, CPA
Clayton J. Nix, Esq.

FOR THE BOARD



Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, BCBSA

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Refer to: 14-1781

CERTIFIED MAIL

JUL 23 2014

Nick Putnam
Strategic Reimbursement, Inc.
360 W. Butterfield Road
Suite 310
Elmhurst, IL 60126

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

RE: Jurisdictional Decision – Presence Provena Mercy Center
Provider No.: 14-0174
FYE: 12/31/2009
PRRB Case No.: 14-1781

Dear Mr. Putnam and Ms. Hartley,

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

Presence Provena Mercy Center was issued an original Notice of Program Reimbursement (NPR) for FYE 12/31/2011 on July 3, 2013. On January 15, 2014, the Provider filed an appeal request with the Board, appealing the ten following issues: SSI – Calculation Error, SSI – Medicare Part C, Dual Eligible – Medicare Part C, SSI – Medicare Part A Exhausted, Medicaid – Part A Exhausted, Medicaid Eligible – Unmatched Medicare, Unmatched Medical Eligible, State Plan/Charity Care/Title 21, Rural Floor Budget Neutrality Adjustment, and Outlier Underpayment/Fixed Loss Threshold.

In its appeal, the Provider noted that it believed that it had mailed a duplicate copy of its appeal in "late December – early January," but could not find its tracking receipt for the package. The Board did not receive an appeal prior to January 15, 2014.

On June 9, 2014, the Board received a Model Form D, as the Provider requested transfer of the Outlier Underpayment/Fixed Loss Threshold to case number 14-3606GC.

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. 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.

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.

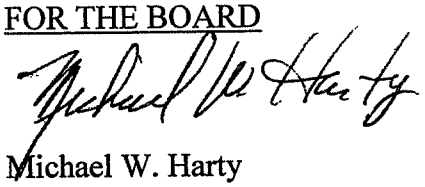
Presence Provena Mercy Center was issued its NPR on July 3, 2013 and presumed to have received it on July 8, 2013. The Provider did not present evidence that the NPR was received later than the five day presumption. An appeal request from this original NPR was delivered by FedEx and received by the Board on January 15, 2014. Thus, the date of filing was 191 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 14-1781 is closed. Furthermore, the Board denies transfer of the Outlier Underpayment/Fixed Loss Threshold to case number 14-3606GC.

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

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

FOR THE BOARD



Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, BCBSA

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Refer to: 13-0899

JUL 23 2014

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

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

RE: Miller Dawn Medical Center
Provider No.: 24-0019
FYE: 06/30/2007
PRRB Case No.: 13-0899

Dear Mr. Knight and Ms. Hartley,

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

Pertinent Facts

On August 28, 2012, Miller Dawn Medical Center was issued a revised Notice of Program Reimbursement (NPR) for FYE 06/30/2007. The revised NPR specifically stated that the revision was as a result of adjustments to the in-state Medicaid days, out-of-state Medicaid days, rehabilitation days, and the Disproportionate Share Hospital (DSH) Ratio/Supplemental Security Insurance (SSI) Percentage. The Provider appealed from this second revised NPR on February 25, 2013, disputing the following five issues: (1) the Inclusion of Medicare Dual Eligible Part A Days in the SSI ration issue, (2) the Inclusion of Medicare Dual Eligible Part C Days in the SSI Ratio issue, (3) the Accuracy of the CMS-Developed SSI Ratio issue, (4) the SSI MMA Section 951 Applicable to the SSI Ratio issue, and (5) the Additional Medicaid Eligible Days issue (Badgercare and Family Planning Days).

On October 17, 2013, the Provider transferred issues 1-4 into the mandatory Common Issue Related Party (CIRP) group appeals, leaving the Additional Medicaid Days issue as the sole issue remaining in the appeal. On January 31, 2014, the Board received a jurisdiction challenge to the Additional Medicaid Eligible Days issue from the Medicare Advantage Contractor (MAC), National Government Services, Inc. On February 14, 2014, the Board received the Provider's response to the jurisdictional challenge.

MAC's Jurisdictional Challenge

On January 31, 2014, the MAC challenged the Board's jurisdiction over the Provider's appeal from a revised NPR. Specifically, the MAC contended that the PRRB does not have jurisdiction over appeals from revised NPRs that did not adjust the specific provisions being appealed. The MAC noted that while some of the Medicaid Eligible Days were adjusted, the categories of Badgercare Days and Family Planning Days which compose the entirety of the 155 disputed days were not specifically adjusted. Thusly, this appeal thus represented intent by the Provider to add contentions not included in its original appeal.

Because the Board lacks jurisdiction over appeals from revised NPRs that did not adjust the specific provisions being challenged, the MAC requested the Board to deny jurisdiction over the Additional Medicaid Days issue and dismiss this case.

Provider's Response

On February 14, 2014, the Board received the Provider's response to the MAC's jurisdictional challenge. The Provider contended that the Medicaid Eligible Days issue challenged fell within the scope of an adjustment on the revised NPR. The response stated that because the MAC adjusted the Medicaid Eligible Days generally, this extended to all categories of Medicaid Eligible Days, regardless of their non-adjustment. Therefore, the Provider asserted that the sole issue in the appeal was specifically adjusted, and asked the Board to find the appeal to be jurisdictionally valid.

Board's Decision

The Board finds that it does not have jurisdiction over the Additional Medicaid Eligible Days issue in Miller Dawn Medical Center's appeal because it is appealing from a revised NPR which did not specifically adjust these additional Medicaid eligible days at issue in the appeal.

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

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

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

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. §§

405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.

(b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.

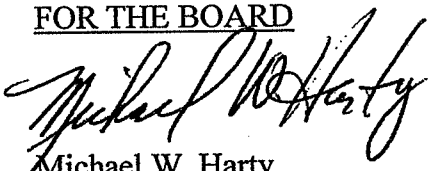
(b)(2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

The Board finds that it lacks jurisdiction over the Additional Medicaid Eligible Days (Badgercare and Family Planning Days) because the revised NPR specifically adjusted to include in-state and out-of-state Medicaid Days but did not revise for the days under appeal. The disputed Badgercare and Family Planning Days may have been requested in the listing a part of the reopening, but as they were neither considered nor adjusted by the MAC when the cost report was revised the issue does not meet the requirements of 42 C.F.R. 405.1889(b)(2). Therefore, the Additional Medicaid Days issue is hereby dismissed. As this was the sole issue remaining in the appeal, the appeal is hereby closed and removed from the Board's docket.

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
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 Shanklin, BCBSA

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

Refer to: 06-0752

JUL 23 2014

CERTIFIED MAIL

HCA, Inc.
H. Anne Browne
Sr. Appeals Analyst Reimbursement Dept.
One Park Plaza, Building 2, 5 East
Nashville, TN 37203

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

RE: Jurisdictional Decision – Sutter Medical Center of Santa Rosa
Provider No.: 05-0291
FYE: 12/31/2001
PRRB Case No.: 06-0752

Dear Ms. Brown and Mr. Lamprecht,

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

Background

The Intermediary issued a Notice of Program Reimbursement (NPR) for FYE 12/31/2001 on September 14, 2005. On February 22, 2006, the Provider submitted an Appeal Request to the Board where it appealed the Medicare SSI% issue. Afterwards, the Provider added the following issues to the appeal on the following dates: the Medicare SSI Realignment and Dual Eligible Patient Days issues on October 8, 2008; the Medicare Unbilled Crossover Bad Debt for inpatient and outpatient services on October 17, 2008; and the Rural Floor Budget Neutrality Adjustment issue on October 20, 2008.

Subsequently, the Provider transferred all but one of the issues into group appeals. On October 13, 2009, Medicare Unbilled Crossover Bad Debt issues for inpatient and outpatient services were transferred into case numbers 02-2168G and 99-3524G, respectively. The Dual Eligible Patient Days issue was transferred into case number 08-2622G on November 12, 2010. The Rural Floor Budget Neutrality Adjustment issue was transferred to case number 09-0644GC on November 8, 2011. The Medicare SSI% issue was transferred into case number 09-1932GC on December 12, 2012.

After the transfers, the sole issue remaining in the appeal is the Medicare SSI Realignment issue, in which the Provider claims that it may exercise its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period once it obtains and reconciles the underlying data.

Board's Decision

The Board has chosen to review whether it has jurisdiction over the SSI realignment issue in this appeal on its own motion and finds that it does not have jurisdiction as the appeal is premature. 42 C.F.R. § 405.1835 (2005) states:

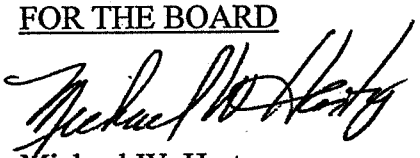
> "The provider... has a right to a hearing before the Board about any matter designated in § 405.1801(a)(1), if...[a]n intermediary determination has been made with respect to the provider."

In this case, there was no final determination made by the Intermediary and the Provider has not yet decided whether it will request realignment. Realignment is a remedy the Provider may pursue if it is dissatisfied with MEDPAR SSI data. Therefore, the SSI realignment issue is hereby dismissed. Since the SSI Realignment Issue was the sole remaining issue in the appeal, case number 06-0752 is hereby closed.

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

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

FOR THE BOARD



Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, BCBSA

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Refer to:
13-1063

CERTIFIED MAIL

JUL 28 2014

Noridian Healthcare Solutions, LLC
James R. Ward
Appeals Resolution Manager
JF Provider Audit Appeals
P.O. Box 6722
Fargo, ND 58108-6722

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

RE: MedCenter One Hospital
Provider No.: 35-0015
FYE: 12/31/2006
PRRB Case No.: 13-1063

Dear Messrs. Ward and Ravindran,

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

Pertinent Facts

On September 17, 2012, MedCenter One Hospital was issued its second revised Notice of Program Reimbursement (NPR) for FYE 12/31/2006. The revised NPR specifically stated that the revision was as a result of adjustments to properly state the Supplemental Security Income Percentage (SSI%) and allowable Disproportionate Share Hospital Percentage (DSH%). The Provider appealed from this second revised NPR on March 15, 2013, disputing the following four issues: SSI Realignment, DSH/SSI Systemic Errors, Rural Floor Budget Neutrality Adjustment (RFBNA) and Medicaid Eligible Days.

On November 7, 2013, the Provider broke out the DSH/SSI Systemic Errors into five separate issues and transferred them into the following optional group appeals: 13-1419G, 13-1436G, 13-1439G, 13-1440G and 13-1442G.[1] On February 19, 2014, the Board received two jurisdiction challenges to the RFBNA and Medicaid Eligible Days issues from the Medicare Administrative Contractor (MAC), Noridian Healthcare Solutions. On March 26, 2014, the Board received the Provider's response to the jurisdictional challenge.

[1] There appears to be a jurisdictional issue on the Medicaid Fraction issues being transferred to case numbers 13-1440G and 13-1442G. The jurisdictional merits of these issues will be reviewed in their respective group cases.

MAC's Jurisdictional Challenge

On February 24, 2014, the MAC challenged the Board's jurisdiction over the Provider's appeal from a revised NPR. Specifically, the MAC contended that the PRRB does not have jurisdiction over appeals from revised NPRs that did not adjust the specific provisions appealed. The MAC stated that neither RFBNA nor the Medicaid Eligible Days were specifically adjusted in the revised NPR from which the Provider is now appealing. Because the Board lacks jurisdiction over appeals from revised NPRs that did not adjust the specific provisions being challenged, the MAC requests the Board to deny jurisdiction and dismiss case number 13-1063.

Provider's Response

On March 16, 2014, the Board received the Provider's response to the MAC's jurisdictional challenge. The Provider withdrew the Medicaid Eligible Days issue, but contends that the RFBNA issue challenged falls within the scope of the revised NPR, as ADJ5 updated previous settlement amount that included DRG payments. While the RFBNA issue was not specifically adjusted, the DRG payments were adjusted, and the RFBNA is used in this calculation. Therefore, the Provider asks that the Board determine that the appeal of the RFBNA issue from the revised NPR is jurisdictionally valid.

Board's Decision

The Board finds that it lacks jurisdiction over the RFBNA issue in MedCenter One Hospital's appeal because it is appealing from a revised NPR which does not adjust RFBNA.

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

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

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

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

> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (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 Board finds that although there was an adjustment to report payments made to the Provider, that adjustment was not made to the RFBNA issue it is now appealing. The RFBNA was clearly not considered or revised in the revised NPR, and is therefore outside the scope of the appeal from a revised NPR under 42 C.F.R. § 405.1885(b)(2). The RFBNA issue is hereby dismissed, leaving only the SSI Realignment issue in the appeal.

The Board has chosen to review whether it has jurisdiction over the SSI realignment issue in this appeal *sua sponte* and finds that it lacks jurisdiction as the appeal is premature. 42 C.F.R. § 405.1835 (2005) states:

> "The provider… has a right to a hearing before the Board about any matter designated in § 405.1801(a)(1), if…[a]n intermediary determination has been made with respect to the provider."

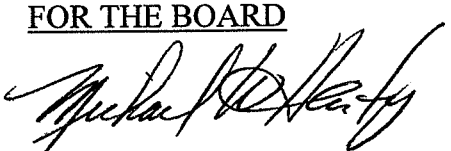
In this case, there was no final determination made by the Intermediary and the Provider has not yet decided whether it will request realignment. Realignment is a remedy the Provider may pursue if it is dissatisfied with MEDPAR SSI data. Therefore, under 42 C.F.R. § 405-1835, the appeal is premature, and the SSI realignment issue is hereby dismissed.

As the Medicaid Eligible Days issue was withdrawn from the appeal, the RFBNA and SSI Realignment issues have been dismissed from this appeal by the Board, and the DSH/SSI Systemic Errors issues have been transferred to other appeals, no other issues remain in dispute in case number 13-1063. The appeal is hereby closed and removed from the Board's docket.

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

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

FOR THE BOARD



Michael W. Harty
Chairman

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

cc: Kevin Shanklin, BCBSA

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Refer to:

13-1078

JUL 28 2014

CERTIFIED MAIL

Noridian Healthcare Solutions, LLC
James R. Ward
Appeals Resolution Manager
JF Provider Audit Appeals
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Fargo, ND 58108-6722

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

RE: Rogue Valley Medical Center
Provider No.: 38-0018
FYE: 09/30/2006
PRRB Case No.: 13-1078

Dear Messrs. Ward and Ravindran,

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

Pertinent Facts

On October 8, 2012, Rogue Valley Medical Center was issued a revised Notice of Program Reimbursement (NPR) for FYE 09/30/2006. The revised NPR specifically stated that the revision was as a result of adjustments to adjust the Supplemental Security Income (SSI) Ratio and Disproportionate Share Hospital Percentage (DSH%) based upon the SSI ratios published by CMS as of 03/16/2002. The Provider appealed from the revised NPR on March 14, 2013, disputing the following issues: DSH/SSI Systemic Errors, SSI Realignment and Rural Floor Budget Neutrality Adjustment (RFBNA).

On October 24, 2013, the Provider broke out the DSH/SSI Systemic Errors into five separate issues and transferred them into the following optional group appeals: 13-1419G, 13-1436G, 13-1439G, 13-1440G and 13-1442G.[1] On February 4, 2014, the Board received a jurisdiction challenge to the RFBNA issue from the Medicare Administrative Contractor (MAC), Noridian Healthcare Solutions. On March 5, 2014, the Board received the Provider's response to the jurisdictional challenge.

[1] There appears to be a jurisdictional issue on the Medicaid Fraction issues being transferred to case numbers 13-1440G and 13-1442G. The jurisdictional merits of these issues will be reviewed in their respective group cases.

MAC's Jurisdictional Challenge

On February 4, 2014, the MAC challenged the Board's jurisdiction over the Provider's appeal from the revised NPR issued on October 8, 2012. Specifically, the MAC contended that the PRRB does not have jurisdiction over appeals from revised NPRs that did not adjust the specific provisions appealed. The MAC stated that the Provider's RFBNA calculation was not specifically adjusted in the revised NPR from which the Provider is now appealing. Because the Board lacks jurisdiction over appeals from revised NPRs that did not adjust the specific provisions being challenged, the MAC requests that Board dismiss the RFBNA issue from case number 13-1078.

Provider's Response

On March 5, 2014, the Board received the Provider's response to the MAC's challenge to the Board's jurisdiction. The Provider contends that the RFBNA issue challenged falls within the scope of a specific adjustment in the revised NPR, as Adjustment No. 2 updated previous settlement amounts that included understated DRG payments. While the RFBNA issue was not specifically adjusted, the DRG payments were adjusted, and the RFBNA is used in this calculation. Therefore, the Provider asks the Board to find the appeal of the RFBNA issue from the revised NPR jurisdictionally valid.

Board's Decision

The Board finds that it does not have jurisdiction over the RFBNA issue in Rogue Valley Medical Center's appeal because it is appealing from a revised NPR which does not adjust RFBNA.

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

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

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

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

> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (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 Board finds that although there was an adjustment to report payments made to the Provider, that adjustment was not made to the RFBNA issue it is now appealing. The RFBNA was clearly not considered or revised in the revised NPR, and is therefore outside the scope of the appeal from a revised NPR under 42 C.F.R. § 405.1885(b)(2). The RFBNA issue is hereby dismissed, leaving only the SSI Realignment under dispute in this appeal.

The Board has chosen to review whether it has jurisdiction over the SSI realignment issue in this appeal *sua sponte* and finds that it lacks jurisdiction as the appeal is premature. 42 C.F.R. § 405.1835 (2005) states:

> "The provider… has a right to a hearing before the Board about any matter designated in § 405.1801(a)(1), if…[a]n intermediary determination has been made with respect to the provider."

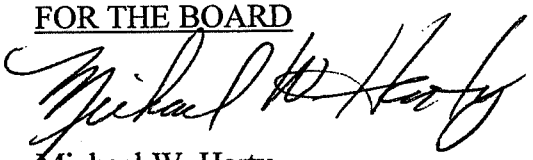
In this case, there was no final determination made by the Intermediary and the Provider has not yet decided whether it will request realignment. Realignment is a remedy the Provider may pursue if it is dissatisfied with MEDPAR SSI data. Therefore, under 42 C.F.R. § 405.1835, the appeal is premature, and the SSI realignment issue is hereby dismissed.

As the RFBNA and SSI Realignment issues have been dismissed from this appeal, and the DSH/SSI Systemic Errors issues have been transferred to other appeals, no other issues remain in dispute in case number 13-1078. The appeal is hereby closed and removed from the Board's docket.

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

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

FOR THE BOARD



Michael W. Harty
Chairman

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

cc: Kevin Shanklin, BCBSA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
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FAX: 410-786-5298
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Refer to: 12-0130G

JUL 29 2014

CERTIFIED MAIL

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

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

RE: Jurisdictional Decision – QRS 2000-2004 DSH Exhausted Medicare Benefits Medicaid Dual Eligible Days Group (2)
Provider No.: Various
FYE: Various
PRRB Case No.: 12-0130G

Dear Mr. Ravindran and Mr. Pike,

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

The Providers filed an initial request for a group appeal on January 5, 2012 with NPR's for FYE's 2002, 2003 and 2004. On September 24, 2012, the Board approved the Providers request to expand the years covered in the group appeal to include FYE 2001. Subsequently on December 17, 2012 expanded the years covered to also include FYE 2000. There are 11 providers listed on the schedule of providers for this group appeal.

The issue addressed in the group appeal, Duel Eligible Days, is subject to CMS Ruling 1498-R; therefore the Board has reviewed the Scheduled of Providers and supporting jurisdictional documentation in preparation for a standard remand.

Board's Decision

A provider has a right to a hearing before the Board, with respect to costs claimed on a timely filed cost report, if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for a hearing is filed within 280 days of the date of the Notice of Program Reimbursement (NPR).[1]
Provider 2: Baptist MC – Jacksonville (FYE 9/30/01), Provider 6: Baptist MC – Jacksonville (FYE 9/30/02), Provider 8: Parkview Medical Center (FYE 6/30/03) , Provider 9: Washington Hospital Center (FYE 6/30/03), Provider10: Parkview Medical Center (FYE 6/30/04)

The Board finds that it does not have jurisdiction over Baptist MC – Jacksonville, FYE 9/30/01 (PN 10-0088), Baptist MC – Jacksonville, FYE 9/30/02 (PN 10-0088), Parkview Medical Center, FYE 6/30/03

[1] 42 U.S.C. §1395oo(a) and 42 C.F.R. §§405-1835-1841

(PN 06-0020), Washington Hospital Center, FYE 6/30/03 (PN 09-0011), and Parkview Medical Center, FYE 6/30/04 (06-0020). Pursuant to 42 C.F.R. § 405.1837 and PRRB Rule 16, a request to transfer an issue to a group appeal must include proper documentation to demonstrate that the issue is currently part of the individual appeal from which it is to be transferred. Here, the Providers did not provide documentation to demonstrate that the Dual Eligible issue was included in the original appeal or in any subsequent requests to add issue to their respective individual appeals. As these Providers did not provide documentation to demonstrate that the Dual Eligible issue is currently a part of their respective individual appeals, the Board denies jurisdiction over these Providers.

Provider 5: St. Francis Hospital & MC, FYE 9/30/02 (PN 07-0002)

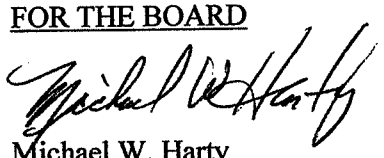
St Francis Hospital for FYE 09/30/2002 filed an individual appeal request from its RNPR dated September 28, 2011 on March 30, 2012. The Board established PRRB Case No. 12-0289. On December 31, 2013 the Board issued a jurisdictional determination related to St. Francis Medical Center RNPR appeal, and found that it lacked jurisdiction over the three issues appealed from the revised NPR, as the revised NPR did not specifically adjust those issues. One of the issues the Board determined it lacked jurisdiction over was the DSH Exhausted Dual Eligible days that the Provider had requested be transferred to this group appeal. As the Board determined it lacked jurisdiction over the issue, it denied the transfer of the issue to this group appeal.

Because the Board previously denied jurisdiction over the Dual Eligible issue for St. Francis and denied the transfer to this group appeal, this issue is deemed no longer part of this group appeal and will be eliminated from the Schedule of Providers.

Review of the jurisdictional determinations for Provider 2: Baptist MC – Jacksonville (FYE 9/30/01), Provider 6: Baptist MC – Jacksonville (FYE 9/30/02), Provider 8: Parkview Medical Center (FYE 6/30/03) , Provider 9: Washington Hospital Center (FYE 6/30/03), Provider10: Parkview Medical Center (FYE 6/30/04) 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 appeal.

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

FOR THE BOARD



Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, BCBSA

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Refer to CERTIFIED MAIL

JUL 30 2014

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

RE: Request for Expedited Judicial Review
UPMC 2005 DSH SSI
Provider Nos.: Various
FYE: 06/30/2005 and 07/31/2005
PRRB Case No.: 07-0232GC

Dear Ms. Webster:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' June 27, 2014 Request for Expedited Judicial Review (EJR) (received June 30, 2014). Set forth below is the Board's decision finding that EJR is not appropriate.

ISSUE

Should the Provider Reimbursement Review Board grant the Providers' request for EJR over the validity of the provisions of the Centers for Medicare & Medicaid Services (CMS) Ruling 1498-R (Ruling), which if valid, render moot and deny the Board jurisdiction over the Providers in this appeal of the disproportionate share adjustment (DSH) supplemental security income (SSI) issue?

MEDICARE STATUTORY AND REGULATORY BACKGROUND

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

Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. Those cost reports show the costs incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. § 413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R.

§ 405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Board if it meets the following conditions: (1) The provider must be dissatisfied with the final determination of the intermediary; (2) the amount in controversy must exceed $10,000 for an individual appeal (or $50,000 for groups); and (3) the appeal must be filed with the Board within 180 days of the receipt of the final determination. 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835-405.1837.

The Medicare statute at 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), require the Board to grant EJR if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling.

Medicare Disproportionate Share Hospital (DSH) Payment

Part A of the Medicare Act covers "inpatient hospital services." 42 U.S.C. § 1395d(a)(1). Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system (PPS). 42 U.S.C. §§ 1395ww(d)(1)-(5); 42 C.F.R. § 412. Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments. *Id.*

One of the PPS payment adjustments is the DSH payment adjustment. The Secretary is required to provide increased PPS reimbursement to hospitals that serve a "significantly disproportionate number of low-income patients." 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106. Whether a hospital qualifies for the DSH adjustment and how large an adjustment it receives depends on the hospital's "disproportionate patient percentage" (DPP). 42 U.S.C. § 1395ww(d)(5)(F)(v).

The DPP is defined as the sum of two fractions expressed as a percentage. 42 U.S.C. § 1395ww(d)(5)(F)(vi). Both of these fractions look, in part, to whether or not the hospital's patients for such days claimed during the particular cost reporting period were "entitled to benefits" under Medicare Part A.

The first fraction used to compute the DSH payment is commonly known as the Medicare fraction. It is also referred to as the SSI fraction because the numerator is determined by the number of patient days for which the patient was entitled to SSI. The statute defines the SSI fraction as:

> (I) the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were **entitled to benefits under Part A** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year

> which were made up of patients who (for such days) were **entitled to benefits under Part A** of this subchapter.

42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) (emphasis added).

The SSI fraction is computed annually by CMS, and the Medicare fiscal intermediaries are required to use CMS's calculation to compute a hospital's DSH payment adjustment. 42 C.F.R. § 412.106(b)(2)-(3).

The second fraction used to compute the DSH payment is the Medicaid fraction, defined as:

> (II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX of this chapter, but who were **not entitled to benefits under Part A** of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.

42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) (emphasis added).

According to CMS' regulation, "[t]he fiscal intermediary determines ... the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period." 42 C.F.R. § 412.106(b)(4).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY

The underlying issue in dispute in these cases involves the proper amount of Medicare reimbursement due the Providers of medical services. The Providers in these group appeals are challenging CMS' calculation of the Medicare Part A/SSI fraction used to determine the Providers' eligibility for, and the amount of, the Medicare DSH payment. The contested issue in each of these group appeals is the SSI "data matching process" issue.

The Providers contend that the Board should grant their request for EJR because the remand provisions of the Ruling 1498-R are invalid and should be set aside, to the extent that those provisions of the Ruling would require or permit CMS or the Medicare contractors to add Medicare Part A non-covered or Medicare Part C patient days to those Medicare Part A/SSI fractions pursuant to a recalculation performed on remand. The Providers maintain that the Medicare Part A/SSI fractions at issue in this group appeal did not include Medicare Part A non-covered or Medicare Part C patient days. The DSH regulation in effect at the time did not permit CMS to include those patient days in the Medicare Part A/SSI fractions.[1]

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[1] *See* 42 C.F.R. § 412.106(b) (2004) (limiting the Medicare Part A/SSI fractions to Medicare Part A covered patient days) *Catholic Health Initiatives-Iowa v. Sebelius*, 718 F.3d 914, 921 n.5 (D.C. Cir. 2013) (noting that "[p]rior to 2004, the Secretary interpreted the phrase "entitled to benefits under part A of [Medicare]" in the Medicare fraction to include only "covered Medicare Part A inpatient days"); *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 13-17

The Providers argue they have not claimed that Medicare Part A non-covered or Medicare Part C patient days should be added to, or otherwise included in, the Medicare Part A/SSI fractions at issue. Nevertheless, in direct violation of the regulation governing the calculation of the Medicare Part A/SSI fractions for federal fiscal year 2004, *i.e.*, the fractions at issue in this group appeal, the Ruling would now permit CMS and the contractors to add the Medicare Part A non-covered and Medicare Part C patient days to those fractions on remand of this appeal.

The Providers contend the Ruling is both expanding the issues in this group appeal and at the same time requiring a calculation including the previously-excluded Part A non-covered and Part C patient days in violation of the controlling regulation in effect for federal fiscal year 2004. The Ruling conflicts with several higher legal authorities that the Board is bound to uphold, including several provisions of the Medicare statute, the Administrative Procedure Act and the DSH regulation in effect for cost reporting periods that began before October 1, 2004.[2]

The Providers maintain that the recalculation of the SSI fractions pursuant to the Ruling would deviate from the court's decision in *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20, amended by 587 F. Supp. 2d 37 (D.D.C. 2008), the process the agency used to implement the court's decision and the Secretary's representations to the court in that case in one significant respect involving the *second issue* covered by the Ruling.[3] The Providers argue specifically that the Ruling requires CMS to include in the revised SSI fractions the hospital patient days for all patients who were enrolled in Medicare part A, regardless of whether Medicare Part A benefits were paid for those patient days. This would include non-covered patient days such as those attributable to individuals who were enrolled in Medicare Part A but had exhausted Part A benefits for inpatient hospital services ("Part A exhausted benefit days") and days that were not paid by Medicare Part A because Medicare's payment liability was secondary to another payor's primary liability (Medicare secondary payor "MSP days"). The Provider contends the court's decision in *Baystate*, however did not hold that Part A exhausted benefit days and MSP days should be counted in the SSI fraction. Quite to the contrary, the Secretary in that case conceded that exhausted benefit days and Medicare secondary payor days not paid under Medicare are properly excluded from the SSI fraction for the years in question.[4,5]

The Provider maintains the Ruling does not require remand of pending appeals on Medicare Part C days for patients who were receiving Medicare benefits under Part C of the Medicare statute through enrollment in Medicare+Choice or Medicare Advantage plans. Nevertheless, it appears that CMS contemplates that Part C days would be added to the SSI fractions for some years that would be recalculated on remand pursuant to the Ruling. The Ruling itself defines the SSI

(D.C. Cir. 2011) (prohibiting the Secretary from retroactively applying the 2004 rule requiring inclusion of Medicare part C days in the SSI fraction to periods beginning prior to October 1, 2004 effective date of that rule).

[2] Providers' EJR Request at 1-2.

[3] The Ruling applies to three issues in jurisdictionally proper pending appeals concerning the calculation of the Medicare DSH payment: 1) the "data matching process" used to calculate the SSI fraction; 2.) certain "non-covered" days for cost reporting periods with patient discharges before October 1, 2004; and 3.) labor and delivery days for cost reporting periods beginning before October 1, 2009.

[4] 545 F. Supp. 2d at 55 n. 37.

[5] Providers' EJR request at 3.

fraction to include days for patients "who are enrolled in a Medicare Advantage (Part C) plan."[6] The Ruling also notes that Part C days will be included in the SSI fraction "only if the individual is enrolled in Part A or Part C and the hospital has submitted a Medicare claim on behalf of the patient."[7] The Provider contends any inclusion of Part C days in the SSI fraction violates the regulation applicable to the periods at issue, which called for the inclusion only of covered Part A days in the SSI fraction.[8]

The Provider argues CMS, when interpreting the regulation through publication and transmission of the SSI fractions to its contractors for the periods at issue, explicitly stated that the fractions only included covered part A entitled days.[9] The Providers dispute any determination pursuant to the Ruling to include non-covered days, Part A exhausted benefit days, MSP days, Part C days and any other days for which patients were not entitled to have payment made under Medicare Part A in the SSI fraction. These days are not attributable to patients who were entitled to benefits under Part A for those days. Accordingly, the Provider contends those days must be included in the numerator of the Medicaid fraction and excluded from the SSI fraction used to calculate their Medicare DSH payments.[10]

The Providers maintain that they submitted schedules of providers and supporting documentation showing that they met all the jurisdictional requirements for a hearing under 42 U.S.C. § 1395oo(a). Their claims are not moot. CMS suggestion that some hospitals might be satisfied with a recalculation performed in exactly the opposite way the hospitals contend it should be calculated is nonsensical and not supported by any evidence or analysis. CMS' determination to add the Part A exhausted benefit days, MSP days and Part C days to the SSI fraction cannot rationally be said to render moot the Provider's pending claims to have the SSI fraction calculated correctly.[11]

The Providers contend the remands that the Ruling purports to require would violate at least three separate provisions of the Medicare Act (42 U.S.C. §§ 1395oo(a), 1395ww(d)(5)(F)(vi)(I) and 1395hh), the Administrative Procedures Act ("APA") and the DSH regulation (42 C.F.R. § 412.106(b)) that was in effect before October 1, 2004. The Board is bound constitutionally and otherwise to uphold and obey those higher legal authorities. Unlike the Ruling, the statutory provisions it violates are law, and the DSH regulation it violates has the force and effect of law for periods before October 1, 2004. All of those provisions are higher authorities than the CMS Ruling, and all of them are binding on the Board. Accordingly, the Providers contend the Ruling is invalid.[12]

The Providers argue in accordance with the plain meaning of 42 U.S.C. § 1395ww(d)(5)(F)(vi), Part A exhausted benefit days, MSP days and Part C days must be excluded from the SSI fraction, because these patients were not "entitled to benefits" under Part A for their patient days.

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[6] CMS Ruling 1498-R at 3 (April 28, 2010).
[7] *Id.* at 8.
[8] *See* 42 C.F.R. § 412.106(b)(2); 52 Fed. Reg. 16772, 16777 (May 6, 1986).
[9] See, e.g., Transmittal 647, CMS Pub. 100-04, Medicare Claims Processing Manual (Aug. 12, 2005) (FFY 2004); Program Memorandum A-01-109 (Sep. 13, 2001) (FFY 2000).
[10] Providers' EJR Request at 3-4.
[11] *Id.* at 6-7.
[12] *Id.* at 8.

The Providers contend the Ruling also violates 42 U.S.C. § 1395hh and the APA's notice and comment rulemaking requirements in 5 U.S.C. § 553. Both statutes prohibit retroactive rulemaking. The Ruling has retroactive effect, at least insofar as it purports to require CMS and the contractor to include Part A exhausted benefit days, MSP days or Part C days in the SSI fraction for periods beginning before October 1, 2004. In this respect, the Ruling applies a new substantive rule for prior cost reporting periods that begin before October 1, 2004.[13] The Providers maintain under the DSH regulation in effect prior to October 1, 2004, 42 C.F.R. § 412.106(b), and the agency's long standing interpretation of that regulation, Part A exhausted benefit days, MSP days and Part C days were not included in the SSI fraction. The CMS administrator himself ruled in 1996 that days billed to and paid by Medicaid after patients had exhausted Medicare Part A benefits, may be included in the numerator of the Medicaid fraction.[14]

The Providers contend CMS' Ruling is an improper attempt on the agency's part to camouflage the reimbursement impact of the corrections to the SSI fractions that the agency is required to make under *Baystate*. The positive impact of the correction of those systemic errors and omissions would be effectively masked by an offsetting penalty imposed by the Ruling. The penalty stems from the Ruling's new retroactive requirement to add to Part A exhausted benefit days, MSP days and/or Part C days, which were not covered or paid under Medicare Part A, to the SSI fraction for the years to which the Ruling would apply. This change was not required by the decision in *Baystate* and it was not made by CMS in the revised SSI fractions that the agency calculated and applied to *Baystate* in June 2009 to implement that decision. CMS' change would have the effect of substantially reducing the SSI fractions.[15]

DECISION OF THE BOARD

The Medicare statute at 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), require the Board to grant EJR if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling.

Issue Under Appeal

The Providers in this group appeal appealed the SSI "data matching process" issue in their group appeal request.[16] The Providers identified the issue under appeal in their group appeal request as "[t]he participating providers contend that the Centers for Medicare & Medicaid Services ("CMS") has improperly computed the fraction reflecting the percentage of the Providers'

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[13] *Id.* at 9.
[14] *Id.* at 10-11, citing *Presbyterian Med. Ctr. of Philadelphia v. Aetna Life Ins. Co.*, CMS Adm'r Dec., MEDICARE & MEDICAID GUIDE (CCH) ¶ 45,032 (Nov. 29, 1996).
[15] *Id.* at 12.
[16] The Providers indicated in their EJR request that the issue under appeal in their group appeal was the SSI "data matching process" issue. The Providers stated "[w]ith respect to the SSI "data matching process" issue, which is contested in each of these group appeals, the Ruling provides (at 4-7 & 29-30) for recalculation of the SSI fractions on remand to the contractors." Providers' EJR request at 2.

Medicare inpatients who were entitled to supplemental security income (the "Medicare fraction"), and thereby failed to pay the hospitals' proper DSH entitlements."[17] The Providers contend "CMS' computation of the Medicare/SSI fraction is systemically flawed, as recently found by the Board in Baystate Medical Center v. Mutual of Omaha, PRRB Dec. No. 2006-D20, Medicare & Medicaid Guide (CCH) ¶ 81,468 (Mar. 17, 2006), and the resulting fraction is therefore understated."[18]

All of the Providers with the exception of one Provider[19] were directly added to this group appeal. The Provider that was not directly added filed an underlying individual appeal[20] and thereafter added the SSI issue to its appeal before transferring the issue to this group appeal. The Provider identified the issue under appeal in its add request as "[t]he Fiscal Intermediary ... understated the SSI component of the formula used to calculate Disproportionate Share (DSH) payments."[21]

EJR Request

The Providers contend that the CMS Ruling 1498-R purports to expand the issue in this group appeal and require a recalculation to include not only the "same data matching process as the agency used to implement the *Baystate* decision", but also to include Medicare Part A non-covered or Medicare Part C patient days to the Medicare Part A/SSI fractions. The Providers request that the Board grant EJR because the remand provisions of the Ruling 1498-R are invalid and should be set aside, to the extent that those provisions of the Ruling would require or permit CMS or the Medicare contractors to add Medicare Part A non-covered or Medicare Part C patient days to those Medicare Part A/SSI fractions pursuant to a recalculation performed on remand. The Providers maintain that the Medicare Part A/SSI fractions at issue in this group appeal did not include Medicare Part A non-covered or Medicare Part C patient days.

The providers describe the issue for which EJR is requested over as CMS' determination to add Part A exhausted benefit days, MSP days and Part C days to the SSI fraction.[22] The Providers argue:

> [s]pecifically the Ruling (at 7-14 & 29-30) requires CMS to include in the revised SSI fractions the hospital inpatient patient days for all patients who were enrolled in Medicare Part A, regardless of whether Medicare Part A benefits were paid for those patient days. As described in the Ruling, this would include non-covered patient days such as those attributable to individuals who were enrolled in Medicare Part A but had exhausted Part A benefits for inpatient hospital services ('Part A exhausted benefit

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[17] Providers' Group Appeal Request at 1.
[18] *Id.* at 2.
[19] Magee-Womens Hospital of UPMC Health System, Provider No. 39-0114, FYE 6/30/2005.
[20] PRRB Case No. 07-0008.
[21] Schedule of Providers and Jurisdictional Documents at Tab 4B.
[22] The Providers stated "[t]he Providers dispute any determination pursuant to the Ruling to include non-covered days, Part A exhausted benefit days, MSP days, Part C days and any other days for which patients were not entitled to have payment made under Medicare Part A in the SSI fraction." Providers EJR request at 4.

> days') and days that were not paid by Medicare Part A because Medicare's payment liability was secondary to another payor's primary liability ('MSP days'). The court's decision in *Baystate*, however, did not hold that Part A exhausted benefit days and MSP days should be counted in the SSI fraction.

The Providers continue:

> [t]he Ruling does not require remand of pending appeals on Medicare Part C days for patients who were receiving Medicare benefits under Part C of the Medicare statute through enrollment in Medicare+Choice or Medicare Advantage plans. Nevertheless, it appears that CMS contemplates that Part C days would be added to the SSI fractions for some years that would be recalculated on remand pursuant to the Ruling. ... Any inclusion of Part C days in the SSI fraction violates the regulation applicable to the periods at issue, which called for the inclusion only of covered part A days in the SSI fraction.[23]

Challenge to the Validity of Ruling

The Providers' current EJR request, which was filed over four years after the issuance of CMS Ruling 1498-R, seeks to invalidate the provisions of the Ruling to the extent that those provisions of the Ruling would require or permit CMS or the Medicare contractors to add Medicare Part A non-covered or Medicare Part C patient days to the Medicare Part A/SSI fractions pursuant to a recalculation performed on remand. The EJR refers to the fact that the Board previously issued EJR over the validity of the Ruling provisions in over 132 similar cases.

The Board's earliest decision granting EJR over the validity of certain Ruling provisions was issued in June of 2010, shortly after the Ruling was issued on April 28, 2010. The Board has since issued twelve similar decisions, covering a total of 149 cases. In those cases, EJR was granted over the question of whether "[it] lacks authority to make a determination whether the Ruling deprives it of continuing jurisdiction because the challenged substantive provisions of the Ruling are also the foundation for CMS' claim the Board lacks jurisdiction to grant EJR." This threshold question regarding jurisdiction, which is now being litigated in Federal Court, allowed the appeals of providers challenging the data matching process to remain open before the Board, thus maintaining the status quo.

Since that time, the challenge to the validity of the Ruling in the courts has been stayed pending issue specific litigation over the inclusion of both the Medicare Part A non-covered days and the Medicare Part C patient days in the Medicare DSH calculation. The abeyance in the courts allowed the separate appeals for the other DSH issues to play out, as they were the underlying dispute in the Providers challenge to the remand required in the data matching cases.

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[23] Providers' EJR request at 3.

In addition, CMS did begin issuing new SSI percentages on its website for FY 2006-2012. These SSI percentages did include both Medicare Part A non-covered days and Medicare Part C patient days in the Medicare Part A/SSI fractions. Those new SSI percentages have been incorporated into open provider cost reports as well cost reports that had been previously finalized, but had reopening notices issued pending the litigation in the *Baystate* decision. New SSI percentages have not been issued for FY 2005 and prior due to the ongoing litigation referenced above.

Federal Litigation after the Issuance of CMS Ruling 1498R

The Federal courts have reviewed the treatment of Medicare Part C days and Medicare/Medicaid dual eligible days in the DSH calculation in four cases. In *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1 (D.C. Cir. 2011), the Court held that Congress has not unambiguously foreclosed the Secretary's interpretation that Medicare Part C enrollees are entitled to benefits under Part A, but also held that the Secretary's present interpretation may not be retroactively applied to periods prior to its 2004 rulemaking. More recently in *Allina Health Services v. Sebelius*, 746 F.3d (D.C. Cir. 2014), the Court concluded that the Secretary did not provide adequate notice and comment before promulgating the 2004 rule regarding inclusion of Medicare Part C days in the Medicare fraction of the DSH calculation and thus vacatur was an appropriate remedy.[24]

Two circuit courts, the D.C. Circuit Court and the Seventh Circuit, have ruled on the dual eligible days issue finding that exclusion of dual eligible exhausted benefit days from the Medicaid fraction was permissible as such patients were "entitled to benefits under part A." *See Metropolitan Hospital v. DHHS*, 712 F.3d 248 (7th Cir. 2013) (*Metropolitan*) and *Catholic Health Initiatives v. Sebelius*, 718 F.3d 914 (D.C. Cir. 2013) (*CHI*). However, the rationale for this conclusion differed significantly. The 7th Circuit in *Metropolitan* concluded that the Secretary's treatment of dual eligible days was a reasonable interpretation of under step two of a *Chevron* analysis and therefore entitled to deference.[25] The D.C. Circuit in *CHI* found that an earlier administrative decision in *Edgewater Medical Center*[26] set forth the Secretary's policy to exclude Medicare exhausted days from the Medicaid fraction and the Secretary's policy was not unfair retroactive rule-making.

Denial of EJR Request

The Board notes that the Ruling applies to three issues in jurisdictionally proper pending appeals concerning the calculation of the Medicare DSH payment: 1) the "data matching process" used to calculate the SSI fraction; 2) certain "non-covered" Part A days for cost reporting periods with patient discharges before October 1, 2004; and 3) labor and delivery days for cost reporting periods beginning before October 1, 2009. Contrary to the EJR decisions rendered in appeals shortly after the Ruling was issued, much is now known about the remand process, as well as to

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[24] Although the rule was promulgated in 2004, the Code of Federal Regulations was never actually amended, so in 2007 the Secretary issued a "technical correction" conforming the language of the C.F.R. to the 2004 rule.
[25] *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984).
[26] *Edgewater Medical Center v. Blue Cross Blue Shield Association*, HCFA Adm. Dec., 2000 WL 1146601 (June 19, 2000).

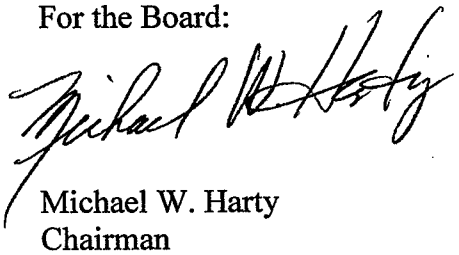
the challenge of the treatment of the Medicare Part A non-covered days and Medicare Part C days in the DSH calculation.

The litigation referenced above related to CMS' inclusion of the Medicare Part C patient days in the Medicare Part A/SSI fractions is distinct litigation from the issues covered by the Ruling. The Board finds that although the Ruling may reference CMS' policy to include Part C days in the Medicare Part A/SSI fraction, the Ruling itself does not direct such days to be included in the Medicare fraction. The final determination regarding the treatment of Part C days will be determined by the outcome of the D.C. Circuit Court litigation. The Ruling does however apply to appeals challenging the inclusion of non-covered Part A days (including exhausted benefit days and MSP days) in the SSI fraction. With final decisions in both *CHI* (for cost reporting periods prior to 10/1/04) and *Metropolitan Hospital* (for periods on or after 10/1/04), the treatment of Medicare Part A non-covered days as still "entitled to benefits under part A" has been upheld by the courts. The Board finds those days are not at issue in this appeal, but there may be no way to bifurcate the recalculation of the SSI percentage to account for only the data matching issue but not the inclusion of the Part A exhausted benefit days and MSP days in the SSI fraction. Therefore, when a provider's appeal of the data matching issue is remanded back to the contractor for inclusion of the new SSI percentage using the proper Baystate data matching process, the SSI percentage calculated by CMS should take into account all appropriate categories of days.

The Board finds that the Providers' request for EJR does not address the issue appealed, the SSI "data matching process" issue, but instead seeks EJR over whether Part A exhausted benefit days, MSP days and Part C days must be included in the numerator of the Medicaid fraction and excluded from the SSI fraction. These issues are not the subject of the Providers' underlying individual and group appeal requests. The deadline for adding issues to an appeal has expired and issues may not be added to group appeals. As such, the Board denies the Providers' request for EJR. The Board finds that this appeal is subject to CMS Ruling 1498-R and is not questioning the validity of the Ruling removing Board jurisdiction in cases where Providers have filed a jurisdictionally valid appeal. Consequently, the Board concludes that this case is appropriate for remand under CMS Ruling 1498-R. A letter will be simultaneously issued with this decision remanding the case to the intermediary pursuant to the Ruling.

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

For the Board:



Michael W. Harty
Chairman

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

cc: Bruce Snyder, Novitas Solutions, Inc.
Kevin D. Shanklin, Blue Cross Blue Shield Association

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

JUL 30 2014

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

RE: Request for Expedited Judicial Review
Baycare 2005 DSH SSI CIRP Group
Provider Nos.: 10-0075 and 10-0127
FYE: 12/31/2005
PRRB Case No.: 09-1019GC

Dear Ms. Webster:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' June 27, 2014 Request for Expedited Judicial Review (EJR) (received June 30, 2014). Set forth below is the Board's decision finding that EJR is not appropriate.

ISSUE

Should the Provider Reimbursement Review Board grant the Providers' request for EJR over the validity of the provisions of the Centers for Medicare & Medicaid Services (CMS) Ruling 1498-R (Ruling), which if valid, render moot and deny the Board jurisdiction over the Providers in this appeal of the disproportionate share adjustment (DSH) supplemental security income (SSI) issue?

MEDICARE STATUTORY AND REGULATORY BACKGROUND

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

Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. Those cost reports show the costs incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. § 413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R.

§ 405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Board if it meets the following conditions: (1) The provider must be dissatisfied with the final determination of the intermediary; (2) the amount in controversy must exceed $10,000 for an individual appeal (or $50,000 for groups); and (3) the appeal must be filed with the Board within 180 days of the receipt of the final determination. 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835-405.1837.

The Medicare statute at 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), require the Board to grant EJR if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling.

Medicare Disproportionate Share Hospital (DSH) Payment

Part A of the Medicare Act covers "inpatient hospital services." 42 U.S.C. § 1395d(a)(1). Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system (PPS). 42 U.S.C. §§ 1395ww(d)(1)-(5); 42 C.F.R. § 412. Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments. *Id.*

One of the PPS payment adjustments is the DSH payment adjustment. The Secretary is required to provide increased PPS reimbursement to hospitals that serve a "significantly disproportionate number of low-income patients." 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106. Whether a hospital qualifies for the DSH adjustment and how large an adjustment it receives depends on the hospital's "disproportionate patient percentage" (DPP). 42 U.S.C. § 1395ww(d)(5)(F)(v).

The DPP is defined as the sum of two fractions expressed as a percentage. 42 U.S.C. § 1395ww(d)(5)(F)(vi). Both of these fractions look, in part, to whether or not the hospital's patients for such days claimed during the particular cost reporting period were "entitled to benefits" under Medicare Part A.

The first fraction used to compute the DSH payment is commonly known as the Medicare fraction. It is also referred to as the SSI fraction because the numerator is determined by the number of patient days for which the patient was entitled to SSI. The statute defines the SSI fraction as:

> (I) the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were **entitled to benefits under Part A** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year

> which were made up of patients who (for such days) were **entitled to benefits under Part A** of this subchapter.

42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) (emphasis added).

The SSI fraction is computed annually by CMS, and the Medicare fiscal intermediaries are required to use CMS's calculation to compute a hospital's DSH payment adjustment. 42 C.F.R. § 412.106(b)(2)-(3).

The second fraction used to compute the DSH payment is the Medicaid fraction, defined as:

> (II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX of this chapter, but who were **not entitled to benefits under Part A** of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.

42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) (emphasis added).

According to CMS' regulation, "[t]he fiscal intermediary determines ... the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period." 42 C.F.R. § 412.106(b)(4).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY

The underlying issue in dispute in this case involves the proper amount of Medicare reimbursement due the Providers of medical services. The Providers in this group appeal are challenging CMS' calculation of the Medicare Part A/SSI fraction used to determine the Providers' eligibility for, and the amount of, the Medicare DSH payment. The contested issue in each of these group appeals is the SSI "data matching process" issue.

The Providers contend that the Board should grant their request for EJR because the remand provisions of the Ruling 1498-R are invalid and should be set aside, to the extent that those provisions of the Ruling would require or permit CMS or the Medicare contractors to add Medicare Part C patient days to those Medicare Part A/SSI fractions pursuant to a recalculation performed on remand. The Providers maintain that CMS changed its policy, effective October 1, 2004, to include Medicare Part C days in the calculation of the Medicare Part A/SSI fraction. The Medicare Part A/SSI fractions that were actually calculated for the 2005 period at issue in this group appeal did not include Medicare Part C patient days, however, and the Providers in the group appeal have not contended that those days should be included.

The Providers argue though they have not claimed that Medicare Part C patient days should be added to, or otherwise included in, the Medicare Part A/SSI fractions at issue, the Ruling would

now permit CMS and the contractors to add Medicare Part C patient days to those fractions on remand of this appeal, in direct violation of the Court of Appeals' decision in *Allina Health Services v. Sebelius,* 2014 WL 1284834 (D.C. Cir. Apr. 1, 2014). The Providers contend the Ruling is both expanding the issues in this group appeal and at the same time requiring a calculation including the previously-excluded Part C patient days in violation of the *Allina* decision vacating the 2004 rule change. The Providers contend the Ruling conflicts with several higher legal authorities that the Board is bound to uphold, including several provisions of the Medicare statute, the Administrative Procedure Act and the DSH regulation in effect for cost reporting periods that began before October 1, 2004.[1]

The Providers maintain that they have simultaneously submitted a schedule of providers and supporting documentation showing that they met all the jurisdictional requirements for a hearing under 42 U.S.C. § 1395oo(a). Their claims are not moot to the extent that CMS would include Medicare Part C days in the SSI fractions recalculated pursuant to the Ruling.[2] The Providers contend to the extent that CMS would add Part C days to the SSI fractions pursuant to the Ruling, the Board cannot order the remands that the Ruling would require without violating the Court of Appeals' recent decision in *Allina*, as well as several provisions of the Medicare Act (42 U.S.C. §§ 1395oo(a), 1395ww(d)(5)(F)(vi)(I) and 1395hh), and the Administrative Procedures Act ("APA"). The Board is bound constitutionally and otherwise to uphold and obey those higher legal authorities. Unlike the Ruling, the statutory provisions it violates are law. All of those provisions are higher authorities than the CMS Ruling, and all of them are binding on the Board. Accordingly, because the Ruling would require the addition of Part C days to the SSI fractions, the Providers contend the Ruling is invalid.[3]

The Providers argue in accordance with the plain meaning of § 1395ww(d)(5)(F)(vi), Part C days must be excluded from the SSI fraction, because these patients were not "entitled to benefits" under Part A for their patient days. The Providers contend the Ruling also violates § 1395hh and the APA's notice and comment rulemaking requirements in 5 U.S.C. § 553, to the extent that Part C days would be added to the SSI fractions calculated upon remand. The Providers maintain CMS' policy first announced in 2004 to count Medicare Advantage days in the SSI fraction was not adopted in accordance with the notice and comment rulemaking requirements prescribed by the APA and the Medicare Act.[4] The Providers contend because the current policy that was first announced in a 2004 rulemaking is the opposite of the policy described in a 2003 notice of the proposed rulemaking,[5] hospitals did not have adequate advance notice or a meaningful opportunity to comment on the new policy.[6] The Providers maintain the Medicare Act explicitly states that when a final rule is not the logical outgrowth of the proposed rule, it "shall be treated

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[1] Providers' EJR Request at 1-2.
[2] *Id.* at 4.
[3] *Id.* at 5.
[4] *See Allina Health Servs.*, 2014 WL 1284834, at *3-6 (affirming vacatur of CMS'rule requiring part C days to be included in the Medicare Part A/SSI fraction because CMS did not provide adequate notice to hospitals regarding the change in interpretation adopted in 2004).
[5] *See* 68 Fed. Reg. at 27,208.
[6] *See Allina Health Servs.*, 2014 WL 1284834, at *3-6 (finding that CMS' 2004 final rule with respect to Part C days was not a "logical outgrowth" of the 2003 proposed rule and affirming district court decision vacating 2004 final rule); see also *Envtl. Def. v. Duke Energy Corp.*, 549 U.S. 561 (2007); see also *Envtl. Integrity Project v. EPA*, 425 F.3d 992, 996, 998 (D.C. Cir. 2005).

as a proposed regulation and shall not take effect" until there is further opportunity for comments.[7] Further, the Medicare Act requires CMS to go through notice and comment rulemaking whenever it establishes or modifies a standard governing payment to providers, and such a regulation may only take effect after publication of the final rule.[8] Accordingly, the Providers contend the 2004 policy cannot be applied to the SSI fractions to be recalculated on remand.

The Providers maintain CMS' Ruling is an improper attempt on the agency's part to camouflage the reimbursement impact of the corrections to the SSI fractions that the agency is required to make under *Baystate*. The positive impact of the correction of those systemic errors and omissions would be effectively masked by an offsetting penalty imposed by the Ruling, as the Ruling would require that Part C days be included in the recalculated SSI fractions. This change was not required by the decision in *Baystate,* and it was not made by CMS in the revised SSI fractions that the agency calculated and applied to *Baystate* in June 2009 to implement that decision. The inclusion of Part C days would have the effect of substantially reducing the SSI fractions.[9]

DECISION OF THE BOARD

The Medicare statute at 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), require the Board to grant EJR if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling.

Issue Under Appeal

The Providers in this group appeal appealed the SSI "data matching process" issue in their group appeal request.[10] The Providers identified the issue under appeal in their group appeal request as "[t]he provider contends that CMS has miscomputed the disproportionate share hospital ("DSH") Medicare fraction and that the Provider's DSH payment determination therefore reflects a significant underpayment to the Provider. The Provider contends that CMS' computation of the Medicare fraction is systemically flawed, as found by the Board in *Baystate Medical Center v. Mutual of Omaha*, PRRB Dec. No. 2006-D20, slip op. (Mar. 17, 2006), and that the Medicare fraction is therefore understated."[11]

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[7] 42 U.S.C. § 1395hh(a)(4).
[8] *Id.* §§ 1395hh(a)(1)-(2), (b), (e).
[9] Providers' EJR Request at 6-7.
[10] The Providers conceded in their EJR request that the issue under appeal in their group appeal was the SSI "data matching process" issue. The Providers stated "[w]ith respect to the SSI "data matching process" issue, which is contested in each of these group appeals, the Ruling provides (at 4-7 & 29-30) for recalculation of the SSI fractions on remand to the contractors." Providers' EJR request at 2.
[11] Providers' Hearing Request at 1.

EJR Request

The Providers contend that the CMS Ruling 1498-R purports to expand the issue in this group appeal and require a recalculation to include not only the "same data matching process as the agency used to implement the *Baystate* decision", but also to include Medicare Part C patient days to the Medicare Part A/SSI fractions. The Providers request that the Board grant EJR because the remand provisions of the Ruling 1498-R are invalid and should be set aside, to the extent that those provisions of the Ruling would require or permit CMS or the Medicare contractors to add Medicare Part C patient days to those Medicare Part A/SSI fractions pursuant to a recalculation performed on remand. [12] The Providers maintain that the Medicare Part A/SSI fractions at issue in this group appeal did not include Medicare Part C patient days and inclusion of such days would be in direct violation of the Court of Appeals decision in *Allina*.

Challenge to the Validity of Ruling

The Providers' current EJR request, which was filed over four years after the issuance of CMS Ruling 1498-R, seeks to invalidate the provisions of the Ruling to the extent that those provisions of the Ruling would require or permit CMS or the Medicare contractors to add Medicare Part C patient days to the Medicare Part A/SSI fractions pursuant to a recalculation performed on remand. The EJR refers to the fact that the Board previously issued EJR over the validity of the Ruling provisions in over 132 similar cases.

The Board's earliest decision granting EJR over the validity of certain Ruling provisions was issued in June of 2010, shortly after the Ruling was issued on April 28, 2010. The Board has since issued twelve similar decisions, covering a total of 149 cases. In those cases, EJR was granted over the question of whether "[it] lacks authority to make a determination whether the Ruling deprives it of continuing jurisdiction because the challenged substantive provisions of the Ruling are also the foundation for CMS' claim the Board lacks jurisdiction to grant EJR." This threshold question regarding jurisdiction, which is now being litigated in Federal Court, allowed the appeals of providers challenging the data matching process to remain open before the Board maintaining the status quo.

Since that time, the challenge to the validity of the Ruling in the courts has been stayed pending issue specific litigation over the inclusion of both the Medicare Part A non-covered days and the Medicare Part C patient days in the Medicare DSH calculation. The abeyance in the courts allowed the separate appeals for the other DSH issues to play out, as they were the underlying dispute in the Providers challenge to the remand required in the data matching cases.

In addition, CMS did begin issuing new SSI percentages on its website for FY 2006-2012. These SSI percentages did include both Medicare Part A non-covered days and Medicare Part C patient days in the Medicare Part A/SSI fractions. Those new SSI percentages have been incorporated into open provider cost reports as well cost reports that had been previously finalized, but had reopening notices issued pending the litigation in the *Baystate* decision. New SSI percentages have not been issued for FY 2005 and prior due to the ongoing litigation referenced above.

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[12] Providers EJR request at 1.

Federal Litigation after the Issuance of CMS Ruling 1498R

The Federal courts have reviewed the treatment of Medicare Part C days in the DSH calculation in two cases.[13] In *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1 (D.C. Cir. 2011), the Court held that Congress has not unambiguously foreclosed the Secretary's interpretation that Medicare Part C enrollees are entitled to benefits under Part A, but also held that the Secretary's present interpretation may not be retroactively applied to periods prior to its 2004 rulemaking. More recently in *Allina Health Services v. Sebelius*, 746 F.3d (D.C. Cir. 2014), the Court concluded that the Secretary did not provide adequate notice and comment before promulgating the 2004 rule regarding inclusion of Medicare Part C days in the Medicare fraction of the DSH calculation and thus vacatur was an appropriate remedy.[14]

Denial of EJR Request

The Board notes that the Ruling applies to three issues in jurisdictionally proper pending appeals concerning the calculation of the Medicare DSH payment: 1) the "data matching process" used to calculate the SSI fraction; 2) certain "non-covered" Part A days for cost reporting periods with patient discharges before October 1, 2004; and 3) labor and delivery days for cost reporting periods beginning before October 1, 2009. Contrary to the EJR decisions rendered in appeals shortly after the Ruling was issued, much is now known about the remand process, as well as to the challenge of the treatment of the Medicare Part A non-covered days and Medicare Part C days in the DSH calculation.

The litigation referenced above related to CMS' inclusion of the Medicare Part C patient days in the Medicare Part A/SSI fractions is distinct litigation from the issues covered by the Ruling. The Board finds that although the Ruling may reference CMS' policy to include Part C days in the Medicare Part A/SSI fraction, the Ruling itself does not direct such days to be included in the Medicare fraction. The final determination regarding the treatment of Part C days will be determined by the outcome of the D.C. Circuit Court litigation. Therefore, when a provider's appeal of the data matching issue is remanded back to the contractor for inclusion of the new SSI percentage using the proper Baystate data matching process, the SSI percentage calculated by CMS should take into account all appropriate categories of days.

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[13] Two circuit courts, the D.C. Circuit Court and the Seventh Circuit, have also ruled on the dual eligible days issue finding that exclusion of dual eligible exhausted benefit days from the Medicaid fraction was permissible as such patients were "entitled to benefits under part A." *See Metropolitan Hospital v. DHHS*, 712 F.3d 248 (7th Cir. 2013) (*Metropolitan*) and *Catholic Health Initiatives v. Sebelius*, 718 F.3d 914 (D.C. Cir. 2013) (*CHI*). However, the rationale for this conclusion differed significantly. The 7th Circuit in *Metropolitan* concluded that the Secretary's treatment of dual eligible days was a reasonable interpretation of under step two of a *Chevron* analysis and therefore entitled to deference. *See Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984).The D.C. Circuit in *CHI* found that an earlier administrative decision in *Edgewater Medical Center* set forth the Secretary's policy to exclude Medicare exhausted days from the Medicaid fraction and the Secretary's policy was not unfair retroactive rule-making. *See Edgewater Medical Center v. Blue Cross Blue Shield Association*, HCFA Adm. Dec., 2000 WL 1146601 (June 19, 2000).

[14] Although the rule was promulgated in 2004, the Code of Federal Regulations was never actually amended, so in 2007 the Secretary issued a "technical correction" conforming the language of the C.F.R. to the 2004 rule.

The Board finds that the Providers' request for EJR does not address the issue appealed, the SSI "data matching process" issue, but instead seeks EJR over whether Medicare Part C days must be included in the numerator of the Medicaid fraction and excluded from the SSI fraction. These issues are not the subject of the Providers' group appeal request.[15] The deadline for adding issues to an appeal has expired and issues may not be added to group appeals. As such, the Board denies the Providers' request for EJR. The Board finds that this appeal is subject to CMS Ruling 1498-R and is not questioning the validity of the Ruling removing Board jurisdiction in cases where Providers have filed a jurisdictionally valid appeal. Consequently, the Board concludes that this case is appropriate for remand under CMS Ruling 1498-R. A letter will be simultaneously issued with this decision remanding the case to the intermediary pursuant to the Ruling.

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For the Board:

Michael W. Harty
Chairman

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

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

[15] Both Providers in the group were directly added to the group so there were no other underlying individual appeal issues.