DEPARTMENT OF HEALTH AND HUMAN SERVICES
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CERTIFIED MAIL

DEC 01 2016

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James Lowe
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RE: Palomar Medical Center
Provider No.: 05-0115
FYE: 6/30/2010
PRRB Case No.: 14-1740

Dear Ms. Oliva and Mr. Lowe,

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

Background

The Provider submitted a request for hearing on January 15, 2014, based on a Notice of Program Reimbursement ("NPR") dated July 24, 2013. The hearing request included thirteen issues,[1] six of which were subsequently transferred to group appeals, four of which were withdrawn and three of which were resolved.[2] The Medicare Contractor filed a jurisdictional challenge on six issues in the appeal on April 27, 2015.[3] The Provider filed a responsive brief on May 26, 2015. The Provider only responded to issues 1B, 2B, 7, 8 and 9, as the Provider notes that Issue 6 has been transferred to a group appeal.

[1] The Provider's hearing request listed eleven issues; Issues No. 1 and 2 actually contained two issues each, bringing the total to thirteen.

[2] Issue No. 2A – Medicare Disproportionate Share Hospital (DSH) – Additional Medicaid Eligible Days, Issue No. 10 – Medicare Bad Debt Reimbursement – 2% Share of Cost Adjustment and Issue No. 11 – Medicare Bad Debt Reimbursement were resolved in a partial administrative resolution executed on March 21, 2016.

[3] The Medicare Contractor challenged Issue No. 1B – Outlier Payments, Issue No. 2B – Medicare Low Income Patients (LIP) Payments – Medicaid Eligible Days, Issue No. 6 - Medicare Disproportionate Share Hospital (DSH) Payments – SSI MMA Section 951 Applicable to SSI Ratio Issued March 16, 2012, Issue No. 7 – Medicare Low Income Patients (LIP) Payment - Inclusion of Medicare Dual Eligible Part A Days in the SSI Ratio Issued March 16, 2012, Issue No. 8 - Medicare Low Income Patients (LIP) Payments – Inclusion of Medicare Dual Eligible Part C Days in the SSI Ratio Issued March 16, 2012, and Issue No. 9 - Medicare Low Income Patients (LIP) Payments – Accuracy of CMS Developed SSI Ratio Issued March 16, 2012. The Provider withdrew Issue No. 2B, Issue No. 7, and Issue No. 8 via a letter dated November 10, 2016 so the challenges to those issues will not be addressed herein. The Provider requested to transfer Issue No. 1B to PRRB Case No. 16-1066GC on February 22, 2016, Issue No. 6 to PRRB Case No. 15-0594GC on December 16, 2014, and Issue No. 9 to PRRB Case No. 17-0387G on November 10, 2016.

Medicare Contractor's Position

Issue No. 1B – Outlier Payments

The Medicare Contractor explains that the Provider disputes the Outlier Payments because they did not result in an aggregate national outlier payment of at least five percent of the total Prospective Payment System ("PPS") payment.

The issue has been described as whether the Centers for Medicare and Medicaid Services ("CMS") underpaid the Provider the required five percent outlier payments by establishing higher the necessary fixed loss thresholds used to calculate the number of cases that qualify for and the amount of outlier payments.[4] The Medicare Contractor also contends that it did not make an adjustment to remove this outlier amount in controversy. The Provider did not preserve its right to claim dissatisfaction as it did not include a claim for the outlier reimbursement now in question.

The Medicare Contractor also maintains that the Provider failed to include the reimbursement impact of the contested Outlier Payments as a protested amount on its filed cost report. Therefore, it did not make an adjustment to the contested Outlier Payment on the final cost report and it has no made a final determination with respect to the Provider for the issue appealed.[5]

The Medicare Contractor asserts that in accordance with 42 C.F.R. § 405.1835(a)(1), the Board does not have jurisdiction over the contested Outlier Payment issue for this cost report and therefore requests that this issue be dismissed.

Issue No. 6 – Medicare Disproportionate Share Hospital (DSH) Payments – SSI MMA Section 951 Applicable to SSI Ratio Issued March 16, 2012

The Medicare Contractor argues that the Provider has not met the jurisdictional requirement that the Provider is dissatisfied with the Medicare Contractor's final determination of the total reimbursement due to the Provider. In the instant case, the Medicare Contractor "did not and cannot make a determination in terms of whether CMS failed to comply with Section 951 of the MMA by failing to release the supporting data to hospitals upon request."[6] Since there is not a Medicare Contractor determination for the Provider to contest, the Board does not have jurisdiction over this issue pursuant to 42 C.F.R. § 405.1803.

The Medicare Contractor requests that the Board dismiss the issue from this appeal because whether CMS complied with Section 951 is not an appealable issue as it is not a Medicare Contractor determination.

Issue No. 9 – Medicare Low Income Patients (LIP) Payments – Accuracy of CMS Developed SSI Ratio Issued March 16, 2012

The Medicare Contractor explains that the IRF LIP issue is being challenged on the basis that IRF LIP is

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[4] Medicare Contractor's jurisdictional challenge at 2.
[5] *Id.* at 4.
[6] *Id.* at 8.

not an appealable issue. The Medicare Contractor argues that the language of Section 1886(j)(8)(B) of the Medicare Act specifically precludes administrative and judicial review of the IRF LIP adjustment, and thereby divests the Board of jurisdiction to hear the Provider's appeal of these issues.[7] Therefore, the Medicare Contractor requests that the Board dismiss the issues from the appeal that specifically pertain to the IRF LIP adjustment for lack of subject matter jurisdiction.

Provider's Position

Issue No. 1B – Outlier Payments

The Provider contends that the Medicare Contractor posted adjustment to the Provider's items of cost claimed in the as-filed cost report which satisfy the criteria of dissatisfaction at 42 U.S.C. § 1395oo(a) and 42 C.F.R. § 405.1835(a). The Provider states that the Medicare Contractor made an audit adjustment that revised the as-filed Medicare Outlier Payments from $1,542,267 to $1,589,821 per audit adjustment number 34, therefore, the Provider is afforded a right to appeal the Outlier Payments based on this audit adjustment.

The Provider also maintains that the Medicare Contractor cited 42 C.F.R. § 412.110 as the Medicare regulations to support their audit adjustments. As set forth in 42 C.F.R. § 412.110, Medicare's total payment for inpatient hospital services will equal the sum of the payments listed in § 412.112 through § 412.115. The total payments in § 412.112 include a provision that appropriate Outlier Payment amounts must be determined under subpart F - § 412.80, § 412.82, § 412.84 and § 412.86. These cited Medicare regulations outline the methods in establishing the outlier thresholds. The Provider contends that its appeal of the Outlier Payments is in accordance with these Medicare regulations in order to account for the proper calculation of the outlier threshold.

Issue No. 6 – Medicare Disproportionate Share Hospital (DSH) Payments – SSI MMA Section 951 Applicable to SSI Ratio Issued March 16, 2012

The Provider in its issue statement contends that CMS failed to comply with Section 951 of the MMA for multiple reasons. Including, that CMS has failed to release the supporting data to hospitals upon request and the data and the understatement of the DSH payments is due to the Medicare Contractor/CMS failing to cohere to the requirements of Section 951 of the MMA, which requires CMS to provide access to "the data necessary" for hospitals to compute the number of patient days used in computing the disproportionate patient percentage.[8]

However, the Provider in its Jurisdictional Challenge Response explains that as indicated and documented, Issue No. 6 – DSH SSI Section 951 of MMA has been transferred from the individual appeal to a group appeal case number 15-0594GC. The Provider contends that this issue no longer remains in this individual appeal and consequently, will not respond to the Medicare Contractor's jurisdictional challenge on the issue.[9]

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[7] *Id.* at 5.
[8] Provider's jurisdictional response at Exhibit 5, Listing of Issues Filed under Protest No. 3.
[9] *Id.* at 1; *See also,* Exhibit 2.

Issue No. 9 – Medicare Low Income Patients (LIP) Payments – Accuracy of CMS Developed SSI Ratio Issued March 16, 2012

The Provider contends that the Medicare Contractor made an adjustment that revised the IRF LIP SSI ration from .0433 to .0381 per audit adjustment 54.[10] Additionally, the Medicare Contractor made an adjustment to remove the as-filed IRF protested amount totaling $48,800 per audit adjustment 49, which includes protest amounts for LIP issues.[11] The Provider also argues that there is no specific language within Section 1886(j)(8) of the Medicare Act prohibiting administrative or judicial review as it pertains to the establishment of LIP. The Provider explains that it is not challenging the establishment of LIP but is it were, then it is clear that LIP is not specifically precluded from administrative and judicial review under this section of the Medicare Act.

Board's Decision

Issue No. 1B – Outlier Payments

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2010), 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 jurisdictional issue presented here is whether or not this hospital has preserved its right to claim dissatisfaction with the amount of Medicare payment. "A provider. . . has a right to a Board hearing . . . only if – (1) the provider has preserved its right to claim dissatisfaction...by...[i]ncluding a claim for specific item(s) on its cost report...or...self-disallowing the specific item(s) by...filing a cost report under protest..."[12]

The Board concludes that it does not have jurisdiction over the Outlier Payments issue because the appeal does not comply with the requirements of 42 C.F.R. § 405.1835(a)(1)(i) (2013) or 42 C.F.R. § 405.1835(a)(1)(ii) (2013).

Effective with cost report periods that end on or after December 31, 2008, CMS amended the regulations governing cost report appeals to incorporate Provider Reimbursement Manual (PRM) 15-2 § 115 *et seq.* into the regulations at 42 C.F.R. §405.1835(a)(1)(ii) (2013) by specifying that, where a provider seeks payments that it believes may not be allowable or may not be in accordance with Medicare policy, the provider must claim the items as self-disallowed costs "by following the applicable procedures for filing a cost report under protest." Here, the Provider's cost report was for FYE June 30, 2010; therefore, any self-disallowed items are required to be protested.

No such self-disallowed costs exists on the Provider's cost report. In considering jurisdiction over the Outlier Payments issues, the Board acknowledges the recent United States District Court for the District of Columbia in *Banner Heart Hosp. v. Burwell* (D.D.C. August 19, 2016). The Court in *Banner* did not invalidate 42 C.F.R. § 405.1835(a)(1)(ii) and the Secretary has not taken action to remove the regulation from the Code of Federal Regulations. Therefore, the Board is still bound by 42 C.F.R. §

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[10] *Id.* at 4.
[11] *Id.*
[12] 42 C.F.R. § 405.1835(a).

405.1835(a)(1)(ii) and its requirement that a self-disallowed cost be filed under protest. Therefore the Board concludes that the Provider has not satisfied the requirement for dissatisfaction and dismisses the issue from the appeal and denies the transfer of the Outlier Payments issue in this appeal to Group Appeal 16-1066GC.

Issue 6 – Medicare DSH – SSI MMA Section 951

The Board concludes that it has jurisdiction over the Medicare DSH – SSI MMA Section 951 issue and grants the transfer of this issue to the group appeal case number 15-0594GC.

Section 951 of the Medicare Modernization Act instructs the Secretary of Health and Human Services to provide the data CMS used in calculating SSI ratios. Section 951 provides in relevant part, "[T]he Secretary shall arrange to furnish…the data necessary for such hospitals to compute the number of patient days used in computing the disproportionate patient percentage under such section for that hospital for the current cost reporting year." The Board has previously determined that the DSH MMA Section 951 and DSH SSI Ratio Systemic Errors/*Baystate* issues are separate legal issues. Furthermore, the Provider included the MMA Section 951 issue as a protested item, as required by the regulation at 42 C.F.R. § 405.1835(a)(1)(ii) for cost reporting periods ending on or after 12/31/2008.

Issue No. 9 – Medicare Low Income Patients (LIP) Payments – Accuracy of CMS Developed SSI Ratio Issued March 16, 2012

In the instant case, the Board finds that the Provider filed its request for hearing timely, met the amount in controversy requirement and met the dissatisfaction requirement. The Board also finds that there is evidence in the record that the Provider included a protested amount on its as filed cost report related to the LIP issue in the appeal. As such, the Board should find that it does have jurisdiction over the LIP issue pursuant to § 405.1835(a)(ii) as it was properly protested.

In reviewing the Medicare Contractor's allegations that 42 U.S.C. § 1395ww(j)(8)(B) unambiguously precludes administrative and judicial review of the IRF-PPS rates, the Board first looked to the statutory provision prohibiting certain judicial and administrative review. 42 U.S.C. § 1395ww(j)(8) specifies:

> There shall be no administrative or judicial review . . . of the *establishment* of—
>
> (A) case mix groups, of the methodology for the classification of patients within such groups, and the appropriate weighting factors thereof under paragraph (2),
>
> (B) The prospective payment rates under paragraph (3),
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> (C) Outlier and special payments under paragraph (4), and
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> (D) Area wage adjustments under paragraph (6).[13]

[13] Emphasis added.

The United States District Court for the District of Columbia in *Mercy Hosp., Inc. v. Burwell ("Mercy")*, No. 15-1236 (JDB), 2016 WL 4007072, at *8 (D.D.C. July 25, 2016), recently concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's interpretation of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates. The Board in *Mercy* had previously held that it had jurisdiction to review the Medicare Contractor's determination of the LIP adjustment.[14] The Administrator of CMS vacated the Board's decision concluding that the Board had lacked authority to hear the hospital's appeal in light of 42 U.S.C. § 1395ww(j)(8).[15] *Mercy* appealed to the United States District Court for the District of Columbia who affirmed the Administrator's decision.

The Board notes the text of § 1395ww(j)(8) prohibits administrative or judicial review of "*the establishment* of" the items listed in Subparagraphs (A) to (D). The Board finds the use of the word "establishment" in the statute significant.[16] Palomar Medical Center is not challenging "the *establishment* of" either the federal rates or "the *establishment* of" the LIP adjustment to those rates, since this appeal challenges no part of the August 2001 Final Rule in which the Secretary established the LIP adjustment itself (*i.e.*, the formula used to calculate the adjustment). Rather, Palomar Medical Center is challenging whether the Medicare Contractor properly executed the LIP adjustment, specifically whether the Medicare Contractor's calculation of the LIP adjustment used the proper provider-specific data elements in that calculation.[17] The Board finds no prohibition in 1395ww(j)(8) to administrative or judicial review of *"the calculation of"* the LIP adjustment where the focus is on the accuracy of the provider-specific data elements being used in the LIP adjustment calculation.

In this case, the Provider's dispute of *LIP - Accuracy of CMS Developed SSI Ratio,* relates to the specific scenarios cited by the United States District Court for the District of Columbia in *Mercy* when responding to *Mercy's* argument that if the limitation on review were as broad as the Secretary urges, then there would be nothing for inpatient rehabilitation providers to challenge.[18] The court stated:

> [b]ut the Secretary's interpretation does not leave inpatient rehabilitation providers with nothing to appeal. Suppose that a contractor failed to account for a number of patients altogether, proposing reimbursement for 475 Medicare beneficiaries instead of the 600 Medicare beneficiaries that the provider believed it had treated. A challenge to the contractor's decision to exclude those 125 patients would ***not*** be a challenge to the prospective payment rates, and so would not be barred by paragraph (8)'s limitation on review. (Emphasis added).

Likewise, Palomar Medical Center is not challenging the establishment of the prospective payment rates for issue #9, but instead is challenging the accuracy of the Medicare Contractor's calculation of the provider-specific data elements being used in the LIP adjustment calculation. As articulated by the U.S.

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[14] *Mercy Hospital v. First Coast Service Options, Inc.*, PRRB Dec. No. 2015-D7, 2013 WL 10381780, at *1 (Apr. 3, 2015).
[15] *Mercy Hospital v. First Coast Service Options, Inc.*, Review of PRRB Dec. 2015-D7, 2015 WL 3760091, at *11 (June 1, 2015).
[16] 42 U.S.C. § 1395ww(j)(8).
[17] Provider's Response to Medicare Contractor's Jurisdictional Challenge at 4.
[18] *Mercy*, 2016 WL 4007072 at *7.

District Court, this is not a challenge to the prospective payment rates and as such would not be barred by paragraph (8)'s limitation on review.

The Board notes however, even in the absence of this exception articulated by the court which is applicable in the instant case, that it respectfully disagrees with the U.S. District Court for the District of Columbia's decision in *Mercy* which found that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the contractor's interpretation of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates. The Board has been clear on its decision in regards to this issue.[19] The Board continues to stand by its conclusion that it has jurisdiction to review the Medicare Contractor's determination of the LIP adjustment including the understatement of the LIP SSI ratio.

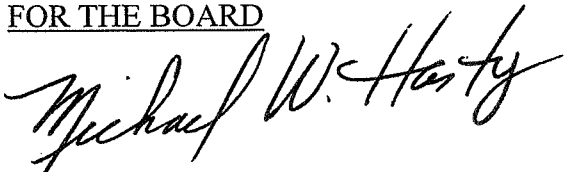
As noted above, the Administrator in *Mercy* and the U.S. District Court for the District of Columbia affirming the Administrator, reversed the Board's decision that it had jurisdiction over the LIP payment factors. The Administrator and the U.S. District Court restated the Medicare Contractor's assertion that administrative and judicial review of the LIP adjustment is precluded because § 1395ww(j)(8) precludes review of the prospective payment rate under paragraph (3) as well as *all* adjustments articulated in subsequent paragraphs. The Board, however, remains unconvinced, and continues to disagree with the Administrator and the U.S. District Court for the District of Columbia's overly broad interpretation.

Based on the above, the Board concludes that it has jurisdiction to hear the LIP SSI Ratio issue in this appeal. In the instant case, the Provider filed its request for hearing timely, met the amount in controversy requirement and met the dissatisfaction requirement. Palomar Medical Center is not challenging the establishment of the prospective payment rates but instead is challenging the accuracy of the Medicare Contractor's calculation of the provider-specific data elements being used in the LIP adjustment calculation. As such, the Board grants the Provider's request to transfer the issue to PRRB Case No. 17-0387G.

As no issues remain in the appeal, the Board hereby closes the case and removes it 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 Participating:
Michael W. Harty
L. Sue Anderson, Esq.
Charlotte F. Benson, CPA
Jack Ahern, M.B.A.

FOR THE BOARD



Michael W. Harty
Chairman

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

[19] See the Board's decision in *Mercy*; See also, the Board's latest decision in *St. Joseph Hospital of Eureka v. Noridian Healthcare Solutions*, PRRB Dec. No. 2016-D4, 2016 WL 10371515 (December 2, 2015).

cc: Federal Specialized Services
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RE: Queen of the Valley Medical Center
Provider No.: 05-0009
FYE: 6/30/2010
PRRB Case No.: 14-1789

Dear Ms. Giberti and Mr. Lowe,

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

Background

The Provider submitted a request for hearing on January 16, 2014, based on a Notice of Program Reimbursement ("NPR") dated July 14, 2013. The hearing request included eleven issues,[1] six of which were subsequently transferred to group appeals, four of which were withdrawn and one of which was resolved. The Medicare Contractor filed a jurisdictional challenge on four issues in the appeal on May 5, 2015.[2] The Provider filed a responsive brief on May 12, 2015.

Medicare Contractor's Position

Issue No. 10B – Medicare Settlement Data - Outlier Payments

The Medicare Contractor contends that the Provider has not established dissatisfaction with the Outlier Payments issue under 42 C.F.R. § 405.1867(a)(1), thereby divesting the Board of jurisdiction to hear an appeal on the issue. The Medicare Contractor also notes that there was no final determination regarding

[1] The Provider's hearing request listed ten issues; Issue No. 10 actually contained two issues, bringing the total to eleven.

[2] The Medicare Contractor challenged Issue No. 4 - Medicare Rehab Low Income Patient (LIP) Payments – Inclusion of Medicare Dual Eligible Part A Unpaid Days in the SSI Ratio Issued March 16, 2012, Issue No. 6 - Medicare Rehab Low Income Patient (LIP) Payments – Inclusion of Medicare Dual Eligible Part C Days in the SSI Ratio Issued March 16, 2012, Issue No. 8 - Medicare Rehab Low Income Patient (LIP) Payments – Accuracy of CMS Developed SSI Ratio Issued March 16, 2012, and Issue No. 10B – Medicare Settlement Data – Outlier Payments. The Provider withdrew Issue No. 6 and Issue No. 8 via a letter dated November 3, 2016 so the challenges to those issues will not be addressed herein. The Provider requested to transfer Issue No. 4 to PRRB Case No. 15-1837GC on March 16, 2015 and Issue No. 10B to PRRB Case No. 14-1783GC on September 24, 2014.

Outlier Payments in the Provider's cost report and that the Provider failed to preserve its right to appeal the issue by self-disallowing the item under protest.

Issue No. 4 - Medicare Rehab Low Income Patient (LIP) Payments – Inclusion of Medicare Dual Eligible Part A Unpaid Days in the SSI Ratio Issued March 16, 2012

The Medicare Contractor contends that the LIP adjustment to the Inpatient Rehabilitation Facility ("IRF") prospective payment rate is not an appealable issue. The Medicare Contractor also asserts that the Board lack subject matter jurisdiction because administrative and judicial review of the IRF-PPS, and all adjustments to it are expressly precluded under Section 1886(j)(8)(B) of the Medicare Act. The Medicare Contractor also maintains that the LIP adjustment is an administratively determined adjustment to the IRF-PPS under Section 1886(j)(3)(A)(v) of the Medicare Act. As such, the LIP adjustment, as a component of the IRF-PPS, is also shielded by the statutory prohibition on review.[3] The Medicare Contractor concludes that pursuant to 42 C.F.R. § 405.1867, the Board must comply with all provisions of the Medicare Act, as well as the regulations that are established under it.

Provider's Position

Issue No. 10B – Medicare Settlement Data - Outlier Payments

The Provider does not address the Outlier Payments issue in its jurisdictional brief, stating that the Medicare Contractor should file a jurisdictional challenge with the group appeal.[4]

Issue No. 4 - Medicare Rehab Low Income Patient (LIP) Payments – Inclusion of Medicare Dual Eligible Part A Unpaid Days in the SSI Ratio Issued March 16, 2012

The Provider contends that it has proper appeal, which was timely filed and meets the criteria for claiming dissatisfaction pursuant to 42 C.F.R. § 405.1835(a). The Provider asserts its disagreement with the Medicare Contractor's interpretation of Section 1886(j)(8)(B) of the Medicare Act for the following reasons: the LIP is not expressly mentioned as a component of the IRF-PPS in the statute and review of the LIP is not expressly restricted by the statute; the LIP is calculated with current cost reporting data and is reported on a separate line in the Medicare cost report as an add-on payment to the IRF-PPS; and Section 1886(j)(8) of the Medicare Act restricts review only "of the establishment of" prospective payment rates, whereas the Provider only seeks review of the accuracy of the LIP in its use.[5]

Board's Decision

Issue No. 10B – Medicare Settlement Data - Outlier Payments

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2010), 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 jurisdictional issue presented here is whether or not this hospital

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[3] Medicare Contractor's Jurisdictional Briefs at 2-3.
[4] Provider's Jurisdictional Brief at 2.
[5] *Id.* at 6-8.

has preserved its right to claim dissatisfaction with the amount of Medicare payment. "A provider. . . has a right to a Board hearing . . . only if – (1) the provider has preserved its right to claim dissatisfaction...by...[i]ncluding a claim for specific item(s) on its cost report...or...self-disallowing the specific item(s) by...filing a cost report under protest..."[6]

The Board concludes that it does not have jurisdiction over the Outlier Payments issue because the appeal does not comply with the requirements of 42 C.F.R. § 405.1835(a)(1)(i) (2013) or 42 C.F.R. § 405.1835(a)(1)(ii) (2013).

Effective with cost report periods that end on or after December 31, 2008, CMS amended the regulations governing cost report appeals to incorporate Provider Reimbursement Manual (PRM) 15-2 § 115 *et seq.* into the regulations at 42 C.F.R. §405.1835(a)(1)(ii) (2013) by specifying that, where a provider seeks payments that it believes may not be allowable or may not be in accordance with Medicare policy, the provider must claim the items as self-disallowed costs "by following the applicable procedures for filing a cost report under protest." Here, the Provider's cost report was for FYE June 30, 2010; therefore, any self-disallowed items are required to be protested.

No such self-disallowed costs exists on the Provider's cost report. In considering jurisdiction over the Outlier Payments issues, the Board acknowledges the recent United States District Court for the District of Columbia in *Banner Heart Hosp. v. Burwell* (D.D.C. August 19, 2016). The Court in *Banner* did not invalidate 42 C.F.R. § 405.1835(a)(1)(ii) and the Secretary has not taken action to remove the regulation from the Code of Federal Regulations. Therefore, the Board is still bound by 42 C.F.R. § 405.1835(a)(1)(ii) and its requirement that a self-disallowed cost be filed under protest. Therefore the Board concludes that the Provider has not satisfied the requirement for dissatisfaction and dismisses the issue from the appeal and denies the transfer of the Outlier Payments issue in this appeal to Group Appeal 14-4378GC.

Issue No. 4 - Medicare Rehab Low Income Patient (LIP) Payments – Inclusion of Medicare Dual Eligible Part A Unpaid Days in the SSI Ratio Issued March 16, 2012

In reviewing this matter, the Board first looked to the statutory provision prohibiting certain judicial and administrative review. 42 U.S.C. § 1395ww(j)(8) specifies:

> There shall be no administrative or judicial review . . . of the *establishment* of—
>
> (A) case mix groups, of the methodology for the classification of patients within such groups, and the appropriate weighting factors thereof under paragraph (2),
>
> (B) the prospective payment rates under paragraph (3),
>
> (C) outlier and special payments under paragraph (4), and

[6] 42 C.F.R. § 405.1835(a).

(D) area wage adjustments under paragraph (6).[7]

The United States District Court for the District of Columbia in *Mercy Hosp., Inc. v. Burwell ("Mercy")*, No. 15-1236 (JDB), 2016 WL 4007072, at *8 (D.D.C. July 25, 2016), recently concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's interpretation of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates. The Board in *Mercy* had previously held that it had jurisdiction to review the Medicare Contractor's determination of the LIP adjustment.[8] The Administrator of CMS vacated the Board's decision concluding that the Board had lacked authority to hear the hospital's appeal in light of 42 U.S.C. § 1395ww(j)(8).[9] *Mercy* appealed to the United States District Court for the District of Columbia who affirmed the Administrator's decision.

The Board notes the text of § 1395ww(j)(8) prohibits administrative or judicial review of "*the establishment* of" the items listed in Subparagraphs (A) to (D). The Board finds the use of the word "establishment" in the statute significant.[10] Queen of the Valley Medical Center is not challenging "the *establishment* of" either the federal rates or "the *establishment* of" the LIP adjustment to those rates, since this appeal challenges no part of the August 2001 Final Rule in which the Secretary established the LIP adjustment itself (*i.e.*, the formula used to calculate the adjustment). Rather, Queen of the Valley Medical Center is challenging whether the Medicare Contractor properly executed the LIP adjustment, specifically whether the Medicare Contractor's calculation of the LIP adjustment used the proper provider-specific data elements in that calculation.[11] The Board finds no prohibition in 1395ww(j)(8) to administrative or judicial review of *"the calculation of"* the LIP adjustment where the focus is on the accuracy of the provider-specific data elements being used in the LIP adjustment calculation.

The LIP issue in this case is similar to the issue raised in *Mercy*, as the Provider is challenging that an entire category of days is missing from the LIP SSI Ratio due to CMS' matching policy. The Board notes however, that it respectfully disagrees with the U.S. District Court for the District of Columbia's decision in *Mercy* which found that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the contractor's interpretation of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates. The Board has been clear on its decision in regards to this issue.[12] The Board continues to stand by its conclusion that it has jurisdiction to review the Medicare Contractor's determination of the LIP adjustment including the understatement of the LIP SSI ratio.

As noted above, the Administrator in *Mercy* and the U.S. District Court for the District of Columbia affirming the Administrator, reversed the Board's decision that it had jurisdiction over the LIP payment factors. The Administrator and the U.S. District Court restated the Medicare Contractor's assertion that administrative and judicial review of the LIP adjustment is precluded because § 1395ww(j)(8) precludes review of the prospective payment rate under paragraph (3) as well as *all* adjustments articulated in

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[7] (emphasis added)
[8] *Mercy Hospital v. First Coast Service Options, Inc.*, PRRB Dec. No. 2015-D7, 2013 WL 10381780, at *1 (Apr. 3, 2015).
[9] *Mercy Hospital v. First Coast Service Options, Inc.*, Review of PRRB Dec. 2015-D7, 2015 WL 3760091, at *11 (June 1, 2015).
[10] 42 U.S.C. § 1395ww(j)(8).
[11] Provider's Response to Medicare Contractor's Jurisdictional Challenge at 4.
[12] See the Board's decision in *Mercy*; See also, the Board's latest decision in *St. Joseph Hospital of Eureka v. Noridian Healthcare Solutions*, PRRB Dec. No. 2016-D4, 2016 WL 10371515 (December 2, 2015).

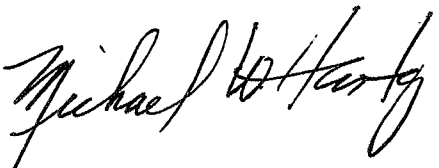
subsequent paragraphs. The Board, however, remains unconvinced, and continues to disagree with the Administrator and the U.S. District Court for the District of Columbia's overly broad interpretation.

Based on the above, the Board concludes that it has jurisdiction to hear the Medicare Rehab Low Income Patient (LIP) Payments – Dual Eligible Unpaid Part A Days in the SSI Ratio Issued March 16, 2015 issue in this appeal. In the instant case, the Provider filed its request for hearing timely, met the amount in controversy requirement and met the dissatisfaction requirement. Queen of the Valley Medical Center is not challenging the establishment of the prospective payment rates but instead is challenging the accuracy of the Medicare Contractor's calculation of the provider-specific data elements being used in the LIP adjustment calculation. As such, the Board approves the Provider's request to transfer the issue to PRRB Case No. 15-1837GC.

As no issues remain in the appeal, the Board hereby closes the case and removes it 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
Clayton J. Nix, Esq.
L. Sue Anderson, Esq.
Charlotte F. Benson, CPA
Jack Ahern, M.B.A.

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: Federal Specialized Services
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Refer to: 17-0304GC, 17-0312GC

DEC 02 2016

Certified Mail

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RE: Whittier Rehabilitation 2007 Unlawful Assessment of Interest Group
Whittier Rehabilitation 2008 Unlawful Assessment of Interest Group
Provider Nos. Various
FYEs 9/30/2007, 5/16/2008, 9/30/2008
PRRB Case Nos. 17-0304GC and 17-0312GC

Dear Ms. Gardner:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' November 3, 2016 requests for hearing and expedited judicial review (EJR) (received November 4, 2016) in the above referenced appeals. The decision of the Board is set forth below.

Issue under Dispute

> Whether the LTCH [Long Term Care Hospital] retrospective outlier reconciliation process established under the outlier payment regulations, 42 C.F.R. §§ 412.525, 412.529, is invalid because it is inconsistent with the Medicare statute in its assessment of the time value of money?[1]

The regulations cited above, deal with the use of the time value of money in conjunction with underpayment or overpayments in the reconciliation of outlier payments in LTCHs. With respect to 42 C.F.R. § 412.525(a)(4)(E), which deals with high-cost outlier payments in LTCHs, the regulations states:

> At the time of any reconciliation under paragraph (a)(4)(iv)(D) of this section, outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Any adjustment is based upon a widely available index to be established in advance by the Secretary, and is applied from the midpoint of the cost reporting period to the date of reconciliation.

[1] Providers' November 3, 2016 EJR Request at 5.

Similarly, with respect to 42 C.F.R. § 412.529(f)(3)(v), which deals with short-stay outlier payments in LTCHs, the regulation states:

> At the time of any reconciliation under paragraph (f)(4)(iv) of this section, outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Any adjustment is based upon a widely available index to be established in advance by the Secretary, and is applied from the midpoint of the cost reporting period to the date of reconciliation.

Background

Issuance of the IPPS and LTCH Outlier Payment Regulations

On March 5, 2003, the Secretary published proposed changes to the methodology for determining outlier payments for inpatient prospective payment system (IPPS) hospitals in the Federal Register.[2] Shortly thereafter, on March 7, 2003, the Secretary published similar changes to the methodology for determining payments for high-cost and short-stay outliers in LTCHs.[3] The rationale for making the changes was the same and all revisions included the time value of underpayments and overpayment adjustments. These proposed changes for both hospitals and LTCH hospitals were finalized in the June 9, 2003 Federal Register.[4] The changes in the payment methodology for both systems were made to correct situations in which rapid increases in charges by certain hospitals maximize their outlier payments.[5]

Hospitals are paid for services to Medicare patients through the PPS[6] under which inpatient operating costs are reimbursed based on a prospectively determined formula. The PPS legislation contains a number of provisions that provide for additional payment based on specific factors. These cases involve one of those factors: outlier payments. Outlier payments are made for patients whose hospitalization is either extraordinarily costly or lengthy.[7] Outlier payments are made from the "outlier pool," which is a regulatory set-aside or subset of the Medicare Part A Trust Fund, maintained by the government to pay for outlier cases. LTCH outlier threshold is set before the applicable rate update year so that total outlier payments are projected to equal 8 percent of total payments under the LTCH PPS.[8]

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[2] 68 Fed. Reg. 10,420 (Mar. 5, 2003).
[3] 69 Fed. Reg. 11,234 (Mar. 7, 2003).
[4] 68 Fed. Reg.34,494 (June 9, 2003).
[5] *Id.* at 34,496.
[6] *See* U.S.C. 42 § 1395ww(m) (prospective payment for LTCHs).
[7] Providers' November 3, 2016 Hearing Request, Tab 2 at 2.
[8] 68 Fed. Reg. at 34,506.

Outlier cases must have costs above a fixed threshold amount.[9] Hospital-specific "cost-to-charge ratios" (CCRs)[10] are then applied to the covered charges for a case to determine whether the costs exceeded the fixed outlier threshold.[11] The Medicare program pays a percentage of the costs above the threshold for eligible cases.[12]

Prior to 2003, the CCR used to adjust covered charges to costs was determined using the most recent settled cost report for each hospital.[13] In response to perceived abuses, the Secretary issued an additional regulatory provision providing that, for discharges occurring on or after October 1, 2003, the CCR would be determined either based on the most recent settled cost report or based on the most recently tentative settled cost report, whichever is later (herein after called "the 2003 Final Rule").[14] The 2003 Final Rule stated that outlier payments would be subject to adjustment when a provider's cost report is settled.[15] Under this new regulatory provision, outlier payments would be based on the relationship between the provider's contemporaneous costs and charges and this would ensure that when final outlier payments were made, they would reflect an accurate assessment of the actual costs that the provider incurred.

In December of 2010, through internal transmittals, the Centers for Medicare & Medicaid Services (CMS) issued instructions adopting criteria for MACs to identify which providers would be subject to outlier reconciliation through the Medicare Claims Processing Manual[16] (the 2010 standards).[17] The Providers explain that CMS directed its Medicare contractors to conduct outlier reconciliations for providers which received more than $500,000 in outlier payments where the actual contemporaneous CCRs were plus or minus 10 percentage points from the CCR used to make the outlier payment.[18] The Providers note that the 2010 standards were promulgated by CMS for publication in agency memoranda and manuals, without advance notice or comment and without publication in the Federal Register.[19]

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[9] 42 U.S.C. § 1395ww(d)(5)(A)(ii)-(iii).

[10] *See* 68 Fed. Reg. 34,394, 34,495-6 (June 9, 2003) (Cost-to-charge ratios are determined using the most recent settled cost report for each hospital. Medicare charges from all claims are accumulated through the Provider Statistical and Reimbursement Report (PS&R). The PS&R contains data such as the number of discharges and the actual charges from each hospital. The hospital also submits a cost report to its fiscal intermediary, which is used to determine total allowable inpatient Medicare costs. Once all these data are available, the fiscal intermediary [now MAC] then determines the cost-to-charge ratio for the hospital by using charges from the PS&R and costs from the cost report.)

[11] *Id. at 34,495.*

[12] 42 U.S.C. § 1395ww(m)(1), referring to § 1395ww(d)(1)(B)(iv).

[13] 68 Fed. Reg. at 34,497.

[14] *Id.* at 34,507-6. Codified at 42 C.F.R. § 412.525(a)(4)(i) (LTCH outliers) and § 412.529(c)(4)(ii) (short stay outliers).

[15] *Id.*

[16] CMS Pub. 100-04, Change Request 7192 (Dec. 3, 2010).

[17] Providers' November 3, 2016 Hearing Request at 2.

[18] *Id.* citing to CMS Pub. 100-04, Change Request 7192.

[19] *Id.*

The Providers point out that in *Clarion Health West, LLC v. Burwell*[20] the D.C. District Court held that the 2010 manual provisions that were used to identify the provider as a candidate for the outlier payment reconciliation process need to be subject to notice and comment. The Court considered the qualifying criteria a substantive, rather than interpretative, rule.

The Providers contend that, although *Clarion* involved a dispute over IPPS policies and criteria for determining PPS outlier payments, the same dispute is presented here for LTCHs. The standards for reviewing LTCH outlier payments were also promulgated under the 2010 standards which were not subject to notice and comment. The Providers believe the criteria for initiating the reconciliation found invalid in *Clarian* is materially indistinguishable from the Providers in this case.[21] In these cases, the MAC retroactively adjusted the Providers' outlier payments and calculated the time value of money. The Providers claim $174,793 (2007) and $260,983 (2008) was recouped from Whittier-Bradford and $133,987 (2007) and $316,197 (2008) was recouped from Whittier-Westborough, as the amount that constituted the time value of money.[22]

The Providers noted that during the rulemaking for the 2003 Final Rule, CMS claimed that the adjustment for the time value of money was consistent with the statutory requirements that "outlier payments approximate the marginal cost of care beyond the threshold."[23] They believe that the marginal cost of care for an outlier case does not change from the time the outlier case is treated to the time payment for that case is determined. And, in any event, the outlier payment formula is, itself, designed to approximate the marginal cost of care beyond the threshold; assessing the interest merely compensates the government or the provider for the delay in the underpayment or overpayment. CMS has failed to provide a reasoned explanation for its decision to depart from the statutory and regulatory requirement that interest be assessed upon final determination; thus the assessment of interest for the outlier adjustment is unlawful.[24]

Providers' Request for EJR

The Providers believe the Board can grant EJR because the issue presented, the question whether the LTCH reconciliation process established under 42 C.F.R. §§ 412.525 and 412.529is valid, is inconsistent with the Medicare statute in its assessment of the time value of money, and is not within the authority of the Board to resolve.[25] The Providers argue that CMS has failed to provide a reasoned explanation for its decision to depart from the statutory and regulatory requirement that interest be assessed upon the issuance of a final determination; thus assessment of interest for the outlier adjustment is unlawful.[26]

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[20] 2016 WL 4506969 (D.D.C. Aug. 8, 2016).
[21] Providers' Hearing Request at 3.
[22] *Id.* at 4.
[23] *Id.* quoting 68 Fed. Reg. at 34,504.
[24] *Id.*
[25] Providers' November 2, 2015 EJR request at 5.
[26] *Id.* at 4.

The Providers contend that the assessment of the time value of any underpayments or overpayments from the midpoint of the cost reporting period to the date of the conciliation of the cost report, is contrary to the Medicare statute and regulations. Rather, they assert the Medicare statute and regulations state that interest on overpayments and underpayments will be calculated from the date of the final determination of the cost report settlement.[27]

During the rulemaking for the 2003 Final Rule, CMS claimed that the adjustment for the time value of money was consistent with the statutory requirement that outlier payments approximate the marginal cost of care beyond the outlier threshold.[28] However, the Providers believe the marginal cost of care for an outlier case does not change from the time the outlier case is treated to the time payment for that case is determined. And, in any event, the outlier payment formula itself is designed to approximate the marginal cost of care beyond the threshold; assessing the interest merely compensates the government or the provider for the delay in adjusting the overpayment or underpayment. The Providers assert that CMS has failed to provide a reasoned explanation for its decision to depart from the statutory and regulatory requirement that interest be assessed upon the issuance of a final determination. Consequently, they assert the assessment of interest for outlier adjustments is unlawful.[29]

Decision of the Board

The Board has reviewed the submissions of the Providers pertaining to the requests for hearing and expedited judicial review. 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permit expedited judicial review where the Board determines that it does not have the authority to decide a question of law, regulation or CMS ruling. In these cases, the Providers are challenging the validity of the outlier regulations, 42 C.F.R. §§ 412.525 and 412.529, as they apply to the time value of money. The Medicare Contractor did not oppose the request for EJR. The documentation shows that in each case the estimated amount in controversy exceeds $50,000 threshold for Board jurisdiction over group appeals and the appeals were timely filed.

The Board finds that:

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

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[27] *See* 42 U.S.C. § 1395g(d) (Whenever a final determination is made [of an overpayment or underpayment] . . . interest shall accrue on the balance of such excess or deficit not paid or offset . . . at a rate determined in accordance with the regulations of the Secretary of the Treasury applicable to the charges for late payments); 42 C.F.R. §§ 305.368(b)(1)-(2) (CMS will charge interest . . . to providers and the interest accrues from the date of the final determination); § 405.378(c)(1)(i)(A)-(B) (defining a final determination as the date the NPR is issued and written demand for payment is made, or written determination of underpayment is made by the Medicare contractor after a cost report is filed).

[28] 68 Fed. Reg. at 34,504.

[29] Providers' EJR request at 4.

2) based upon the Providers' assertions regarding the outlier regulations, 42 C.F.R. §§ 412.525 and 412.529, there are no findings of fact for resolution by the Board;

3) it is bound by the regulations; and

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

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

Board Members Participating

Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Anderson, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

FOR THE BOARD:

Michael W. Harty
Chairman

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

cc: Pam VanArdale, NGS (Certified Mail w/ Schedules of Providers
Wilson Leong, FSS (w/Schedules of Providers)

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Refer to: 17-0487

CERTIFIED MAIL DEC 07 2016

Healthcare Reimbursement Services, Inc.
Corinna Goron
President
c/o Appeals Department
17101 Preston Road, Suite 220
Dallas, TX 75248-1372

RE: Pampa Regional Medical Center, Provider No. 45-0099, FYE 12/31/2013
PRRB Case No. 17-0487

Dear Ms. Goron:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeal. The pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

Healthcare Reimbursement Services, Inc. filed an individual appeal for Pampa Regional Medical Center on November 14, 2016. The appeal request did not include a copy of the final determination (the Notice of Program Reimbursement (NPR)). The Board established case number 17-0487 and issued an acknowledgement letter on November 21, 2016.

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 final determination.

42 C.F.R § 405.1835(b) specifically requires the Provider to include the final determination it is appealing with the timely request, and authorizes the Board to dismiss with prejudice any appeal that does not include a copy of the determination under appeal with its filing. In the referenced case, Pampa Regional Medical Center is filing an appeal that does not meet the regulatory requirements.

Board Rule 9 also addresses the acknowledgement of an appeal and issuance of critical due dates:

> The Board will send an acknowledgement via email indicating that the appeal request has been received and identifying the case number assigned. If the appeal request does not comply with the filing requirements, the Board may dismiss the appeal or take other remedial action. An acknowledgement does not limit the Board's authority to require more information or dismiss the appeal if it is later found to be jurisdictionally deficient.

Because the appeal request was not filed in conformance with 42 C.F.R § 405.1835 and the Board Rules, the Board hereby dismisses the individual appeal.

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

Board Members Participating:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, C.P.A.
Jack Ahern, MBA

For the Board:

Michael W. Harty
Chairman

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

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DEC 12 2016

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RE: Akin Gump 2016 PPS Rate Reduction Group Appeals
Provider Nos.: Various
FFY 2016
PRRB Case Nos.: See Attached List

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' November 21 and 29, 2016 requests for expedited judicial review (EJR) (received November 22 and 30, 2016, respectively) for the group appeals on the attached list. The decision of the Board with respect to this request is set forth below.

Issue

The Providers are seeking a correction of their Medicare payment rates per discharge for operating and capital related costs of inpatient services furnished during Federal fiscal year (FFY) 2016. In the final IPPS rule for FFY 2014, the Secretary effected a 0.2 percent reduction to the standardized amount[1] paid for operating costs under IPPS, the hospital-specific rates for some sole-community hospitals and Medicare-dependent hospitals,[2] and the Federal rate for

[1] The standardized amount is the sum of: (1) a labor component which represents labor cost variations among different areas of the country and (2) a non-labor component which represents a geographic calculation based on whether the hospital is located in a large urban or other area. The labor component is then adjusted by the wage index. *See* OFFICE OF INSPECTOR GENERAL, MEDICARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM: HOW DRG RATES ARE CALCULATED AND UPDATED (Aug. 2001), http://oig.hhs.gov/oei/reports/oei-09-00-00200.pdf.

[2] Although payments to most hospitals under IPPS are made on the basis of the standardized amounts, some categories of hospitals are paid in whole or in part based on their hospital-specific rate, which is determined from their costs in a base year. SCHs receive payment on the higher of the hospital-specific rate based on their updated costs in a base year (the highest of FY 1982, FY 1987, FY 1996, or FY 2006) or the IPPS Federal rate based on their standardized amount, whichever yields the greatest payment. MDHs received the higher of the Federal rate or the Federal rate plus 50 percent of the amount by which the Federal rate is exceeded by the higher of its FY 1982 or FY 1987 hospital-specific rate. For discharges occurring on or after October 1, 2007, but before October 1, 2013, a MDH would receive the higher of the Federal rate or the Federal rate plus 75 percent of the amount by which the Federal rate is exceeded by the highest of its FY 1982, FY 1987 or FY 2002 hospital-specific rate. *See* 78 Fed. Reg. 50,496, 50,509 and 50,987 (Aug. 19, 2013).

capital costs.[3,4] The Secretary . . . applied this reduction to the payment rates in connection with agency's[5] adoption of a change in coverage policy for inpatient hospital services known as the "2-midnight rule." In the final IPPS rule for FFY 2015, the Secretary did not reverse the 0.2 percent reduction to the standardized amount made in FFY 2014.[6] The Secretary continued to apply the contested reduction for the FFY 2016 period.[7]

The Providers are not contesting the coverage change here, but contend that even if the coverage rule is appropriate, the payment rate reduction should be set aside because it exceeds the Secretary's statutory authority under the prospective payment statute, 42 U.S.C. §§ 1395ww(d) and 1395ww(g), is contrary to the plain language and intent of the statute, procedurally invalid, and is arbitrary, capricious, not based upon substantial evidence, and otherwise contrary to the law.[8,9]

Statutory and Regulatory Background

In the final IPPS rule for FFY 2014, the Secretary of Health and Human Services (Secretary) indicated that she had expressed concern in the proposed calendar year (CY) Outpatient PPS (OPPS) rule[10] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving observation services. In recent years, the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours increased from approximately 3 percent in 2006 to 8 percent in 2011. This raised a concern about the financial impact on Medicare beneficiaries who may incur greater financial liability than they would if they were admitted to the hospital as inpatients.[11]

The Secretary noted that the trend towards the extended observation services may be attributable, in part, to hospitals' concerns about their ability to receive payment from Medicare under Part B when a Part A hospital inpatient claim is denied because the Medicare review contractor determined the inpatient admission was not reasonable and necessary under 42 U.S.C. § 1395y(a)(1)(A). CMS has been advised by stakeholders that the hospitals appear to be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays, that may later be denied upon contractor review, by electing to treat beneficiaries as

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[3] *See* 78 Fed. Reg. 50,496, 50,746, 50,952-54, 50,990 (Aug. 19, 2013).
[4] More specifically, *see* 78 Fed. Reg. at 50,949 (The Secretary believes "that *all* hospitals, LTCHs and CAHs, with the exception of IRFs, would appropriately be included in our final polices regarding the 2-midnight admission guidance and medical review criteria for determining the general appropriateness of inpatient admission and Part A payment" (emphasis added)).
[5] The "agency" is the Centers for Medicare & Medicaid Services (CMS).
[6] *See* 79 Fed. Reg. 49,854, 50,382-83 (Aug. 22, 2014).
[7] *See* 80 Fed. Reg. 49,326, 49,787-88 (Aug. 7, 2015); *see also Cape Cod Hosp. v. Sebelius,* 630 F.3d 203, 205 (D.C. Cir. 2011) (explaining that, except as otherwise adjusted in the final rule, the standardized amount is calculated by carrying forward the previous fiscal year's standardized amount).
[8] *See* 5 U.S.C. § 706.
[9] Providers' Hearing Requests, Tab 2.
[10] 77 Fed. Reg. 45,061, 45,155-57 (July 30, 2012) and the final rule with comment period, 77 Fed. Reg. 68,210, 68,426-33 (Nov. 15, 2012).
[11] 78 Fed. Reg. 50,496, 50,907 (Aug. 19, 2013).

outpatients receiving observation services for long periods of time, rather than admitting them as inpatients. These hospitals believe that Medicare's standards for inpatient admission were not clear.[12]

In response to this concern, the Secretary proposed clarifications and changes regarding hospital payment under both Part A and Part B. The Secretary proposed to revise the Medicare Part B inpatient payment policy to allow payment under Part B for all reasonable and necessary hospital services furnished if the beneficiary had been treated as a hospital outpatient, rather than admitted as an inpatient. This policy would apply when a Medicare Part A hospital inpatient claim was denied or when a hospital determines after a discharge that the inpatient visit was not reasonable and necessary. The timely filing restrictions for Part B billing were not changed (claims must be filed within one year from the date of service).[13]

Medicare Part A

In addition, the Secretary reviewed hospital inpatient status criteria to improve CMS' policies governing when a Medicare beneficiary should be admitted as an inpatient and how hospitals should be paid for associated costs. The Medicare Benefit Policy Manual[14] states that the typical decision to admit a beneficiary as an inpatient should be made within 24 to 48 hours after observation care and that an overnight stay may be a factor in the admission decision. Physicians should use the 24-hour or overnight period as a benchmark, i.e., patients who are expected to need care for 24 hours or overnight should be admitted. Generally, a beneficiary is considered an inpatient if formally admitted with the expectation that he or she will remain in the hospital overnight, regardless of whether there is a later transfer or discharge resulting in no overnight patient stay. Only rarely and in exceptional cases do reasonable and necessary observation services span more than 48 hours. Length of stay is not the sole basis for payment; it is the physician responsible for patient care who determines if the patient should be admitted.[15]

In the FFY 2014 IPPS proposed rule,[16] the Secretary proposed a new benchmark for purposes of medical review of hospital inpatient admissions (Medicare Part A payment). Under this proposal, beneficiaries who were expected to remain in the hospital to receive medically necessary care surpassing 2-midnights after the initiation of care would generally be appropriate for inpatient admission and inpatient payment (known as the "2-midnight rule"). Medicare contractors were to consider all the time after the initiation of care at the hospital in applying the benchmark that inpatient admissions are generally reasonable and necessary (as long as a hospital was not prolonging the provision of care to surpass the 2-midnight timeframe).[17]

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[12] *Id.*
[13] *Id.*
[14] CMS Pub. 100-02, Chapter 6, § 20.6 and Chapter 1, § 10.
[15] 78 Fed. Reg. at 50,907-08.
[16] *See generally* 78 Fed. Reg. 27,486 (May 10, 2013).
[17] 78 Fed. Reg. 50,908.

Medicare Part B

In the final IPPS rule, the Secretary noted there had been an increasing number of hospitals appealing Part A inpatient claim denials in which it was determined the inpatient admissions were not reasonable or necessary. These claims received partial favorable treatment by the Medicare Appeals Council or Administrative Law Judges (ALJs). In those cases, the Medicare review contractor determinations that the inpatient admission was not reasonable or necessary was upheld, however, the Medicare Appeals Council and ALJ decisions ordered payment of the services as if they were rendered in an outpatient or observation level of care. These decisions effectively required Medicare to issue payment for all Part B services that would have been payable had the patient been treated as an outpatient (rather than an inpatient). In addition, payments were made regardless of whether or not the subsequent hospital claims were within the applicable time limit for filing Part B claims. The Secretary pointed out that this was contrary to longstanding polices that permitted billing for only a limited list of Part B inpatient services and required that the services be billed within specific timeframes.[18]

As a result of the number of these administrative adjudications, the CMS Administrator issued Ruling CMS-1455-P[19] (the Ruling) which established a standard process for effectuating the decisions granting Part B coverage. Among other things, where the administrative adjudicator had issued an order for payment under Medicare Part B, the request for Part B payment would not be rejected if more than one year had elapsed (the time period for filing Part B claims), if the Part A claim had been submitted timely. The Ruling was to remain in effect until the effective date of regulations that finalized "Medicare Program; Part B Billing in Hospitals." In the August 19, 2013 Federal Register, the Secretary revised the Part B inpatient payment policy to allow payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require outpatient status.[20] The 1-year deadline for filing claims remained unchanged and the Secretary stated that she was not creating an exception to this requirement (as found in 42 C.F.R. §§ 424.44(b)(1)-(4)) even though the contractor claims review and appeal process could exceed the 1-year filing period.[21]

The 2-Midnight Rule

In the final IPPS rule, the Secretary pointed out that CMS had established policy that recognized there were certain situations in which an inpatient hospital admission was rarely appropriate. This IPPS rule included instructions that provided a benchmark to ensure that all

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[18] *Id.*
[19] *See* 78 Fed. Reg. 16,614 (Mar. 18, 2013), http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings.html.
[20] 78 Fed. Reg. at 50,909.
[21] *Id.* at 50,927.

beneficiaries receive consistent application of their Part A benefits to whatever clinical services were medically necessary.[22]

Due to persistently large, improper payment rates for short-stay hospital inpatient claims, and, in response to requests to provide additional guidance regarding proper billing of those services, the Secretary proposed to modify and clarify 42 C.F.R. § 412.3(c)(1). This regulation designates services that are inpatient only (without regard to duration of care), such as surgical procedures, diagnostic tests and other treatments that would be appropriate for inpatient admission and inpatient payment under Medicare Part A when the physician expects the beneficiary to require a stay that crosses 2 midnights and admits the beneficiary based on that expectation. The starting point for this 2-midnight instruction would be when the beneficiary is moved from any outpatient area to a bed in the hospital in which additional services would be provided and is based on the judgment of the physician and the physician order (the physician must certify that the inpatient services were medically necessary).[23] The Secretary maintains that she has consistently provided physicians with a time-based admission framework to effectuate appropriate inpatient hospital admission decisions.[24]

The Secretary's actuaries estimated that the 2-midnight rule would increase IPPS expenditures by approximately $220 million. These additional expenditures would result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving from OPPS to IPPS and some encounters of less than 2 midnights moving from IPPS to OPPS. The actuaries estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient from the approximately 11 million encounters paid under IPPS. This shift of 40,000 net encounters represents an increase of approximately 1.2 percent in the number of shorter stay hospital inpatient encounters paid under IPPS. This additional expenditure would be partially offset by reduced expenditures from the shift of shorter stay hospital inpatient encounters to hospital outpatient encounters. The actuaries estimated that, on average, the per encounter payments for these hospital outpatient encounters would be approximately 30 percent of the per encounter payments for the inpatient encounters. In light of the impact of the 2-midnight rule on IPPS and the systematic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, the Secretary decided it was appropriate to use her exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i) to offset the $220 million in additional IPPS expenditures associated with the 2-midnight policy. Consequently, the standardized amount was reduced by 0.2 percent.[25] The Secretary made the same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[26]

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[22] *Id.* at 50,944.
[23] *Id.*
[24] *Id.* at 50,945.
[25] *Id.* at 50,952-53.
[26] *Id.* at 50,990.

Providers' Request for EJR

The Providers contend that the continued application of the 0.2 percent payment reduction in FY 2016 violates the Medicare statute and exceeds the Secretary's authority. They believe that the statute precisely prescribes the calculation of the standardized amount for operating costs,[27] the Federal rate for capital costs,[28] and the hospital specific rates for sole community and Medicare-dependent hospitals,[29] and the statutory provisions do not provide or allow for the Secretary's 0.2 percent reduction. Further, they assert, the 0.2 percent reduction also exceeds the Secretary's authority to adopt additional adjustments and exceptions under section 42 U.S.C. § 1395ww(d)(5)(I), and violates the language and intent of that provision and the IPPS statute as a whole.30

The Providers argue that section 1395ww(d)(5)(I) was not intended to permit the Secretary to make global payment reductions to the standardized amount and the hospital specific rates that apply across the board to all cases and all types of hospitals. The context of the exceptions and adjustments provisions in section 1395ww(d)(5)(I), as well as the language, structure and intent of the statute as a whole, and the application of the canons of statutory construction, all confirm that the exceptions and adjustments clause authorizes only limited "adjustments" and "exceptions" that account for the special circumstances of discrete types of hospitals, much like the adjustments and exceptions expressly authorized in the proceeding clauses of section 1395ww(d)(5).

In addition, the Providers assert, the 0.2 percent reduction is arbitrary and capricious, and is not a reasonable interpretation of the statute. They contend that the 0.2 percent reduction constitutes an unacknowledged and unexplained departure from the Secretary's prior, more limited application of the adjustments and exceptions authority under 42 U.S.C. § 1395ww(d)(5)(I). Prior to the 2014 IPPS rule, the Secretary interpreted that section of the statute to preclude the adoption of a global adjustment for the purposes of offsetting aggregate payment increases. The Secretary has never before interpreted that section to effect a global payment rate reduction that applies across the board to all cases, all types of hospitals, and to both the prospective payment rates for operating and capital costs as well as the hospital-specific rates for exception hospitals.

Further, the Providers allege, the Secretary has failed to provide any coherent explanation as to why an estimated net addition of inpatient hospitals cases, which are properly covered and paid as inpatient hospital services, justifies an across-the-board reduction in the payment rate per discharge. There has not been an adequate explanation of how the agency derived the estimates that were used to calculate the 0.2 percent reduction. In particular, the Secretary has not adequately explained or responded to comments regarding the basis, data, or calculations underlying the agency's estimated 360,000 cases that otherwise would have been billed and paid as inpatient services will now be billed as outpatient services and that 400,000 cases that otherwise would have been billed and paid as outpatient services will now be paid as inpatient services.

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27 42 U.S.C. §§ 1395ww(d)(1),(3).
28 *Id.* 1395ww(g).
29 *Id.* 1395ww(d)(5)(D) and (G).
30 42 U.S.C. §§ 1395ww(d), 1395ww(g).

Finally, the Secretary is alleged to not have provided sufficient notice in the FFY 2014-2016 proposed or final rules, regarding the data and methodology under underlying the agency's estimates. This prevents providers from providing meaningful and informed commentary on the rule.

Decision of the Board

The Board has reviewed the Providers' requests for hearing and EJR. The regulation at 42 C.F.R. § 405.1842(a) permits the Board to consider whether it lacks the authority to decide a legal question relevant to the matter at issue once it has made a finding that it has jurisdiction to conduct a hearing under the provisions of 42 C.F.R. §§ 405.1840(a) and 405.1837(a). The Board concludes that the Providers timely filed their requests for hearing from the issuance of the August 27, 2015 Federal Register[31] and the amount in controversy exceeds the $50,000 threshold necessary for a group appeal.[32] Consequently, the Board has determined that it has jurisdiction over Providers' appeals.[33] This issue involves a challenge to the application of the 0.2 percent reduction, for which the promulgation background is found in the proposed and final rules published in the Federal Register. Further, the Board finds that it lacks the authority to decide the legal question of whether the 0.2 percent adjustment to IPPS is appropriate; therefore, EJR is appropriate for the issue under dispute in these cases.

The Board finds that:

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

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

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

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[31] *Washington Hospital Center v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986) ([A] year end cost report is not a report necessary in order for the Secretary to make PPS payments, and the appeals provisions applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal) and *District of Columbia Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993), *Medicare & Medicaid Guide* (CCH) ¶ 41,025 (publication of the wage index in the Federal Register is a final determination which can be appealed to the Board).

[32] *See* 42 C.F.R. § 405.1837(a)(3).

[33] The Board notes that one or more of the participants in this consolidated group appeal have cost report periods beginning on or after January 1, 2016, which would subject their appeals to the newly-added 42 C.F.R. § 405.1873 and the related revisions to 42 C.F.R. § 413.24(j) regarding submission of cost reports. *See* 80 Fed. Reg. 70298, 70555-70604 (Nov. 13, 2015). However, the Board notes that § 405.1873(b) has not been triggered because neither party has questioned whether any provider's cost report included an appropriate claim for the specific item under appeal. *See* 80 Fed. Reg. at 70556.

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

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

Board Members Participating

Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA

FOR THE BOARD:

Charlotte F Benson

Charlotte F. Benson, CPA
Board Member

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1877 and 405.1877
List of PPS Rate Reduction Group Cases and Schedules of Providers

cc: Danene Hartley, Nat'l Gov't Servs. (Certified Mail w/Case Listing and Schedules)
Bill Tisdale, Novitas Solutions (Certified Mail w/Case Listing and Schedules)
Bruce Snyder, Novitas Solutions (Certified Mail w/Case Listing and Schedules)
Byron Lamprecht, Wis. Physicians Serv. (Certified Mail w/Case Listing and Schedules)
James Ward, Noridian Healthcare (Certified Mail w/Case Listing and Schedules)
Geoff Pike, First Coast Service Options (Certified Mail w/Case Listing and Schedules)
Pam VanArsdale, Nat'l Gov't Servs. (Certified Mail w/Case Listing and Schedules)
Laurie Polson, Palmetto GBA d/b/a Nat'l Gov't Servs. (Certified Mail w/Case Listing and Schedules)
Evaline Alcantara, Noridian Healthcare Solutions (Certified Mail w/Case Listing and Schedules)
Wilson Leong, FSS (w/Case Listing and Schedules)

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CERTIFIED MAIL

DEC 15 2016

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RE: Jurisdiction Decision
Kern Medical Center
Provider No. 05-0315
FYE 6/30/2009
PRRB Case No. 13-2719

Dear Ms. Giberti and Mr. Lowe,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the Medicare Contractor's Jurisdictional Challenge. The Board finds that it does not have jurisdiction over any of the issues under appeal based on the reasons set forth below.

BACKGROUND:

On February 22, 2013, Kern Medical Center ("Kern") is issued an original Notice of Program Reimbursement ("NPR") for fiscal year end **6/30/2009**. The Provider timely filed an appeal request with the Board in which it appealed 10 issues, including: Medicare Settlement Data and DSH-Medicaid Eligible Days. The other eight issues were transferred to group appeals or withdrawn by the Provider.

On May 31, 2014, the Medicare Contractor filed a jurisdictional challenge with the Board over the outlier payment issue and the Medicaid eligible days issue. The Provider filed a response to the jurisdictional challenge, which the Board received on June 6, 2014. On November 18, 2014, the Provider filed its Final Position Paper with the Board in which it indicates that the only issue pending is the Medicaid eligible days issue.

MEDICARE CONTRACTOR'S CONTENTIONS:

The Medicare Contractor has filed a jurisdictional challenge over the two remaining issues in the appeal – outlier payments and Medicaid eligible days.

Issue 1 – Outlier Payments

The Medicare Contractor argues that the Board does not have jurisdiction over the outlier payments issue because the issue was not identified in the Provider's individual appeal request, nor was the issue timely added to its appeal as required by 42 C.F.R. § 405.1835(c).

Issue 2 – Medicaid Eligible Days

The Medicare Contractor asserts that the Board does not have jurisdiction over the Medicaid eligible days issue because the Medicare Contractor did not make a final determination over the Medicaid days that the Provider now seeks to include in its Medicaid ratio.

The Medicare Contractor explains that it made an adjustment to the Medicaid eligible days that the Provider included on its as-filed cost report, but that it did not make an adjustment to the 995 additional Medicaid eligible days that the Provider is now requesting. Furthermore, the Medicare Contractor asserts that the Provider did not properly file its cost report under protest because it did not submit any workpapers explaining what amounts it was protesting. The Medicare Contractor concludes that as the Provider did not claim or protest the additional Medicaid eligible days on its cost report, there was no final determination made with respect to those days.

PROVIDER'S CONTENTIONS:

Issue 1 – Medicare Settlement Data (Specific to Outlier)

The Provider argues that it included the Outlier Payments issue in its individual appeal request as part of Issue No. 1: Medicare Settlement Data. According to the Provider, this issue referenced several audit adjustment numbers, one of which includes a revision to the Provider's filed outlier payments. The Provider categorizes the outlier payment issue as a "component" of the Medicare settlement data.

The Provider goes on to explain that in its March 28, 2014 preliminary position paper it explained why the Medicare settlement data component of the outlier payments is incorrectly stated and how additional outlier payments must be adjusted.

Issue 2 – Medicaid Eligible Days

The Provider argues that it reported 17,714 Medicaid eligible days and 31,141 Medicaid HMO days for a total of 48,855 reported Medicaid eligible days. The Provider then explains that the Medicare Contractor reduced total Medicaid eligible days by 25,677 (1,941 and 23,736) at adjustment 8. Adjustment 6 implemented an additional 2,815 Medicaid eligible days, although the Provider was left with a net 22,862 (-25,677 + 2,815) Medicaid eligible day deficit compared to the Provider's reported Medicaid eligible days.

The Provider contends that the Medicare Contractor has done now investigative work to establish that the 995 additional Medicaid eligible days the Provider is requesting were not claimed by the

Provider as part of the Medicaid eligible days it claimed on its cost report. The Provider argues that the reduction of 22,862 days exceeds the 995 days the Provider has requested.

Finally, the Provider argues that the State of California's verification of Medicaid eligibility cannot occur within the time the Provider is given to file its cost report.

BOARD'S DECISION

Outlier Payments and Medicare Settlement Data Issues

The Board finds that it does not have jurisdiction over the outlier payments issue because the Provider did not timely appeal or add this issue to its individual appeal. The Provider essentially argues that the outlier payments issue is a narrowing of the Medicare Settlement Data issue that was included in its individual appeal request. The issue statement for the Medicare Settlement Data issue reads:

> The intermediary implemented adjustments to the Provider's filed Medicare settlement data by reconciling to the Intermediary's record of paid claims through July 25, 2012. The Provider contends there are additional claims that have been paid by the Medicare Program that were not included in the Intermediary's reconciliation of Medicare settlement data. The Medicare Program allows the Provider to process claims up to eighteen months after the end of the Provider's fiscal year end. The applicable regulation is 42 C.F.R. 412.110.[1]

The outlier payment issue is raised for the first time in the Provider's Preliminary Position Paper, received by the Board on March 31, 2014. The Provider identified the issue as "Medicare Settlement Data – Outlier Payments" and the issue statement as "Whether the Provider received the reimbursement Congress intended under the Medicare Act for treating certain cases that incurred extraordinarily high costs? Was the cost outlier threshold set improperly?"[2]

In its Final Position Paper, dated November 17, 2014, the Provider again identifies issue 1 as Medicare Settlement Data – Outlier Payments. The Provider indicates that this issue has been transferred to case number 14-4384G[3] on September 24, 2014. The issue statement in the Final Position Paper reads:

> The Provider contends the Secretary's final determination of outlier payments was arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law within the meaning of 5 U.S.C. Section 706(2)(A), and is short of statutory rights within the meaning of 5 U.S.C. Section 706(2)(c), because the Secretary acted in an arbitrary and capricious manner and abused her discretion when settling the outlier threshold and calculating outlier payments. As a result of these arbitrary and capricious actions, the threshold was set too high, the

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[1] Kern Medical Center's Request for Hearing, Tab 3 at 1-2 (Aug. 12, 2013).
[2] Provider's Response to Jurisdiction Challenge, Exhibit P5 at 3.
[3] Toyon 2009 Understatement of Outlier Payments Group, which remains open and pending before the Board.

> resulting amount of outlier payments fell short of the percentage required by the Medicare Act and hospitals did not receive the amount of outlier payments that Congress intended. The applicable Medicare regulation is 5 U.S.C. Section 706(a)(A) and 5 U.S.C. Section 706(2)(c).[4]

The issue that the Provider briefed in its position paper is not the same issue as it included in its appeal request. Furthermore, the Provider did not timely request to add the outlier payments issue to its appeal.

On May 23, 2008, the Secretary published updated regulatory provisions concerning PRRB appeals.[5] The May 23, 2008 Final Rule states that the new regulations were effective beginning August 21, 2008, and applicable to all appeals filed on or after this date.[6] Under these new regulations, a provider's request for hearing must contain an issue statement that describes each contested item with a certain degree of specificity. Specifically, a provider's hearing request must include "[a]n explanation (for each specific item at issue . . .) of the provider's dissatisfaction with the contractor's or Secretary's determination under appeal . . ."[7] The regulation also specifies that a provider may add an issue to its pending individual appeal if, "[t]he Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180-day period" the Provider has to file an appeal from its final determination.[8]

Here, the Provider filed its individual appeal request with the Board and included the Medicare Settlement Data issue, but did not include the outlier payments issue. The Provider's issue statement does not encompass both issues, because the issue statement does not comport with the specificity requirements of 42 C.F.R. § 405.1835(b)(2). Furthermore, the Provider did not timely add the outlier payments issue to its individual appeal. The issue was not raised until its preliminary position paper, which was received on March 31, 2014.[9] Based on the new regulation, the Provider only had until October 25, 2013 to add new issues to its pending appeal, therefore it did not timely add the outlier payments issue.

Furthermore, the Board finds that the original issue, Medicare Settlement Data, has been abandoned because the Provider did not brief the issue in its final position paper.

Medicaid Eligible Days Issue

The Provider is appealing from a 6/30/2009 cost report, which means that it either had to claim the cost at issue or it is subject to the protest requirement in order for the Board to have jurisdiction.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), 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

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[4] Kern Medical Center Final Position Paper at 1-2 (Nov. 17, 2014).
[5] Provider Reimbursement Determinations and Appeals, 73 Fed. Reg. 30190 (May 23, 2008) ("May 23, 2008 Final Rule").
[6] *Id.*
[7] 42 C.F.R. § 405.1835(b)(2).
[8] 42 C.F.R. § 405.1835(e)(3).
[9] Response to Jurisdiction Challenge, Exhibit P5.

$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 jurisdictional issue presented here is whether or not this hospital has preserved its right to claim dissatisfaction with the amount of Medicare payment. "A provider. . . has a right to a Board hearing . . . only if – (1) the provider **has preserved its right to claim dissatisfaction . . . by . . . [i]ncluding a claim for specific item(s) on its cost report . . . or . . . self-disallowing the specific item(s) by . . . filing a cost report under protest.**[10]

The Board finds that it does not have jurisdiction over the Medicaid eligible days issue in this appeal. The Provider did not protest the Medicaid eligible days currently under appeal on its cost report notwithstanding the fact that it knew California would have additional days at a later point in time. Therefore, the Board could only have jurisdiction over those days if the Provider included a claim for the specific items on its cost report, as required by 42 C.F.R. § 405.1835(a).

The Board finds that the Provider did not include a claim for the specific days at issue in this appeal on its cost report, therefore it does not have jurisdiction over the days. The Board acknowledges that Kern filed Medicaid days on various lines on its as-filed cost report, to which the Medicare Contractor made an adjustment.[11] However, the Provider has presented no evidence that the 995 days at issue were part of the days adjusted off. Therefore, the Board finds that Kern has not met the dissatisfaction requirement of including a specific claim on the cost report, or protesting the specific Medicaid eligible days at issue.

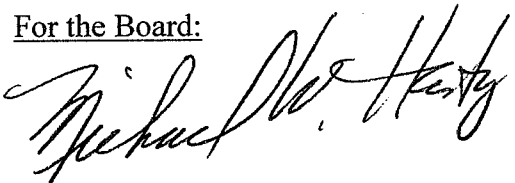
CONCLUSION

The Board finds that it does not have jurisdiction over the outlier payments, Medicare settlement data, or Medicaid eligible days issues and dismisses the issues from case number 13-2719. As these were the only pending issues in the appeal, case number 13-2719 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
Clayton J. Nix. Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

For the Board:



Michael W. Harty
Chairman

cc: Wilson Leong, FSS

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[10] 42 C.F.R. § 405.1835(a) (emphasis added).

[11] On its as filed cost report, the Provider erroneously filed more Medicaid days than total days. The Provider reported 31,141 total Medicaid days on line 12 column 5 and 31,141 HMO Medicaid days on line 2 column 5 for a total of 62,282. The Provider only reported 60,119 total days on line 12 column 6, therefore the total Medicaid patient day to total day percentage on W/S E Part A, line 4.01 was 103%. Medicare Contractor's Jurisdictional Challenge, Exhibit A.

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Refer to:

CERTIFIED MAIL

DEC 19 2016

Barry W. Cook, CPA
5025 Hill Place Drive
Nashville, TN 37205

RE: Austin Surgical Hospital, Provider No. 52-0045

FYE: 09/30/10	PRRB Case No. 13-0005
FYE: 09/30/09	PRRB Case No. 14-2394
FYE: 09/30/11	PRRB Case No. 15-0260

Dear Mr. Cook:

The Provider Reimbursement Review Board (the Board) recently began a review of the above-captioned appeals and notes an impediment related to the Rural Floor Budget Neutrality Adjustment ("RFBNA") issue in each of the appeals. The pertinent facts and the Board's determination are set forth below.

Background:

The Provider, in each of its hearing requests, is asserting that the "Medicare payments made under the Inpatient Prospective Payment System (IPPS) are understated." Each request contends that "CMS has erroneously implemented the budget neutrality provision of the Balanced Budget Act of 1997 (BBA) and has failed to properly apply the rural floor adjustment in the computation of the IPPS payments."[1] The RFBNA issue is the sole issue in each appeal. The Medicare Contractor filed a jurisdictional challenge in two (Case Nos. 14-2394 and 15-0260) of the three appeals, and the Board, on its own motion, is reviewing jurisdiction in the third case (Case No. 13-0005).

Medicare Contractor's Jurisdictional Challenge:

The Medicare Contractor states that it "believe[s] that the Provider Reimbursement Review Board (PRRB) does not have jurisdiction over Issue 1, (Rural Floor Budget Neutrality Adjustment)." The Medicare Contractor contends that it "made no adjustment to the cost report" as is required under 42 C.F.R. § 405.1835. To support its contention the Medicare Contractor states that the "Provider did not claim the budget neutrality factors as a protested item on their submitted cost report; therefore, the Medicare Contractor could not have made an adjustment. See Exhibit I-2 for a copy of the Provider's submitted Worksheet E, Part A, which indicates no protested amounts[2] on line 30 (Case No. 14-2394) and line 75 (Case No. 15-0260). The Medicare Contractor goes on to say that since "this is the only issue in the

[1] *See* "Issue" section on page 1 of each hearing request.
[2] *See* "II. FACTS" section on page 3 of the Jurisdictional Challenge.

case, the MAC also requests that the PRRB dismiss the case in its entirety due to lack of jurisdiction."

Provider's Response to Jurisdictional Challenge:

The Provider did not respond to either of the Medicare Contractor's jurisdictional challenges.

Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840[3], 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.

Similarly, 42 C.F.R. § 405.1835(a)(1) provides, in relevant part:

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

The Board notes that Case Nos. 13-0005, 14-2394 and 15-0260 are for cost reports with reporting periods that ended after December 31, 2008. In accordance with the aforementioned regulation, the Provider needed to have claimed the item on its cost report or listed the item as a protested item to have a right to a Board hearing.

In the three cases at hand, the Provider cites an audit adjustment relating to updating payments to the PS&R. None of the adjustments cited by the Provider reference an

[3] Regulation effective August 21, 2008 to September 30, 2014.

adjustment for the RFBNA. In addition, the Provider has failed to supply additional documentation showing how the PS&R adjustments removed its claim for the issue under appeal. Since the Provider did support documentation that it made a claim for the RFBNA issue on its cost report, in order for the Board to have jurisdiction as required under 42 C.F.R. § 405.1835(a)(1)(i), the Provider must meet the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii).

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

In the preamble to the final rule published on May 23, 2008 ("2008 Final Rule"),[4] the Secretary explained that he believed that the requirement to follow procedures for filing cost reports under protest was appropriate under the decision in *Bethesda Hospital Association v. Bowen.*[5] In *Bethesda*, the providers were dissatisfied with malpractice reimbursement and did not file a claim for the additional reimbursement on their cost report, nor did they file a statement with the cost report challenging the validity of the regulation. Hence, there was no final determination with respect to malpractice costs. The Court rejected the Secretary's argument that 42 U.S.C. § 1395oo(a)(1)(A)(i), which requires dissatisfaction with a final determination of the intermediary, "necessarily incorporates an exhaustion requirement." The Court found that this "strained interpretation" of the statutory dissatisfaction requirement was inconsistent with the express language of the statute.[6] However, the Court agreed, that under § 1395oo(a)(1)(A)(i), a provider's dissatisfaction with the amount of its total reimbursement is a condition of the Board's jurisdiction, but held that "it is clear, however, that the submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations. No statute or regulation expressly mandates that a challenge to the validity of a regulation be submitted first to the intermediary. . . . Thus, [the providers in *Bethesda]* stand on different ground than do providers who bypass clearly prescribed exhaustion requirements or who fail to request from the intermediary reimbursement for costs to which they are entitled under the applicable rules. While such defaults might well establish that a provider was satisfied with the amounts requested in its cost report and awarded by the intermediary, those circumstances are not presented here."[7] The Secretary noted that the Court recognized that an exhaustion requirement could be imposed by regulation, and that a

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[4] 73 Fed. Reg. 30190 (May 23, 2008).
[5] 485 U.S. 399 (1988).
[6] 73 Fed. Reg. at 30196 citing *Bethesda* at 404.
[7] *Id.* at 404-405.

provider who fails to claim all costs to which it is entitled may fail to meet the jurisdictional prerequisite of dissatisfaction.[8] In light of the ability to enact such regulations, 42 C.F.R. § 405.1835(a)(1)(ii) was promulgated, requiring providers to claim all items for which they seek additional reimbursement.

The Secretary went on to state that "[a]lthough there may be nothing in the statute indicating that dissatisfaction must be expressed with respect to 'each claim,' there also is nothing in the statute indicating that the Secretary cannot interpret the dissatisfaction requirement in this manner."[9]

The final determination, which in these cases is the Notice of Program Reimbursement (NPR), is not just the total amount of program reimbursement. Rather, it is composed of many individual calculations representing the various items for which a provider seeks payment. Providers generally challenge discrete reimbursement items. Thus, dissatisfaction with total reimbursement is based on dissatisfaction with items that result in total reimbursement. Consequently, the Secretary believes it is reasonable under 42 U.S.C. § 1395oo(a) to require dissatisfaction be shown with respect to each issue being appealed.[10] In light of this and the requirements of the regulation, the Board finds that the challenge to the RFNBA must be claimed as a protested item and the Provider has furnished no evidence to show that it complied with this requirement.

In the cases at hand the Provider failed to furnish any evidence to indicate that the items were protested as required on W/S E Part A of the as-filed cost report. Because the Provider did not respond to the Medicare Contractor's jurisdictional challenges, there is also no evidence furnished by the Provider to refute the Medicare Contractor's claim that the Provider did not protest the items as shown on lines 30 (PRRB Case No. 14-2394) and 75 (PRRB Case No. 15-0260) of the respective Worksheets E, Part A furnished by the Medicare Contractor.[11] Since each cost report involves a fiscal year that ends after December 31, 2008, self-disallowed items (such as the RFBNA issue) must have been filed under protest in order to have complied with the rules and regulations of the Secretary relating to such [cost] report. The Board finds that the Provider in Case Nos. 13-0005, 14-2394 and 15-0260 did not protest the RFBNA and fails to meet the standard for Board jurisdiction under 42 U.S.C. § 1395oo(a)(1). Therefore, the Provider does not have the right to a Board hearing regarding these items because it has failed to meet the requirements under 42 CFR § 405.1835(a)(1)(ii). Since the Board does not have jurisdiction over the RFBNA issue in all three appeals it hereby grants the Medicare Contractor's request to dismiss each case for lack of jurisdiction as the RFBNA issue was the sole issue in each appeal.

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

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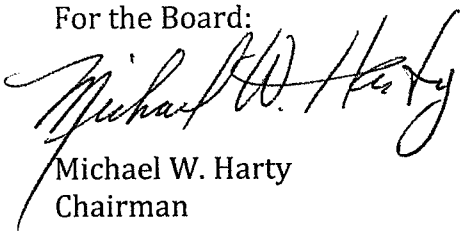
[8] 73 Fed. Reg. at 30196 citing *Bethesda* at 404-405.
[9] 73 Fed. Reg. at 30197.
[10] *Id.*
[11] *See* Exhibit I-2

Board Members Participating:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

For the Board:



Michael W. Harty
Chairman

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

cc: Bill Tisdale, Novitas Solutions, Inc. (J-H)
Wilson C. Leong, Esq., CPA, Federal Specialized Services

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Refer to: 13-0314GC

DEC 20 2016

Certified Mail

Russell Kramer
Director
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue
Suite 570A
Arcadia, CA 91006

RE: QRS HMA 2005 DSH Dual Eligible Days Group
Provider Nos. Various
FYE 2005
PRRB Case No. 13-0314GC

Dear Mr. Kramer:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' November 29, 2016 request for expedited judicial review (EJR) (received November 30, 2016) submitted for the above-referenced appeal. The decision of the Board is set forth below.

Issue

The Providers' request for EJR identified the issue subject to EJR as:

> . . . .whether the MAC should have excluded from the Medicare [disproportionate share hospital (DSH)] fraction non-covered patient days, i.e., days attributable to patients who were enrolled in Medicare and entitled to SSI, but for whom Medicare did not make a payment for their hospital stay, either because that patient's Medicare benefit days were exhausted, or because a third party made payment for that patient's hospital stay. The provider [sic] contends that these non-covered patient days should be excluded from the Medicare fraction. Provider [sic] further contends that these non-covered patient days should be treated consistently; that is, they should either be included in both the top and bottom of the SSI fraction, or excluded from both the top and bottom fraction.[1]

[1] Providers' November 29, 2016 EJR Request at 1.

Background

The August 11, 2004 Federal Register[2] the Secretary[3] responded to comments to the proposed inpatient prospective payment system (IPPS) rules regarding payment to DSH hospitals. With respect to dual eligible days the Secretary explained that:

> . . . the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits. If a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual-eligible and the patient days are included in the Medicare fraction of the DSH patient percentage but not the Medicaid fraction. This is consistent with the language of section 1886(d)(5)(F)(vi)(II)[4] of the Act, which specifies that patients entitled to benefits under Part A are excluded from the Medicaid fraction.
>
> It has come to our attention that we inadvertently misstated our current policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 (68 FR 27207). In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. Our policy has been that only covered patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (http://www.cms.hhs.gov/providers/ hipps/dual.asp) on July 9, 2004.
>
> **********
>
> . . .the statute also requires that patient days attributable to patients entitled to benefits under Medicare Part A are to be excluded from the Medicaid fraction. [5]

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[2] 69 Fed. Reg. 48,916 (Aug. 11, 2004).
[3] of the Department of Health and Human Services.
[4] 42 U.S.C. § 1394ww(d)(5)(F)(vi)(II).
[5] 69 Fed. Reg. at 49098.

The Providers' Request for EJR

The Providers explain that the applicable regulation requires that non-covered patient days be included in the Medicare fraction of the DSH calculation.[6] This was accomplished through the deletion of the word "covered" where is previously appeared in the definition of the Medicare fraction in 42 C.F.R. § 412.106(b)(2)(i).[7] Thus, the 2004 regulations required inclusion in the Medicare fraction of both exhausted benefit days and Medicare secondary payment days associated with patient discharges occurring on or after October 1, 2004.[8]

The Providers assert that the 2004 regulation mandating inclusion of non-covered exhausted benefit and Medicare secondary payor days in the Medicare fraction is invalid. The Providers believe that EJR is appropriate because the Board lacks the authority to order post 2004 non-covered exhausted benefit and Medicare secondary payor days to be removed from the Medicare fraction.[9]

The 2004 Regulations are Invalid Due to Lack of Adequate Notice and Comment

The Providers explain that this case involves the question of whether inpatient hospital days attributable to individuals who are eligible for both Medicare and Medicaid (hereinafter "dual eligibles") and for whom Medicare has not made a payment for that inpatient stay (hereinafter "non-covered days") should be included in the Medicare fraction of the DSH adjustment or should be excluded from the Medicare fraction of the DSH adjustment.

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), states that Medicaid eligible patients who are "entitled to benefits under [Medicare] Part A" should be included in the Medicare fraction of the DSH calculation. However, under the regulation promulgated in 2004, 42 C.F.R. § 412.106(b)(2)(i), Medicare enrollees are considered to be entitled to benefits under Part A even if their stay is not covered by Medicare Part A. As a result, the Providers note, the 2004 regulation required that non-covered days be included in the Medicare fraction of the DSH adjustment. The Providers believe that the 2004 regulation was improperly promulgated and should be vacated; and if the days are excluded from the Medicare fraction they must be included in the Medicaid fraction.[10]

The Providers explain that the case involves two types of non-covered days. The first category involves exhausted benefit days, which are patient days for individuals who are eligible for both Medicare and Medicaid, but who have exhausted their Medicare benefits during all or a portion of their hospitalization. The second category involves Medicare Secondary Payor (MSP) days. These are days for which a party other than Medicare, such as an employer health plan, made

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[6] *Id.* at 49098-9.
[7] *See* 42 C.F.R. § 412.106(b)(2)(i) (2003) verses 42 C.F.R. § 412.106(b)(2)(1) (2004)
[8] Providers' November 29, 2016 EJR Request at 2.
[9] *Id.*
[10] Providers' EJR Request at 2.

payment for the inpatient hospital stay. In both cases, Medicare does not pay for the inpatient hospital stay, and as such the days are not "covered" days.[11]

The Providers assert that the 2004 regulations should be vacated because the Secretary failed to adhere to the Administrative Procedure Act (APA) notice and comment procedures found at 5 U.S.C. § 553(b)-(c). They contend that the Agency may promulgate a rule that differs from a proposed rule only if the final rule is a logical outgrowth of a proposed rule.[12] The APA requires that the agency provide sufficient factual detail and rationale for the rule to permit interested parties to comment meaningful.[13]

The Providers believe the proposed rule was misleading as to the Secretary's policy with respect to non-covered days. Specifically, the Secretary's statement in the proposed IPPS rule that "[i]f a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible and the patient days are included in the Medicare fraction of the DSH patient percentage but not the Medicaid fraction."[14] The Providers opine that this sentence would cause a reasonable person to believe that the Secretary's prior policy was to include all dual eligible patient days in the Medicare fraction, including non-covered exhausted benefit days and Medicare secondary payor days. This was reinforce by the statement that the "current policy regarding dual eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[15] The Secretary failed to explain her rationale for departing from this policy in the final rule.[16] The change in the final rule cannot be viewed as a logical outgrowth of the proposed rule[17] nor is it a product of reasoned decision-making.[18]

Decision of the Board

The Board has reviewed the Providers' requests for hearing and EJR. The regulation at 42 C.F.R. § 405.1842(a) permits the Board to consider whether it lacks the authority to decide a legal question relevant to the matter at issue once it has made a finding that it has jurisdiction to conduct a hearing under the provisions of 42 C.F.R. §§ 405.1840(a) and 405.1837(a) . The Board concludes that the Providers timely filed their requests for hearing from the issuance of Notices of Program Reimbursement and the amount in controversy exceeds the $50,000 threshold necessary for a group appeal.[19] Consequently, the Board has determined that it has jurisdiction over Providers' appeals. This issue involves a challenge to the validity of the regulation, 42 C.F.R. § 412.106(b)(2)(i). Further, the Board finds that it lacks the authority to

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[11] *Id.* at 3.
[12] *Ass'n of Private Sector Colleges & Universities v. Duncan*, 681 F. 3d 427, (D.C. Cir. 2012)
[13] Providers' EJR Request at 6-7.
[14] 68 Fed. Reg. 27,154, 27,207 (May 19, 2003)
[15] Providers' EJR request at 7
[16] *Id.* at 8.
[17] *Id.* at 9.
[18] *Id.* at 10.
[19] *See* 42 C.F.R. § 405.1837(a)(3).

decide the legal question of whether 42 C.F.R. § 412.106(b)(2)(i) is valid; therefore, EJR is appropriate for the issue under dispute in this case.

The Board finds that:

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

2) based upon the Providers' assertions regarding the validity of 42 C.F.R. § 412.106(b)(2)(i)there are no findings of fact for resolution by the Board;

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

4) it is without the authority to decide the legal question of whether 42 C.F.R. § 412.106(b)(2)(i) is valid.

Accordingly, the Board finds that the issue regarding the validity of 42 C.F.R. § 412.106(b)(2)(i) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for expedited judicial review for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

Board Members Participating

Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA

FOR THE BOARD:

Charlotte F. Benson

Charlotte F. Benson, CPA
Board Member

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

cc: Byron Lamprecht, WPS (Certified Mail w/Schedule of Providers)
Wilson Leong, FSS (w/Schedule Providers)

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Refer to: 13-0315GC
Certified Mail

DEC 20 2016

Russell Kramer
Director
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue
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Arcadia, CA 91006

RE: QRS HMA 2006 DSH Dual Eligible Days Group
Provider Nos. Various
FYE 2006
PRRB Case No. 13-0315GC

Dear Mr. Kramer:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' November 29, 2016 request for expedited judicial review (EJR) (received November 30, 2016) submitted for the above-referenced appeal. The decision of the Board is set forth below.

Issue

The Providers' request for EJR identified the issue subject to EJR as:

> . . . .whether the MAC should have excluded from the Medicare [disproportionate share hospital (DSH)] fraction non-covered patient days, i.e., days attributable to patients who were enrolled in Medicare and entitled to SSI, but for whom Medicare did not make a payment for their hospital stay, either because that patient's Medicare benefit days were exhausted, or because a third party made payment for that patient's hospital stay. The provider [sic] contends that these non-covered patient days should be excluded from the Medicare fraction. Provider [sic] further contends that these non-covered patient days should be treated consistently; that is, they should either be included in both the top and bottom of the SSI fraction, or excluded from both the top and bottom fraction.[1]

[1] Providers' November 29, 2016 EJR Request at 1.

Background

The August 11, 2004 Federal Register[2] the Secretary[3] responded to comments to the proposed inpatient prospective payment system (IPPS) rules regarding payment to DSH hospitals. With respect to dual eligible days the Secretary explained that:

> . . . the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits. If a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual-eligible and the patient days are included in the Medicare fraction of the DSH patient percentage but not the Medicaid fraction. This is consistent with the language of section 1886(d)(5)(F)(vi)(II)[4] of the Act, which specifies that patients entitled to benefits under Part A are excluded from the Medicaid fraction.
>
> It has come to our attention that we inadvertently misstated our current policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 (68 FR 27207). In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. Our policy has been that only covered patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (http://www.cms.hhs.gov/providers/ hipps/dual.asp) on July 9, 2004.
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> . . . the statute also requires that patient days attributable to patients entitled to benefits under Medicare Part A are to be excluded from the Medicaid fraction. [5]

[2] 69 Fed. Reg. 48,916 (Aug. 11, 2004).
[3] of the Department of Health and Human Services.
[4] 42 U.S.C. § 1394ww(d)(5)(F)(vi)(II).
[5] 69 Fed. Reg. at 49,098.

The Providers' Request for EJR

The Providers explain that the applicable regulation requires that non-covered patient days be included in the Medicare fraction of the DSH calculation.[6] This was accomplished through the deletion of the word "covered" where is previously appeared in the definition of the Medicare fraction in 42 C.F.R. § 412.106(b)(2)(i).[7] Thus, the 2004 regulations required inclusion in the Medicare fraction of both exhausted benefit days and Medicare secondary payment days associated with patient discharges occurring on or after October 1, 2004.[8]

The Providers assert that the 2004 regulation mandating inclusion of non-covered exhausted benefit and Medicare secondary payor days in the Medicare fraction is invalid. The Providers believe that EJR is appropriate because the Board lacks the authority to order post 2004 non-covered exhausted benefit and Medicare secondary payor days to be removed from the Medicare fraction.[9]

The 2004 Regulations are Invalid Due to Lack of Adequate Notice and Comment

The Providers explain that this case involves the question of whether inpatient hospital days attributable to individuals who are eligible for both Medicare and Medicaid (hereinafter "dual eligibles") and for whom Medicare has not made a payment for that inpatient stay (hereinafter "non-covered days") should be included in the Medicare fraction of the DSH adjustment or should be excluded from the Medicare fraction of the DSH adjustment.

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), states that Medicaid eligible patients who are "entitled to benefits under [Medicare] Part A" should be included in the Medicare fraction of the DSH calculation. However, under the regulation promulgated in 2004, 42 C.F.R. § 412.106(b)(2)(i), Medicare enrollees are considered to be entitled to benefits under Part A even if their stay is not covered by Medicare Part A. As a result, the Providers note, the 2004 regulation required that non-covered days be included in the Medicare fraction of the DSH adjustment. The Providers believe that the 2004 regulation was improperly promulgated and should be vacated; and if the days are excluded from the Medicare fraction they must be included in the Medicaid fraction.[10]

The Providers explain that the case involves two types of non-covered days. The first category involves exhausted benefit days, which are patient days for individuals who are eligible for both Medicare and Medicaid, but who have exhausted their Medicare benefits during all or a portion of their hospitalization. The second category involves Medicare Secondary Payor (MSP) days. These are days for which a party other than Medicare, such as an employer health plan, made

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[6] *Id.* at 49098-9.
[7] *See* 42 C.F.R. § 412.106(b)(2)(i) (2003) verses 42 C.F.R. § 412.106(b)(2)(1) (2004)
[8] Providers' November 29, 2016 EJR Request at 2.
[9] *Id.*
[10] *Id.*

payment for the inpatient hospital stay. In both cases, Medicare does not pay for the inpatient hospital stay, and as such the days are not "covered" days.[11]

The Providers assert that the 2004 regulations should be vacated because the Secretary failed to adhere to the Administrative Procedure Act (APA) notice and comment procedures found at 5 U.S.C. § 553(b)-(c). They contend that the Agency may promulgate a rule that differs from a proposed rule only if the final rule is a logical outgrowth of a proposed rule.[12] The APA requires that the agency provide sufficient factual detail and rationale for the rule to permit interested parties to comment meaningful.[13]

The Providers believe the proposed rule was misleading as to the Secretary's policy with respect to non-covered days. Specifically, the Secretary's statement in the proposed IPPS rule that "[i]f a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible and the patient days are included in the Medicare fraction of the DSH patient percentage but not the Medicaid fraction."[14] The Providers opine that this sentence would cause a reasonable person to believe that the Secretary's prior policy was to include all dual eligible patient days in the Medicare fraction, including non-covered exhausted benefit days and Medicare secondary payor days. This was reinforce by the statement that the "current policy regarding dual eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[15] The Secretary failed to explain her rationale for departing from this policy in the final rule.[16] The change in the final rule cannot be viewed as a logical outgrowth of the proposed rule[17] nor is it a product of reasoned decision-making.[18]

Decision of the Board

Providers that Did Not Include Notices of Program Reimbursement in Their Respective Jurisdictional Documents

The Providers listed below did not include the required Notices of Program Reimbursement[19] behind Tab A of their jurisdictional documents. Since this document is required to determine if the appeals are timely filed under 42 C.F.R. §§ 405.1835 and 405.1840, the appeal for the Providers listed below are hereby dismissed:

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[11] *Id.* at 3.
[12] *Ass'n of Private Sector Colleges & Universities v. Duncan*, 681 F. 3d 427, (D.C. Cir. 2012)
[13] Providers' EJR Request at 6-7.
[14] 68 Fed. Reg. 27,154, 27,207 (May 19, 2003)
[15] *Id.*
[16] Providers' EJR request at 8.
[17] *Id.* at 9.
[18] *Id.* at 10.
[19] *See* Provider Reimbursement Review Board Rules 20.1, 20.3 and 21 require the submission of a final determination of reimbursement. The Board's Rules can be found on the Internet at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB_Instructions.html.

#8 10-0137 Heart of Florida Medical Center
#9 10-0211 Pasco Regional Medical Center
#10 10-0249 Seven Rivers Regional Medical Center
#27 44-0144 Harton Regional Medical Center
#29 45-0031 Medical Center of Mesquite

EJR Determination

The Board has reviewed the remaining Providers' requests for hearing and EJR. The regulation at 42 C.F.R. § 405.1842(a) permits the Board to consider whether it lacks the authority to decide a legal question relevant to the matter at issue once it has made a finding that it has jurisdiction to conduct a hearing under the provisions of 42 C.F.R. §§ 405.1840(a) and 405.1837(a) . The Board concludes that the remaining Providers timely filed their requests for hearing from the issuance of Notices of Program Reimbursement and the amount in controversy exceeds the $50,000 threshold necessary for a group appeal.[20] Consequently, the Board has determined that it has jurisdiction over remaining Providers' appeals. This issue involves a challenge to the validity of the regulation, 42 C.F.R. § 412.106(b)(2)(i). Further, the Board finds that it lacks the authority to decide the legal question of whether 42 C.F.R. § 412.106(b)(2)(i) is valid; therefore, EJR is appropriate for the issue under dispute in this case.

The Board finds that:

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

2) based upon the remaining Providers' assertions regarding the validity of 42 C.F.R. § 412.106(b)(2)(i)there are no findings of fact for resolution by the Board;

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

4) it is without the authority to decide the legal question of whether 42 C.F.R. § 412.106(b)(2)(i) is valid.

Accordingly, the Board finds that the issue regarding the validity of 42 C.F.R. § 412.106(b)(2)(i) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the remaining Providers' request for expedited judicial review for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial

[20] *See* 42 C.F.R. § 405.1837(a)(3).

review. The Providers for which the Board concluded it lack jurisdiction may appeal that decision under the provisions of 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877. Since this is the only issue under dispute, the Board hereby closes the cases on the attached list.

Board Members Participating

Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA

FOR THE BOARD:

Charlotte F Benson

Charlotte F. Benson, CPA
Board Member

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

cc: Byron Lamprecht, WPS (Certified Mail w/Schedule of Providers)
Wilson Leong, FSS (w/Schedule Providers)

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Refer to: 13-0316GC
Certified Mail

DEC 20 2016

Russell Kramer
Director
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150 N. Santa Anita Avenue
Suite 570A
Arcadia, CA 91006

RE: QRS HMA 2007 DSH Dual Eligible Days Group
Provider Nos. Various
FYE 2007
PRRB Case No. 13-0316GC

Dear Mr. Kramer:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' November 29, 2016 request for expedited judicial review (EJR) (received November 30, 2016) submitted for the above-referenced appeal. The decision of the Board is set forth below.

Issue

The Providers' request for EJR identified the issue subject to EJR as:

> . . . .whether the MAC should have excluded from the Medicare [disproportionate share hospital (DSH)] fraction non-covered patient days, i.e., days attributable to patients who were enrolled in Medicare and entitled to SSI, but for whom Medicare did not make a payment for their hospital stay, either because that patient's Medicare benefit days were exhausted, or because a third party made payment for that patient's hospital stay. The provider [sic] contends that these non-covered patient days should be excluded from the Medicare fraction. Provider [sic] further contends that these non-covered patient days should be treated consistently; that is, they should either be included in both the top and bottom of the SSI fraction, or excluded from both the top and bottom fraction.[1]

[1] Providers' November 29, 2016 EJR Request at 1.

Background

The August 11, 2004 Federal Register[2] the Secretary[3] responded to comments to the proposed inpatient prospective payment system (IPPS) rules regarding payment to DSH hospitals. With respect to dual eligible days the Secretary explained that:

> . . . the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits. If a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual-eligible and the patient days are included in the Medicare fraction of the DSH patient percentage but not the Medicaid fraction. This is consistent with the language of section 1886(d)(5)(F)(vi)(II)[4] of the Act, which specifies that patients entitled to benefits under Part A are excluded from the Medicaid fraction.
>
> It has come to our attention that we inadvertently misstated our current policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 (68 FR 27207). In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. Our policy has been that only covered patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (http://www.cms.hhs.gov/providers/ hipps/dual.asp) on July 9, 2004.
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> **********
>
> . . . the statute also requires that patient days attributable to patients entitled to benefits under Medicare Part A are to be excluded from the Medicaid fraction. [5]

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[2] 69 Fed. Reg. 48,916 (Aug. 11, 2004).
[3] of the Department of Health and Human Services.
[4] 42 U.S.C. § 1394ww(d)(5)(F)(vi)(II).
[5] 69 Fed. Reg. at 49,098.

The Providers' Request for EJR

The Providers explain that the applicable regulation requires that non-covered patient days be included in the Medicare fraction of the DSH calculation.[6] This was accomplished through the deletion of the word "covered" where is previously appeared in the definition of the Medicare fraction in 42 C.F.R. § 412.106(b)(2)(i).[7] Thus, the 2004 regulations required inclusion in the Medicare fraction of both exhausted benefit days and Medicare secondary payment days associated with patient discharges occurring on or after October 1, 2004.[8]

The Providers assert that the 2004 regulation mandating inclusion of non-covered exhausted benefit and Medicare secondary payor days in the Medicare fraction is invalid. The Providers believe that EJR is appropriate because the Board lacks the authority to order post 2004 non-covered exhausted benefit and Medicare secondary payor days to be removed from the Medicare fraction.[9]

The 2004 Regulations are Invalid Due to Lack of Adequate Notice and Comment

The Providers explain that this case involves the question of whether inpatient hospital days attributable to individuals who are eligible for both Medicare and Medicaid (hereinafter "dual eligibles") and for whom Medicare has not made a payment for that inpatient stay (hereinafter "non-covered days") should be included in the Medicare fraction of the DSH adjustment or should be excluded from the Medicare fraction of the DSH adjustment.

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), states that Medicaid eligible patients who are "entitled to benefits under [Medicare] Part A" should be included in the Medicare fraction of the DSH calculation. However, under the regulation promulgated in 2004, 42 C.F.R. § 412.106(b)(2)(i), Medicare enrollees are considered to be entitled to benefits under Part A even if their stay is not covered by Medicare Part A. As a result, the Providers note, the 2004 regulation required that non-covered days be included in the Medicare fraction of the DSH adjustment. The Providers believe that the 2004 regulation was improperly promulgated and should be vacated; and if the days are excluded from the Medicare fraction they must be included in the Medicaid fraction.[10]

The Providers explain that the case involves two types of non-covered days. The first category involves exhausted benefit days, which are patient days for individuals who are eligible for both Medicare and Medicaid, but who have exhausted their Medicare benefits during all or a portion of their hospitalization. The second category involves Medicare Secondary Payor (MSP) days. These are days for which a party other than Medicare, such as an employer health plan, made

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[6] *Id.* at 49098-9.
[7] *Compare* 42 C.F.R. § 412.106(b)(2)(i) (2003) verses 42 C.F.R. § 412.106(b)(2)(1) (2004)
[8] Providers' November 29, 2016 EJR Request at 2.
[9] *Id.*
[10] *Id.*

payment for the inpatient hospital stay. In both cases, Medicare does not pay for the inpatient hospital stay, and as such the days are not "covered" days.[11]

The Providers assert that the 2004 regulations should be vacated because the Secretary failed to adhere to the Administrative Procedure Act (APA) notice and comment procedures found at 5 U.S.C. § 553(b)-(c). They contend that the Agency may promulgate a rule that differs from a proposed rule only if the final rule is a logical outgrowth of a proposed rule.[12] The APA requires that the agency provide sufficient factual detail and rationale for the rule to permit interested parties to comment meaningful.[13]

The Providers believe the proposed rule was misleading as to the Secretary's policy with respect to non-covered days. Specifically, the Secretary's statement in the proposed IPPS rule that "[i]f a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible and the patient days are included in the Medicare fraction of the DSH patient percentage but not the Medicaid fraction."[14] The Providers opine that this sentence would cause a reasonable person to believe that the Secretary's prior policy was to include all dual eligible patient days in the Medicare fraction, including non-covered exhausted benefit days and Medicare secondary payor days. This was reinforce by the statement that the "current policy regarding dual eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[15] The Secretary failed to explain her rationale for departing from this policy in the final rule.[16] The change in the final rule cannot be viewed as a logical outgrowth of the proposed rule[17] nor is it a product of reasoned decision-making.[18]

Decision of the Board

Provider that Did Not Include a Notice of Program Reimbursement in Its Respective Jurisdictional Documents

The Provider listed below did not include the required of Notice Program Reimbursement[19] behind Tab A of its jurisdictional documents. Since this document is required to determine if the Provider's appeal is timely filed under 42 C.F.R. §§ 405.1835 and 405.1840, the appeal for #5 Seven Rivers Regional Medical Center (provider number 10-0249) is hereby dismissed from the case.

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[11] *Id.* at 3.
[12] *Ass'n of Private Sector Colleges & Universities v. Duncan*, 681 F. 3d 427, (D.C. Cir. 2012)
[13] Providers' EJR Request at 6-7.
[14] 68 Fed. Reg. 27,154, 27,207 (May 19, 2003)
[15] *Id.*
[16] Providers' EJR request at 8.
[17] *Id.* at 9-10.
[18] *Id.* at 10.
[19] *See* Provider Reimbursement Review Board Rules 20.1, 20.3 and 21 require the submission of a final determination of reimbursement. The Board's Rules can be found on the Internet at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB_Instructions.html.

Provider That Did Not Include the Issue in Its Hearing Request

In their individual hearing requests all but one of the Providers, # 1 Stringfellow Memorial Hospital ("Stingfellow"), included the issue below in their hearing requests and then transferred the issue to first case number 08-1382GC and then the current case 13-0316GC. The issue appearing in either the hearing request or the letter adding the issue to the Providers respective appeal is:

> The Provider contends that the Intermediary [now Medicare Administrative Contractor] did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(f)(vi(II). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, the Medicaid days proxy, set forth at 42 C.F.R. [§] 412.106(b)(4) of the Secretary's regulations.
>
> The Provider contends that the Intermediary failed to include all Medi-Medi patient days (patients who are eligible for Medicaid and have days paid and/or covered by Medicare) in the Medicare DSH calculation. These days should have been included in the Medicaid percentage of the DSH calculation. *See* 42 CFR § 412.106 and Section § [sic] 1886(d)(5)(F)(vi)(II) of the Social Security Act.

This is the issue that all of the Providers, with the exception of Stingfellow, transferred first to case number 08-1382GC and, subsequently, transferred a second time to this group appeal, case number 13-0316GC. Since Stringfellow Hospital (provider number 01-0028) did not include the issue that is the subject of the EJR in its initial appeal, the Board hereby dismisses the Provider from the case number 13-0316GC.

EJR Determination

The Board has reviewed the remaining Providers' requests for hearing and EJR. The regulation at 42 C.F.R. § 405.1842(a) permits the Board to consider whether it lacks the authority to decide a legal question relevant to the matter at issue once it has made a finding that it has jurisdiction to conduct a hearing under the provisions of 42 C.F.R. §§ 405.1840(a) and 405.1837(a) . The Board concludes that the remaining Providers timely filed their requests for hearing from the issuance of Notices of Program Reimbursement and the amount in controversy exceeds the $50,000 threshold necessary for a group appeal.[20] Consequently, the Board has determined that it has jurisdiction over remaining Providers' appeals. This issue involves a challenge to the validity of the regulation, 42 C.F.R. § 412.106(b)(2)(i). Further, the Board finds that it lacks the

[20] *See* 42 C.F.R. § 405.1837(a)(3).

authority to decide the legal question of whether 42 C.F.R. § 412.106(b)(2)(i) is valid; therefore, EJR is appropriate for the issue under dispute in this case.

The Board finds that:

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

2) based upon the remaining Providers' assertions regarding the validity of 42 C.F.R. § 412.106(b)(2)(i)there are no findings of fact for resolution by the Board;

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

4) it is without the authority to decide the legal question of whether 42 C.F.R. § 412.106(b)(2)(i) is valid.

Accordingly, the Board finds that the issue regarding the validity of 42 C.F.R. § 412.106(b)(2)(i) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the remaining Providers' request for expedited judicial review for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. The Provider for which the Board dismissed for lack of jurisdiction can appeal this determination under the provisions of 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877. Since this is the only issue under dispute, the Board hereby closes the case.

Board Members Participating

Clayton J. Nix, Esq.
L. Sue Anderson, Esq.
Charlotte F. Benson, CPA

FOR THE BOARD:

Charlotte F. Benson

Charlotte F. Benson, CPA
Board Member

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

cc: Byron Lamprecht, WPS (Certified Mail w/Schedule of Providers)
Wilson Leong, FSS (w/Schedule Providers)

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

Refer to:

DEC 22 2016

Certified Mail

Nina Adatia Marsden, Esq.
Hooper, Lundy & Bookman
1875 Century Park East, Suite 1600
Los Angeles, CA 90067-2517

RE: Hooper Lundy & Bookman FFY 2016 Two Midnight
0.2 Percent IPPS Payment Reduction Groups
Case Numbers: 16-0782GC, 16-0783GC, 16-0784GC, 16-0785GC, 16-0786GC, 16-0787GC, 16-0788GC, 16-0790G, 16-0792GC, 16-0801GC, 16-0802GC, 16-0803GC, 16-0804GC, 16-0805GC, 16-0806GC, 16-0807GC
Expedited Judicial Review Decision

Dear Ms. Marsden:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' December 6, 2016 request for expedited judicial review (EJR) (received December 7, 2016). The Board's decision is set forth below.

Background

Issue Under Appeal

The Providers are challenging the 0.2 percent reduction to Medicare Inpatient Prospective Payment System (IPPS) rates for inpatient discharges at all IPPS hospitals, including the Providers, occurring on and after October 1, 2015, set forth by the Centers for Medicare and Medicaid Services ("CMS") in the FFY [Federal fiscal year] 2016 IPPS Final Rule (the "2016 IPPS Final Rule")[1] and discussed in the Calendar Year [("CY")] Outpatient Prospective Payment System (OPPS) Final Rule").[2]

Statutory and Regulatory Background

In the final IPPS rule for FFY 2014, the Secretary of Health and Human Services ("Secretary") indicated that she had expressed concern in the proposed CY OPPS rule[3] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving observation services. In recent years, the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours increased from approximately 3 percent in 2006 to 8 percent in 2011. This

[1] 80 Fed. Reg. 49,326 (Aug. 17, 2015).
[2] 80 Fed. Reg. 70,298 (Nov. 13, 2015).
[3] 77 Fed. Reg. 45,061, 45,155-57 (July 30, 2012) and the final rule with comment period, 77 Fed. Reg. 68,210, 68,426-33 (Nov. 15, 2012).

raised a concern about the financial impact on Medicare beneficiaries who may incur greater financial liability than they would if they were admitted to the hospital as inpatients.[4]

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

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

Medicare Part A

In addition, the Secretary reviewed hospital inpatient status criteria to improve CMS' policies governing when a Medicare beneficiary should be admitted as an inpatient and how hospitals should be paid for associated costs. The Medicare Benefit Policy Manual[7] states that the typical decision to admit a beneficiary as an inpatient should be made within 24 to 48 hours after observation care and that an overnight stay may be a factor in the admission decision. Physicians should use the 24-hour or overnight period as a benchmark, i.e., patients who are expected to need care for 24 hours or overnight should be admitted. Generally, a beneficiary is considered an inpatient if formally admitted with the expectation that he or she will remain in the hospital overnight, regardless of whether there is a later transfer or discharge resulting in no overnight patient stay. Only rarely and in exceptional cases do reasonable and necessary observation services span more than 48 hours. Length of stay is not the sole basis for payment; it is the physician responsible for patient care who determines if the patient should be admitted.[8]

In the FFY 2014 IPPS proposed rule,[9] the Secretary proposed a new benchmark for purposes of medical review of hospital inpatient admissions (Medicare Part A payment). Under this

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[4] 78 Fed. Reg. 50,496, 50,907 (Aug. 19, 2013).
[5] *Id.*
[6] *Id.*
[7] CMS Pub. 100-02, Chapter 6, § 20.6 and Chapter 1, § 10.
[8] 78 Fed. Reg. at 50,907-08.
[9] *See generally* 78 Fed. Reg. 27,486 (May 10, 2013).

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

Medicare Part B

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

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

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[10] 78 Fed. Reg. 50,908.
[11] *Id.*
[12] *See* 78 Fed. Reg. 16,614 (Mar. 18, 2013), http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings.html.
[13] 78 Fed. Reg. at 50,909.
[14] *Id.* at 50,927.

The 2-Midnight Rule

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

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

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

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[15] *Id.* at 50,944.
[16] *Id.*
[17] *Id.* at 50,945.
[18] *Id.* at 50,952-53.

projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[19] In the final IPPS rule for 2015, the Secretary did not reverse the 0.2 percent reduction to the standardized amount made in 2014, and, therefore, continued to apply the contested reduction for the FFY 2015 period.[20]

Providers' Position

In the FFY 2016 IPPS Final Rule, the Providers note that the Secretary failed to eliminate the allegedly improper 0.2 percent reduction to all IPPS payments to offset the expected increase in national inpatient reimbursement under IPPS due to implementation of the 2-midnight policy, thereby carrying the reduction forward to FFY 2016. The Providers point ot that the Secretary avoided any discussion of the 0.2 percent reduction in the FFY 2016 IPPS Proposed Rule, stating that it expected to include a discussion of "the broader set of issues related to short inpatient hospital stays, long outpatient stays with observation services, and the related -0.2 percent IPPS payment adjustment in the CY 2016 hospital outpatient prospective payment system proposed rule that will be published this summer."[21]

Even though the Secretary failed to address the reduction in the FFY 2016 IPPS Proposed Rule, interested parties still submitted comments to the Proposed Rule to object to the Secretary finalizing the continuation of the reduction without providing the public with the data requested by the commenters, which the Secretary had in her possession at the time the FFY 2016 IPPS Proposed Rule was published. Nonetheless, and without any response whatsoever to these comments, the Secretary maintained the 0.2 percent reduction in the FFY 2016 IPPS Final Rule.[22] Further, when the Secretary issued the CY 2016 OPPS Proposed Rule, the Secretary offered new data and a new rationale for the IPPS payment rate reduction.[23] The Providers believe that the hospital industry offered robust comments to the Secretary's discussion of the reduction that appeared in the CY 2016 OPPS Proposed Rule. Most notably, commenters pointed out that the data the Secretary presented clearly indicated that the volume of discharges had done the opposite of what the Secretary assumed they would do in support of the rate reduction – that is, discharges in every length-of-stay stratum actually decreased rather than increased. Instead of responding to these comments in the CY 2016 OPPS Final Rule, the Secretary delayed again, indicating that she would respond in December 2015 via another publication.[24]

The Administrative Procedure Act (APA) prohibits "agency action, findings, and conclusions found to be... arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law . . . in excess of statutory jurisdiction, authority, or limitations, or short of statutory right . . . [or] without observance of procedure required by law."[25] The Providers challenge the FFY 2016 0.2 percent reduction because it: (1) exceeds the Secretary's statutory authority; (2) was

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[19] *Id.* at 50,990.
[20] 79 Fed. Reg. 49,854, 50,382-83 (Aug. 22, 2014).
[21] 80 Fed. Reg. 24,324, 24,523 (April 30, 2015).
[22] *See* 80 Fed. Reg. 49,325 *et seq.* (Aug. 17, 2015).
[23] 80 Fed. Reg. 39,200, 39,369-39,370 (July 8, 2015).
[24] 80 Fed. Reg. 70,298, 70,594-70,595 (November 13, 2015).
[25] 5 U.S.C. § 706(2).

developed in an arbitrary and capricious manner; (3) lacks support from substantial evidence, including that the data available to the Secretary at the time she finalized the FFY 2016 IPPS payment rates dictated that the adjustment should have been positive rather than negative; (4) was adopted without appropriate notice for meaningful comment; and (5) is otherwise defective both procedurally and substantively under the Administrative Procedure Act ("APA"), 5 U.S.C. § 551 *et seq.*, and other authorities.

On September 21, 2015, in the consolidated case involving the Providers' challenge to the FFY 2014 reduction, the Court held that the Secretary had failed to disclose to the public critical assumptions in her methodology for the reduction and ordered the Secretary to provide an additional notice with comment period in which the Secretary would identify these assumptions and offer the public an opportunity to comment.[26] The Secretary published the required notice on December 1, 2015.[27] Following the receipt of the public's comments in response to the December 1, 2015 notice, the Secretary published the FFY 2017 IPPS Proposed Rule, in which she proposed that she would permanently remove the 0.2 percent reduction related to the two-midnight rule beginning in FFY 2017 and temporarily increase rates for FFY 2017 to address the effect of the 0.2 percent reduction it applied to rates in FFY 2014, FFY 2015, and FFY 2016.[28] The Secretary finalized her proposal in the FFY 2017 IPPS Final Rule.[29] Nonetheless, the Secretary's remedy does not pay hospitals what they lost in reimbursement for FFY 2016 due to the reduction because it: (1) purports to base its payback on discharges in FFY 2017, not the discharges that actually occurred in FFY 2016; (2) has made only partial payment at this time; and (3) ignores the data that clearly indicates the adjustment in question should have been a positive and not a negative adjustment from the outset. As the appeal for FFY 2016 is currently postured, the Providers have not been paid the amounts they are owed for FFY.

The Providers argue that the Secretary lacks the statutory authority to apply the 0.2 percent reduction because it violates the Medicare statutes and regulations that require precise reimbursement methodologies. Provisions of the Medicare statute and regulations (*e.g.*, 42 U.S.C. §§ 1395ww(d)(1), (3), (5)(D), and (5)(G), and 42 C.F.R. §§ 412.308(c)(1)(ii) and 412.312(b)(3)) specifically state the calculation of the standardized amount for operating costs, the hospital-specific rates for sole community and Medicare-dependent hospitals, and the Federal rate for capital costs do not permit an across-the-board 0.2 percent inpatient payment reduction. The 0.2 percent reduction improperly disregards these mandatory provisions, thus exceeding the Secretary's statutory authority. Further, 42 U.S.C. § 1395ww(d)(5)(I)(i) does not create a broad exception allowing for the 0.2 percent reduction to IPPS. The reduction is inconsistent with the structure and intent of IPPS because it effectively leave providers uncompensated for medically necessary covered services provided to beneficiaries.

The Providers contend, among other things, that the 0.2 percent reduction violates the APA because:

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[26] *Shands Jacksonville Medical Center v. Burwell*, 139 F. Supp. 3d (D.D.C. Sept. 21, 2015).
[27] *See* 80 Fed. Reg. 75,107 (Dec. 1, 2015).
[28] *See* 81 Fed. Reg. 24,946, 25,136-25,138 (April 27, 2016).
[29] *See* 81 Fed. Reg. 56,762, 57,058-57,060 (August 22, 2016).

(1) The Secretary failed to furnish pertinent data and methodologies that lead to the conclusion that the 2-midnight policy would increase IPPS expenditures due to net increased inpatient admissions;

(2) The Secretary improperly excluded medical cases in her calculation of how many patients would shift from inpatient to outpatient.

(3) The Secretary failed to adequately explain and provide data, methodologies, assumptions and calculations that led to the 0.2 percent reduction.

The Providers believe that EJR is appropriate because the Board has jurisdiction over the appeals but lacks the authority to grant the relief sought by the Providers.

Decision of the Board

The Board has reviewed the Providers' requests for hearing and EJR. The regulation at 42 C.F.R. § 405.1842(a) permits the Board to consider whether it lacks the authority to decide a legal question relevant to the matter at issue once it has made a finding that it has jurisdiction to conduct a hearing under the provisions of 42 C.F.R. §§ 405.1840(a) and 405.1837(a). The Board concludes that the Providers timely filed their requests for hearing from the issuance of the August 17, 2015 Federal Register[30] and the amount in controversy exceeds the $50,000 threshold necessary for a group appeal.[31] Consequently, the Board has determined that it has jurisdiction over Providers' appeals. This issue involves a challenge to the application of the 0.2 percent reduction, for which the promulgation background is found in the proposed and final rules published in the Federal Register. Further, the Board finds that it lacks the authority to decide the legal question of whether the 0.2 percent adjustment to IPPS is appropriate; therefore, EJR is appropriate for the issue under dispute in these cases.

The Board finds that:

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

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

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[30] *Washington Hospital Center v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986) ([A] year end cost report is not a report necessary in order for the Secretary to make PPS payments, and the appeals provisions applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal) and *District of Columbia Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993), *Medicare & Medicaid Guide* (CCH) ¶ 41,025 (publication of the wage index in the Federal Register is a final determination which can be appealed to the Board).

[31] *See* 42 C.F.R. § 405.1837(a)(3).

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

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

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

Board Members Participating

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FOR THE BOARD:

Charlotte F Benson for

Michael W. Harty
Chairman

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

cc: Wilson C. Leong, Federal Specialized Services (w/Schedules of Providers)
Evaline Alcantara, Noridian Healthcare Solutions (Certified Mail w/Schedules of Providers)
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DEC 29 2016

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James Lowe
Cahaba Safeguard Administrators, LLC
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Morrisville, NC 27560-2008

RE: Pomerado Hospital
Provider No.: 05-0636
FYE: 6/30/10
PRRB Case No.: 14-1739

Dear Ms. Oliva and Mr. Lowe,

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

Background

The Provider submitted a request for hearing on January 15, 2014, based on a Notice of Program Reimbursement ("NPR") dated July 24, 2013. The hearing request included nine[1] issues, five of which were subsequently transferred to group appeals, two of which were withdrawn, and one of which was resolved in a Partial Administrative Resolution dated March 9, 2016.[2] The Medicare Contractor filed a jurisdictional challenge on four issues in the appeal on February 25, 2016.[3] The Provider filed a responsive brief on March 24, 2016.

[1] The Provider's hearing request listed eight issues; Issue No. 1 actually contained two issues, bringing the total to nine.
[2] The Provider's Final Position Paper dated October 21, 2015 shows four outstanding issues: Issue No. 1B – Understatement of Outlier Payments, Issue No. 2 – Medicare Disproportionate Share Hospital (DSH) Payment – Additional Medicaid Eligible Days, Issue No. 7 – Medicare Bad Debt Reimbursement – 2% Share of Cost, and Issue No. 8 – Medicare Bad Debt Reimbursement. Issue No. 2 was withdrawn in a letter to the Board on February 23, 2016 and Issue No. 3 was resolved in the Partial Administrative Resolution.
[3] The Medicare Contractor challenged Issue No. 1B – Understatement of Outlier Payments. This issue was transferred to PRRB Case No. 16-1066GC - Palomar Pomerado Health 2010 Understatement of Outlier Payments CIRP Group. The challenge and the transfer will be addressed herein. The Medicare Contractor also challenged Issue No. 3 – Medicare Disproportionate Share Hospital (DSH) Payments – Inclusion of Medicare Dual Eligible Part A Days in the SSI Ratio Issued March 16, 2012 and Issue No. 4 – Medicare Disproportionate Share Hospital (DSH) Payments – Inclusion of Medicare Dual Eligible Part C Days in the SSI Ratio Issued March 16, 2012. The Provider submitted requests to transfer these issues to PRRB Case No. to PRRB Case No. 15-0462 - GNP/Palomar Health 2010 DSH SSI Ratio Medicare Dual Eligible Part A Exh/Non-Paid Days CIRP Group and PRRB Case No. 15-0461GC - GNP/Palomar Health 2010 DSH SSI Ratio Medicare Dual Eligible Part C Days CIRP Group respectively. The challenges will be addressed in the group appeals. Finally, the Medicare Contractor challenged Issue No. 8 – Medicare Bad Debt Reimbursement which will be addressed herein.

Medicare Contractor's Position

Issue No. 1B – Understatement of Outlier Payments

The Medicare Contractor contends that adjustments 1 and 27, cited by the Provider in its Final Position Paper, do not render a determination over the outlier fixed loss threshold. The outlier fixed loss threshold is not an item or amount reported on the cost report. Rather, it is an amount set by the Secretary in the Federal Register that determines whether a Provider receives an outlier payment reimbursement. The Medicare Contractor does not have the authority to make any changes to the outlier fixed loss threshold.[4]

The Medicare Contractor explains that the Provider filed its cost report identifying $10,000 of Part A protested amounts. The Medicare Contractor removed the Part A protested amounts via adjustment 25. The Medicare Contractor argues that a review of the Provider's high-level summary of protested items submitted with the as-filed cost report shows that the Provider did not establish a self-disallowed item for the outlier fixed loss threshold.[5] Therefore, the Provider did not preserve its right to claim dissatisfaction for this issue as a self-disallowed item in accordance with 42 C.F.R. § 405.1835(a)(1)(ii).[6]

Issue No. 8 – Medicare Bad Debt Reimbursement

The Medicare Contractor explains that the Provider is disputing the amount of reimbursement it received for crossover bad debts. The Medicare Contractor states that the Provider contends that the crossover bad debts were understated due to additional claims that were processed and disputes adjustments 1, 23, 24, 29 and 30.[7]

The Medicare Contractor contends that adjustments 1, 23, 24, 29 and 30 do not render a final determination over the additional crossover bad debts. The Medicare Contractor states that the Provider is unable to show that the disputed bad debts were claimed on the cost report (or presented) and then disallowed by the Contractor. Because they were not claimed, the Medicare Contractor did not render a final determination over them.[8]

Additionally, the Medicare Contractor explains that the Provider filed its cost report identifying $10,000 of Part A protested amounts. The Medicare Contractor removed the Part A protested amounts via adjustment 25. The Medicare Contractor argues that a review of the Provider's high-level summary of protested items submitted with the as-filed cost report shows that the Provider did not establish a self-disallowed item for the additional crossover bad debts.[9] Therefore, the Provider did not preserve its right to claim dissatisfaction for this issue as a self-disallowed item in accordance with 42 C.F.R. § 405.1835(a)(1)(ii).[10]

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[4] Medicare Contractor's jurisdictional challenge at 5.
[5] Medicare Contractor's jurisdictional challenge, Exhibit D.
[6] Medicare Contractor's jurisdictional challenge at 9.
[7] *Id.* at 12.
[8] *Id.* at 13.
[9] Medicare Contractor's jurisdictional challenge, Exhibit D.
[10] Medicare Contractor's jurisdictional challenge at 13.

Provider's Position

Issue No. 1B – Understatement of Outlier Payments

As the Provider requested to transfer this issue to PRRB Case No. 16-1066GC, the Provider did not respond to the jurisdictional challenge.

Issue No. 8 – Medicare Bad Debt Reimbursement

The Provider contends that the NPR issued on July 24, 2013 constitutes a final determination by the Medicare Contractor with respect to the provider's cost report. In 42 C.F.R. § 405.1801(a)(2), it defines a final determination as follows: "An intermediary determination is defined as a "determination of the total amount of payment due to the hospital, pursuant to § 405.1803 following the close of the hospital's cost reporting period…"[11]

The Provider contends that the Medicare Contractor made audit adjustments that revised the as-filed Medicare Part A crossover bad debt on Worksheet E Part A Line 21 from $245,000 to $245,300, per audit adjustment number 23, and the as-filed Medicare Part B crossover bad debt on Worksheet E Part B line 27 from $0 to $256,344 per audit adjustment number 27. These adjustments created Provider dissatisfaction with the amount of Medicare crossover bad debt reflected in the Provider's NPR.[12]

The Provider explains that all Medicare crossover bad debt claimed on the Provider's FYE 6/30/2010 Medicare cost report were processed by the State of California's Department of Health Care Services (DHCS) to ensure the state was not obligated to pay a portion of the Medicare beneficiary's unpaid coinsurance or deductible amount. The processing of Medicare crossover debt claims applicable to the Provider's FYE 6/30/2010 Medicare beneficiaries can continue long after the Provider's FYE 6/30/2010 Medicare cost report is filed. In this case DHCS adjusted their payment determination on the Provider's Medicare bad debt claims after the filing of the Provider's FYE 6/30/2010 Medicare cost report. Consequently, had DHCS completed their bad debt payment adjustments in a more timely manner prior to the filing of the Provider's Medicare cost report, the Provider would have reported $247,468 of allowable Medicare inpatient bad debt on Worksheet E, Part A Line 21 and $263,819 of allowable Medicare outpatient bad debt on Worksheet E, Part B, Line 27.[13]

The Provider maintains the position the Board's authority is set forth in 42 U.S.C. § 1395oo(a). This section of the statute gives the Board the power to affirm, modify, or reverse the final determination of the Medicare Contractor with respect to the cost report and make other revisions to matters covered by the cost report. In short, the Board has the authority to reach a conclusion on an issue that achieves equity.[14]

The Provider argues that under the Medicare Contractor's narrow interpretation of 42 C.F.R. §405.1835(a)(1)(i) a Provider is entitled to appeal only those Medicare crossover bad debts (i.e.

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[11] Provider's jurisdictional response at 2 (Emphasis included).
[12] *Id.* at 4.
[13] *Id.*
[14] *Id.*

numerical values per the Medicare Contractor's interpretation in this case) that were specifically present in the filed cost report, irrespective of the fact that additional Medicare crossover bad debt that is unknown to the provider at the time of its cost report filing could be identified after the cost report is filed. The Provider contends that the Medicare Contractor's narrow interpretation is inconsistent with the regulatory language at 42 C.F.R. § 405.1835(a)(1)(i) which requires the Provider to make a claim for specific items(s), not specific numerical values, on its cost report where the Provider seeks payment (i.e. must include a claim of Medicare crossover bad debt on the filed cost report). The Medicare Contractor's narrow interpretation, if erroneously upheld, would trump the Board's statutory authority to modify a final determination of the Medicare Contractor for purposes of making a proper payment determination in situations where the proper numerical value is in dispute. This could potentially lead to payment inequities between a Provider and the Medicare Program.[15]

The Provider contends that Congressional authority given to the Board in statute 42 U.S.C. § 1395oo(a) to modify a final determination of the Medicare Contractor cannot be superseded by a CMS regulation. Only Congress has this authority. If there is a conflict between the two, the statute must prevail. The Medicare Contractor's reliance on upon 42 C.F.R. § 405.1835 (a)(1)(i) is misguided as this regulation did not exist at the time the Provider filed its appeal request.[16]

Board's Decision

Issue No. 1B – Understatement of Outlier Payments and Issue No. 8 – Medicare Bad Debt Reimbursement

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2009), 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 jurisdictional issue presented here is whether or not this hospital has preserved its right to claim dissatisfaction with the amount of Medicare payment. "A provider. . . has a right to a Board hearing . . . only if – (1) the provider has preserved its right to claim dissatisfaction.....by.....[i]ncluding a claim for specific item(s) on its cost report...or...self-disallowing the specific item(s) by....filing a cost report under protest.....[17]

The Board concludes that it does not have jurisdiction over the Outlier Payments issue or the Medicare Bad Debt issue because the Provider's appeal does not comply with the requirements of 42 C.F.R. § 405.1835(a)(1)(i) (2009) or 42 C.F.R. § 405.1835(a)(1)(ii) (2009).

Effective with cost report periods that end on or after December 31, 2008, CMS amended the regulations governing cost report appeals to incorporate Provider Reimbursement Manual (PRM) 15-2 § 115 *et seq.* into the regulations at 42 C.F.R. §405.1835(a)(1)(ii) (2009) by specifying that, where a provider seeks payments that it believes may not be allowable or may not be in accordance with Medicare policy, the provider must claim the items as self-disallowed costs "by following the applicable procedures for filing

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[15] *Id.* at 4-5 (Emphasis included).
[16] *Id.* at 5.
[17] 42 C.F.R. § 405.1835(a).

a cost report under protest." Here, the Provider's cost report was for FYE June 30, 2010; therefore, any self-disallowed items are required to be protested.

In reviewing the composition of the Provider's Hospital Part A protested amount as evidenced in Exhibit D of the Medicare Contractor's jurisdictional challenge the Board finds that the Provider failed to file the Outlier Payments issue under protest. Therefore, the Provider failed to preserve its rights to claim dissatisfaction. The Board concludes that it does not have jurisdiction over the Outlier Payments issue as there was no adjustment related to the issue and the issue was not properly protested and dismisses the issue from the appeal. The Provider's request to transfer the issue to PRRB Case No. 16-1066GC is denied.

The Board finds that it is undisputed that the Provider did not include the additional Medicare crossover bad debts in its as-filed cost report. Additionally, the Board finds that there is no evidence in the record that the Provider included a protested amount on its as-filed cost report related to the additional Medicare bad debts it believed it would be due. The Provider says "it would have claimed" the bad debts if the State would have processed timely, but did not. They could have protested, however, and failed to do so. The Medicare Contractor did make an adjustment to increase bad debts. Nothing in the record shows the bad debts in question were presented on audit. Therefore, the Board concludes that it does not have jurisdiction over the additional Medicare crossover bad debts under 42 U.S.C. § 1395oo(a) or § 1395oo(d) as they were not claimed for payment or properly protested. Consequently, the Board dismisses the issue from the appeal.

In considering jurisdiction over the Outlier Payments and Additional Medicare Bad Debts issues, the Board acknowledges the recent United States District Court for the District of Columbia in *Banner Heart Hosp. v. Burwell* (DDC August 19, 2016). The Board finds that as the Court did not invalidate the regulation, the Board remains bound by the regulation, which requires either a claim for payment on the cost report or reporting as a protest item.[18]

As no issues remain in the appeal, the Board hereby closes the case and removes it 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.

[18] *Banner Heart Hosp. v. Burwell* (DDC August 19, 2016). The District Court in *Banner* concluded that the Board "violates the administrative appeal provision of the Medicare statute and the key Supreme Court precedent interpreting it, *Bethesda*" *Bethesda* emphasizes the futility of presenting a legal challenge to an intermediary when the intermediary has no authority to entertain or decide such challenges. Here, the Provider has challenged the outlier regulation, which is the same issue in Banner, as well as appealed additional bad debts. The Provider has not documented that it would have been futile to claim the bad debts. Therefore, the Board finds for the bad debt issue, the Provider would stand on "separate" ground than those in *Bethesda*, as it was not futile (i.e., the provider was barred by neither statute nor regulation) to make the claim. Under the 2008 regulation, the Board is not able to grant jurisdiction over the additional bad debts without the specific claim, but under the *Bethesda* test, the Provider still fails.

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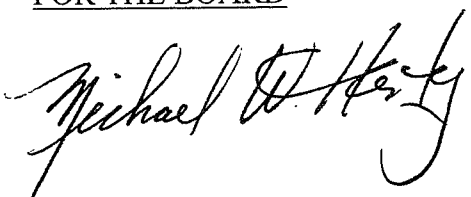
FOR THE BOARD



Michael W. Harty
Chairman

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

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DEC 29 2016

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RE: Bismarck MedCenter One Hospital
Provider No.: 35-0015
FYE: 12/31/10
PRRB Case No.: 14-3489

Dear Mr. Ravindran and Mr. Ward,

The Provider Reimbursement Review Board ("Board") has reviewed jurisdiction in the above-captioned appeal. The Board's jurisdictional decision is set forth below.

Background

The Provider submitted a request for hearing on May 16, 2014, based on a Notice of Program Reimbursement ("NPR") dated January 13, 2014. The hearing request included nine issues, six of which were subsequently transferred to group appeals. Three issues remain in the appeal: Issue 1 – SSI (Provider Specific), Issue 3 – Additional Eligible Days, and Issue 9 – Rural Floor Budget Neutrality Adjustment (RFBNA). The Medicare Contractor submitted a jurisdictional challenge on Issue 1 and Issue 3 on April 29, 2015. The Provider submitted a responsive brief on May 26, 2015.

Medicare Contractor's Position

The Medicare Contractor contends the Boards lacks jurisdiction over two of the remaining three appealed issues, SSI (Provider Specific) and Additional Eligible Days.

Issue 1 - SSI (Provider Specific)

The Medicare Contractor contends that the SSI (Provider Specific) issue and the SSI (Systemic Errors), which was transferred to group appeal 14-1815G, are identical. The Medicare Contractor referenced Board Rule 4.5 which states that "(a) Provider may not appeal an issue from a final determination in more than one appeal." The Medicare Contractor asserts that since the SSI issues appear to be identical, the Provider now has the same issue in a group appeal and an individual appeal. For this reason, the Medicare Contractor requests that the Board dismiss the SSI (Provider Specific) issue from the individual appeal as duplicative.

Issue 3 - Additional Eligible Days

The Medicare Contractor contends the Provider did not protest the Additional Eligible Day issue on W/S E part A. The Medicare Contractor cites to 42 CFR § 405.1835(a)(1)(ii), which states, effective with cost reporting periods ending on or after December 31, 2008, a provider that wishes to appeal a self-disallowed item must report the item as a protested amount on its cost report. The Medicare Contractor asserts that the protested amount of $309, 232 relates to RFBNA issue. The Medicare Contractor asserts that the Provider failed to identify Additional Eligible Days as a protested amount on its as filed cost report in accordance with 42 CFR § 405.1835(a)(1)(ii). Therefore, the Provider did not preserve its right to claim dissatisfaction with this item.

Furthermore, the Medicare Contractor contends denying jurisdiction over Additional Eligible Days would be consistent with recent PRRB determinations covering cost reporting periods ending on December 31, 2008 and after. On February 11, 2014 the PRRB denied jurisdiction over the additional Title XIX days issue in PRRB case no. 08-2838. In PRRB case no. 08-2838 jurisdiction was denied because the Provider did not claim those specific additional days or claim a protested amount related to those specific additional days.[1] The Medicare Contractor contends that the cited case is similar to the current PRRB case no. 14-3489 and consequently jurisdiction over Additional Eligible Days should be denied as well.

Provider's Position

Issue 1 - SSI (Provider Specific)

The Provider contends that the SSI (Provider Specific) and the SSI (Systemic Errors) are separate and distinct. Under the SSI (Provider Specific) issue the Provider is not only addressing a realignment of the SSI percentage, but also addressing various errors of omission and commission that do not fit into the "systemic errors" category. The Provider further asserts that this is an appealable item because the Medicare Contractor specifically adjusted the Provider's SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year 2010 as a result of its understated SSI percentage.

Additionally, the Provider asserts that the SSI (Provider Specific) and the SSI (Systemic Errors) issues are based on different legal basis and should be treated as separate and distinct issues. The Provider contends that the Medicare Contractor's determination of Medicare Reimbursement for their DSH Payments is not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(i). The Provider further contends that the SSI percentages calculated by CMS and used by the Medicare Contractor to settle their Cost Report does not address all the deficiencies and incorporates a new methodology inconsistent with the Medicare statute.[2]

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[1] The key issue in PRRB case no. 08-2838 was, whether the Board had jurisdiction over a claim for Medicaid eligible days for which there was no adjustment made by the Intermediary within the Notice of Program Reimbursement. The Board found that: (1) a provider does have an obligation to submit Medicaid eligible days information as part of the cost reporting process; and (2) this obligation is separate and distinct from the DSH adjustment determination process handled by its intermediary.

[2] The Provider cites to *Baystate Medical Center v. Leavit*, 545 F. Supp. 2d 20, as amended, 587 F. Supp. 2d 37, 44 (D.D.C. 2008). This case describes the deficiencies with SSI percentage calculations.

Issue 3 - Additional Eligible Days

The Provider contends that although not necessary, the Medicare Contractor specifically adjusted the Provider's DSH payments and the Provider is dissatisfied with its DSH reimbursement. In this case the adjustment was made to the Provider's DSH with Audit Adjustment Number 42.[3] The Provider asserts that such an adjustment is enough to warrant the Board jurisdiction over this appeal issue. However, the Provider contends that the adjustment is not required, as DSH is not an item that had to be adjusted or claimed on a cost report. Therefore, the presentment requirement does not apply, but should the Board determine it does apply, the Provider contends this requirement is not valid. In addition, the documentation necessary to pursue DSH is often not available from the state in time to include all DSH/Medicaid Eligible Days on the cost report. Accordingly, the Provider also self-disallowed DSH in the cost report in accordance with Board Rule 7.2(B). The Provider requests that the Board find it has jurisdiction over PRRB case no. 14-3489.

Board's Decision

The Board concludes that it lacks jurisdiction over the three issues remaining in the appeal.

Issue 1 - SSI (Provider Specific)

The Board finds that the first portion of the SSI (Provider Specific) issue is covered by the issue as stated in the SSI (Systemic Errors) issue statement. The SSI (Provider Specific) issue statement states that the Provider is dissatisfied because "the Medicare Contractor did not determine Medicare DSH reimbursement in accordance with the Statutory Instructions. Specifically, the Provider disagrees with the Medicare Contractor's calculation of the computation of the DSH percentage." The explanation of the issue in the issue statement is duplicative of the SSI Systemic Errors issue. The SSI (Systemic Errors) issue statement also states that "the Secretary improperly included... days in the SSI Fraction" and "the Secretary used an improper method...in computing the SSI Fractions." The SSI (Systemic Errors) issue was transferred to a group appeal and no longer remains pending in this individual appeal. The Board finds that the DSH/SSI (Provider Specific) issue is duplicative of the issue the Provider is appealing in PRRB Case No. 14-1815G - QRS 2010 DSH SSI Percentage (Baystate) Group. As such, the Board concludes that it does not have jurisdiction over the issue and dismisses it from the appeal.

The DSH/SSI (Provider Specific) issue statement also states, "The Provider also hereby preserves its right under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period." Under 42 C.F.R § 412.106(b)(3), a provider may use its cost reporting period data instead of the federal fiscal year data in determining the DSH Medicare fraction. If a hospital decides to use its own cost reporting period, it then must submit a written request to the Medicare Contractor. Without this request, it is impossible for the Medicare Contractor to issue a final determination from which the Provider could appeal. In addition, even if the Provider had requested a SSI realignment based on its own cost reporting data, 42 C.F.R. § 412.106(b)(3) states that the provider must use that data from its cost reporting year; there is no appeal right from a realignment request. The Board also

[3] Provider's Jurisdictional Response at Exhibit 1.

concludes that it does not have jurisdiction over the SSI (Provider Specific) Issue as there is no final determination with which the Provider could be dissatisfied.

Issue 3 – Additional Eligible Days

Effective with cost report periods that end on or after December 31, 2008, (The cost reporting period in dispute is 12/31/10) CMS amended the regulations governing cost report appeals to incorporate Provider Reimbursement Manual (PRM) 15-2 § 115 *et seq.* into the regulations at 42 C.F.R. §405.1835(a)(1)(ii) (2009) by specifying that:

> (a) Criteria. A provider (but no other individual, entity, or party) has a right to a Board hearing as a single provider appeal, for specific items claimed for a cost reporting period covered by a Intermediary or Secretary determination, only if –
> (1) The provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue, by either –
> (i) Including a claim for specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or
> (ii) Effective with cost reporting periods that ends on or after December 31, 2008, self-disallowing the specific item(s) by following the applicable procedures for filing a cost report under protest, where a provider seeks payments that it believes may not be allowable or may not be in accordance with Medicare policy.

The Board finds that the Provider did not make a claim for the Medicaid days in dispute in this appeal and the Medicare Contractor did not make an adjustment to remove any Medicaid days from the cost report. Furthermore, Board finds that the Provider did not file any Medicaid days under protest on the W/S E Part A protest line. Finally, in its appeal request, the Provider included a statement that the Provider self-disallowed Medicaid eligible days.

Therefore, the Board concludes that the Provider failed to preserve its right and lacks any legal basis to appeal the item to the Board under 42 C.F.R. § 405.1835(a)(1)(i) or (ii). The Provider argues that the 2008 regulation requiring a provider to claim an item on its cost report in order to preserve its appeals rights is inconsistent with the PRRB statute; however, the Board is bound by the regulation and concludes that the Provider failed to meet it. Accordingly, the Board concludes that it does not have jurisdiction over the Additional Eligible Days issue and dismisses it from the appeal.

Issue 9 - RFBNA

Although the Medicare Contractor did not challenge jurisdiction over the issue, the Board concludes that it does not have jurisdiction over the RFBNA issue because the Provider did not claim the cost on the cost report or include it as a protested item. The Medicare Contractor comments in its jurisdictional challenge that the Provider protested the RFBNA costs,[4] however the documentation submitted by the Provider in the appeal does not support this assertion. Audit Adjustment 38 identifies that the Provider included $309,232 in protested amounts, which the Medicare Contractor removed.[5] The Provider

[4] Medicare Contractor's Jurisdictional Brief at 3.
[5] Appeal Request, Tab 4.

submitted a document entitled "Total Estimated Impact Summery" with its appeal request[6], which identifies that the impact of all the issue to be $717,242 in total, and that the impact of the RFBNA amount in controversy to be $344,678. Neither the total of $717,242 nor the impact of just the RFBNA adjustment tie to the protested amounts. Based on these facts, the Board finds that the Provider has failed to document that the $309,232 reported on its cost report as a protested item, included a claim for the RFBNA issue, now estimated to be worth $344,678. As such, the Board concludes that it does not have jurisdiction over the issue and dismisses it from the appeal.

As no issues remain in the appeal, the Board hereby closes the case and removes it 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 Participating:
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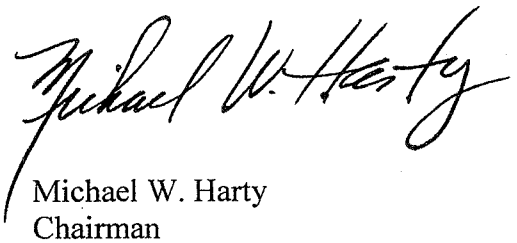
FOR THE BOARD



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

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[6] *Id.*, Tab 5.

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RE: KY FFY 2008 Wage Index/Rural Floor Group
FYE: 9/30/2008
PRRB Case No.: 08-0928G

Dear Mr. Price and Mr. Leong,

The Provider Reimbursement Review Board ("Board") has reviewed the record and the comments received regarding the suitability of the issue under appeal for Expedited Judicial Review ("EJR"). The Board has determined, on its own motion, that it lacks the authority to decide the legal question and therefore grants EJR of the group issue pursuant to 42 C.F.R. § 405.1842(c).

Issue under Appeal

Whether the Centers for Medicare & Medicaid Services ("CMS") properly excluded the wage data for Owensboro Medical Health System ("OMHS") when it calculated the Federal Fiscal Year ("FFY") 2008 wage index for rural areas in Kentucky.

Factual Background and Parties' Arguments

OMHS applied to be reclassified from an urban to a rural area pursuant to 42 C.F.R. § 412.103(a)(3) based on the fact that it would qualify as a sole community hospital if it was located in a rural area.[1] CMS granted OMHS' Request for Reclassification from Urban to Rural Area on April 20, 2007 with an effective date of March 27, 2007.[2]

In the May 3, 2007 Federal Register, the Secretary of the Department and Health and Human Services published the Proposed Rule Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates.[3] CMS published the Final Rule, which included the following provision regarding the effect of reclassification on revisions to the wage index:

> In cases where urban hospitals have reclassified to rural areas under 42 C.F.R. § 412.103, the urban hospital wage data are: (a) included in the rural wage index calculation, unless doing so would reduce the rural wage index, and (b) included

[1] Providers' Position Paper at Exhibit P-2.
[2] *Id.*
[3] 72 Fed. Reg. 24680 (May 3, 2007).

in the urban area where the hospital is physically located.[4]

The Providers state that, because OMHS was reclassified from urban to rural and its wage index was higher than Kentucky's statewide rural wage index, OMHS' wage data should have been included in Kentucky's rural wage index for FFY 2008 but was not.[5]

CMS concedes that OMHS' data should have been included in the rural wage index, but argues that under 42 C.F.R. § 412.64 it cannot now be included.[6] 42 C.F.R. § 412.64(k) (2007) states:

> *Midyear corrections to the wage index.* (1) CMS makes a midyear correction to the wage index for an area only if a hospital can show that –
>
> (i) The Intermediary or CMS made an error in tabulating its data; and
>
> (ii) The hospital could not have known about the error, or did not have the opportunity to correct the error, before the beginning of the federal fiscal year.

The Medicare Contractor argues that this regulation prevents CMS from adding OMHS to the Kentucky rural wage index for FFY 2008 because the Provider should have known about the error before the beginning of the federal fiscal year. According to the Medicare contractor, OMHS should have been aware that the inclusion of its wage index data would have increased the rural wage index of Kentucky as put forth in the May 3, 2007 Proposed Rule.[7] Consequently, when the Final Rule was published and the rural wage index actually decreased, OMHS should have known that there was likely an error and requested a change at that time, which was before the beginning of the FFY.[8] Therefore, the Medicare contractor concludes, 42 C.F.R. § 412.64(k) prohibits CMS from making a change to the wage data

OMHS refutes the Medicare contractor's claim that 42 C.F.R. § 412.64(k) by first arguing that there was no reason for it to think that there was an error with the wage data because it did not have access to all of the relevant information, which CMS has conceded.[9] Furthermore, OMHS argues that 42 C.F.R. § 412.64(k) is not applicable in the current appeal. According to the Provider, that regulation is designed to "encourage provider's [sic] to timely ferret out problems with their individual wage data," whereas here, OMHS submitted the correct data, CMS just did not use it.[10] OMHS is asking that its wage data be included in the Kentucky rural wage index for FFY 2008, and that if the Board is not able to grant that relief, EJR may be appropriate.[11]

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[4] 72 Fed. Reg. 47130, 47332 (Aug. 22, 2007).
[5] Providers' Position Paper at 5.
[6] Medicare Contractor's Position Paper at 5-6.
[7] Medicare contractor's Position Paper at 6.
[8] *Id.*
[9] Providers' Position Paper at 6; *see also* Medicare contractor's Position Paper at 7.
[10] Providers' Position Paper at 10.
[11] *Id.* at 16-17.

BOARD'S DECISION

Jurisdiction

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2007), 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 the notice of the intermediary's determination was mailed to the provider.

In the instant appeal, the Board finds that it has jurisdiction over all of the Providers in the appeal, including OMHS. All of the Providers timely filed their appeals, met the amount in controversy requirement, and established dissatisfaction by appealing from the Federal Register section that published the wage index rates.[12]

The Medicare Contractor argues that the Board does not have jurisdiction over OMHS because that Provider did not exhaust its administrative remedies in that the Provider did not request a midyear correction to its wage data pursuant to 42 C.F.R. § 412.64(k). That regulation states:

> *Midyear corrections to the wage index.* (1) CMS makes a midyear correction to the wage index for an area only if a hospital can show that –
>
> (i) The Intermediary or CMS made an error in tabulating **its data**; and
>
> (ii) The hospital could not have known about the error, or did not have the opportunity to correct the error, before the beginning of the federal fiscal year.[13]

The Board finds that this regulation is not applicable to the issue before it. OMHS is not seeking a correction to its wage data. Rather, OMHS argues that its wage data is correct, but CMS erred by violating its own regulation and not including the Provider's wage data in the calculation for Kentucky rural wage index. OMHS is simply seeking for CMS to properly classify the data as it should have done in 2008 and is asking to be properly included. The preamble to the Changes to the Hospital IPPS and FY 2007 rates confirms that 42 C.F.R. § 412.64(k) applies to a correction to a provider's data, which is not the issue here. The preamble states:

> If a hospital wished to request a change to **its data** as shown in the October 7, 2005 wage index data files, the hospital was to submit corrections . . .

The Board therefore finds that OMHS was not required to request a midyear correction pursuant to 42 C.F.R. § 412.64(k) in order to exhaust its administrative remedies. OMHS and the other Providers in the group appeal have filed jurisdictionally valid appeals.

EJR

The regulation at 42 C.F.R. § 405.1842(a) permits the Board to consider whether it lacks the

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[12] 72 Fed. Reg. 47332, 57722.

[13] Emphasis added.

authority to decide a legal question relevant to the matter at issue once it has made a finding that it has jurisdiction to conduct a hearing under the provisions of 42 C.F.R. §§ 405.1840(a) and 405.1837(a). As discussed above, the Board finds that it has jurisdiction over the Providers in this appeal, however it does not have the authority to grant the relief sought by the Providers.

The Board finds that it lacks the authority to review and/or change the published rural rate for Kentucky. The wage index is published through notice and comment and as such it is binding on the Board unless the Secretary has granted the Board the authority to review it. Here, the Secretary has only given the Board the authority to review wage index data revisions. The Board does not have the authority to review and change a published rate as the Providers have requested in this appeal[14], therefore EJR is appropriate.

The Board finds that:

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

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

3) it is bound by published rural rate for Kentucky for FFY 2008 (72 Fed. Reg. 57634, 57722 (Oct. 10, 2007)); and

4) it is without the authority to review and change the published rural rate for Kentucky for FFY 2008.

Accordingly, the Board finds on its own motion that the challenge to the implementation date of the OPPS payment adjustment as contrary to the Social Security Act properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants expedited judicial review on its own motion for the issue and the subject years. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. As the challenge to the implementation date of the OPPS payment adjustment is the only issue under review, case number 08-0928G is hereby closed and removed from the Board's docket.

Board Members
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

FOR THE BOARD

Michael W. Harty
Chairman

[14] "[H]ospitals are entitled to appeal any denial of a request for a wage data revision made as a result of HCFA's wage data correction process to the Provider reimbursement Review Board." 64 Fed. Reg. 41490, 41513 (July 30, 1999).

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

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