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

FEB 0 6 2017

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Hall, Render, Killian, Heath & Lyman, P.C.
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Bruce Snyder
JL Provider Audit Manager
Novitas Solutions, Inc.
Union Trust Building
501 Grant Street, Suite 600
Pittsburgh, PA 15219

RE: Brackenridge Hospital as Participant in CN 13-2594GC – Ascension 2009 Labor and Delivery Room Days CIRP Group
Provider No.: 45-0124
FYE: 6/30/09

Dear Ms. Obrien Griffin and Mr. Snyder,

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

Background

By letter dated August 2, 2013 the group Representative submitted a *Request to Form Mandatory Group Appeal* and accordingly attached the Model Form B (Group Appeal Request) in order to establish a CIRP group with the following summarized issue:

> The Providers challenge the Medicare Contractor's exclusion of Labor and Delivery Room days for Medicaid eligible beneficiaries from the numerator and denominator of the Medicaid fraction. Also, where applicable, Providers challenge the exclusion of LDR Days from the Medicare numerator.[1]

On November 1, 2016, the Medicare Contractor submitted a challenge on the Board's jurisdiction over Participants #2, #3, and #4 in the appeal. The Provider Representative submitted a response to the jurisdictional challenge on December 29, 2016. In a letter dated January 6, 2017, the Provider Representative withdrew Participants #2 and #4 from the appeal. Two providers remain in this appeal: Participant # 1 - Providence Health Center (Prov. No. 45-0042, 6/30/09) and Participant #3 – Brackenridge Hospital (Prov. No. 45-0124, 6/30/09).

1 *See* Provider Final Position Paper and Request for Appeal.

Medicare Contractor's Jurisdictional Challenge

The Medicare Contractor contends that it didn't render a final determination to exclude LDR Days from the DSH calculation. Further, Brackenridge Hospital has not properly preserved 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).[2]

The Medicare Contractor contends that Brackenridge Hospital cites adjustments from the Notice of Program Reimbursement ("NPR") as the source of its dissatisfaction, however these adjustments do not render a determination to exclude LDR days from the DSH calculation. The Medicare Contractor further contends that Brackenridge Hospital has not shown how the LDR days were claimed on the cost report (or presented) and then disallowed by the Medicare Contractor. The Medicare Contractor also challenges Brackenridge Hospital's assertions that LDR days were self-disallowed, since Brackenridge Hospital did not follow the requirements under applicable rules and regulations[3] to preserve the right to claim dissatisfaction for self-disallowed items as they did not report protested amounts on their as-filed cost reports.[4]

Provider's Response to Jurisdictional Challenge

Brackenridge Hospital contends that the Medicare Contractor's challenge is without merit as it failed to comply with the CMS Ruling 1498-R mandate and the cost reports fall within the Board's statutory jurisdiction under the "Bethesda Doctrine".[5]

Brackenridge Hospital contends that it submitted its cost report in late 2009. At the time of filing of the cost report it was a CMS policy to count LDR inpatient days only if the patient occupied a routine care bed prior to occupying an ancillary LDR bed before the census taking hour. The CMS 1498-R was issued on April 28, 2010 to resolve pending cases and avoid potential appeals from cost reports which were not settled by an initial NPR at the time CMS1498-R was issued. Brackenridge Hospital states that it falls into the latter category.[6] Brackenridge Hospital points out that since its cost report was open (NPR not issued) with the Medicare Contactor, when the 1498 ruling was issued (April 28, 2010), and the cost report was a pre October 1, 2009 cost report, the Medicare Contractor should have ensured that appropriate LDR days were included in the NPR.[7]

Brackenridge Hospital contends that it submitted its cost report in full compliance with the Medicare rules existing at the time, as the DSH regulation explicitly excluded the LDR days at issue. Brackenridge Hospital asserts, exactly like the Provider in *Bethesda,* that it was barred from including LDR days on its cost report.[8]

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[2] Medicare Contractor's jurisdictional challenge at 9.
[3] 42 C.F.R. § 405.1835(a)(1)(ii) and CMS-Pub.15-2 Section 115.
[4] Medicare Contractor's jurisdictional challenge at 7-9.
[5] *Bethesda Hospital Ass'n v. Bowen, 485 U.S. 399 (1988).*
[6] CMS-1498-R P. 16. (Exhibit P-2).
[7] Provider's jurisdictional response at 2-3.
[8] *Id.* at 5-6.

As to the protesting requirement, Brackenridge Hospital contends the only exhaustion requirement available to it was to file this appeal for the Medicare Contractor's failure to follow the requirements of CMS Ruling 1498-R.[9]

Brackenridge Hospital puts forth two additional arguments. Brackenridge argues that the Board previously agreed with the application of the *Bethesda* doctrine in another LDR case for this system under appeal herein, PRRB Case No. 09-0195GC – Ascension Health 2004-2007 L&D DSH Group. Also, the Medicare Contractor's jurisdictional challenge is completely nullified by the recent decision issues by the District Court for the District of Columbia in *Banner Heart Hospital v. Burwell* (DDC August 19, 2016).[10]

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Board concludes that it does not have jurisdiction over the LDR days issue for Brackenridge Hospital (Prov. No. 45-0124, 6/30/09) since its 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). The Board finds that the adjustments appealed by Brackenridge Hospital did not relate to the specific issue under dispute which is the inclusion of LDR days in the DSH calculation. Without a claim for the issue as a reimbursable cost and specific audit adjustment to the issue under appeal, the Board lacks jurisdiction under § 405.1835(a)(1)(i).

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 a cost report under protest." Here Brackenridge Hospital's cost report was for FYE June 30, 2009; therefore, any self-disallowed items are required to be protested. The Board finds that there is no evidence in the record that Brackenridge Hospital included a protested amount on its as-filed cost report related to the LDR days issue. Therefore, the Board concludes that Brackenridge Hospital failed to preserve its rights, and lacks any legal basis to appeal the item to the Board under §405.1835(a)(1)(ii) for self-disallowed costs.[11] In considering jurisdiction over the LDR days issue, the Board

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[9] *Id.* at 7.
[10] *Id.* at 7-8.
[11] The Board notes that the cost reporting periods involved in PRRB Case No. 09-0195GC cited by the Provider in its jurisdictional response were before December 31, 2008, therefore the requirement to claim or protest did not apply in that case.

acknowledges the recent United States District Court for the District of Columbia decision in *Banner Heart Hosp. v. Burwell* (DDC August 19, 2016).[12]

Since the Board lacks jurisdiction over the LDR days issue for Brackenridge Hospital (Prov. No. 45-0124, 6/30/09) under 42 C.F.R. § 405.1835(a)(1)(i) (2009) or 42 C.F.R. § 405.1835(a)(1)(ii) (2009), the Board dismisses Brackenridge Hospital from the appeal. The Board concludes that it has jurisdiction over the remaining Provider in the appeal, Participant #1 – Providence Health Center (Provider No. 45-0042, 6/30/09 as the Provider submitted the required documentation to file an appeal under 42 C.F.R. § 405.1835(b).

Because there is only one participant remaining in case number 13-2594GC, Providence Health Center, the Board should convert the group case to an individual case for this participant and remove the GC extension from the case number.

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

Board Members Participating:
L. Sue Andersen, Esq.
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Jack Ahern, M.B.A.

FOR THE BOARD

L. Sue Andersen
Chairperson

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

cc: Federal Specialized Services
Wilson C. Leong, Esq., CPA
PRRB Appeals
1701 S. Racine Avenue
Chicago, IL 60608-4058

[12] 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 not documented that it would have been futile to claim these items. Therefore, 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 these items without the specific claims, but under the *Bethesda* test, the Providers still fail.

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Refer to:

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FEB 0 6 2017

Byron Lamprecht
Wisconsin Physicians Service
Cost Report Appeals
2525 N. 117th Ave., Suite 200
Omaha, NE 68164

Cynthia F. Wisner
Associate Counsel
Trinity Health
20555 Victor Parkway
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RE: Standard Remand of the SSI fraction under CMS Ruling CMS-1498-R
Group Name: Trinity Health Pre-2000 DSH SSI CIRP Group
Provider Nos. and FYEs: Various – See Attached Schedule of Providers
PRRB Case No.: 12-0241GC

Dear Byron Lamprecht and Cynthia F. Wisner:

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

The issue in this group appeal is whether the Providers' Disproportionate Share Hospital (DSH) Supplemental Security Income (SSI) percentage was properly calculated. Four of the Providers are appealing from revised Notices of Program Reimbursement (NPRs) and seven are appealing from original NPRs.

Board Determination:

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

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885(2002) provides, in relevant part:

> A determination of an intermediary...may be reopened with respect to findings on matters at issue in such determination or decision, by such intermediary...either on motion of such intermediary...or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings...

A revised NPR is considered a separate and distinct determination from which the provider may appeal. 42 C.F.R. § 405.1889, effective October 1, 2002, through May 22, 2008, stated:

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

In this group appeal, Participant No. 1 (Mercy Medical Center Sioux City, Provider No. 16-0153, FYE 1999) is appealing from a RNPR, and refers to Audit Adj. No. R001 on the Schedule of Providers. However, this adjustment was to "[a]djust to incorporate data relating to additional T-19 days noted by provider for DSH purposes." *See* Official Record 000036. The Medicare Contractor informed the Provider that the cost report was being reopened to "incorporate additional Medicaid days into the cost report for the calculation of the disproportionate share hospital adjustment." *See* Official Record 000030. There is no indication in the Record, from the Notice of Reopening (November 3, 2004) or the Audit Adjustment Report (Print date December 1, 2004) that the revised NPR adjusted the DSH SSI ratio which is the issue appealed in this group appeal. Therefore, the Board finds that Participant No. 1 has failed to preserve its right to claim dissatisfaction with the issue at hand, and this Participant is dismissed from Case No. 12-0241GC.

Participant No. 2 (St. Agnes Medical Center, Provider No. 05-0093, FYE 1997) is appealing from a revised NPR, and refers to Adjustment No. R4-002 on the Schedule of Providers. However, this adjustment was to adjust the "allowable dispropor[tionate] share percentage to adjust the DSH adjustment factor to revised audited percentage..." *See* Official Record 000086. The Medicare Contractor informed the Provider that the cost report was being reopened to "[t]o review the factors in determination of DSH adjustment amount" and "[t]o adjust the capital payment amount based on change resulted from the review of DSH adjustment factor." *See* Official Record 000062. There is no indication in the Record, from the Revised Notice of Amount of Program Reimbursement (June 24, 2003) or the Audit Adjustment Report (run date May 21, 2003) that the RNPR adjusted the DSH SSI ratio which is the issue appealed in this group appeal. Therefore, the Board finds that Participant No. 2 has failed to preserve its right to claim dissatisfaction with the issue at hand, and this Participant is dismissed from Case No. 12-0241GC.

Regarding Participant No. 11, the Board previously issued a jurisdictional decision on March 20, 2015 in Case No. 02-1329 which denied the Provider's request to transfer the SSI % issue from

Case No. 02-1329 to 12-0241GC. Therefore, the Board finds Participant No. 11 is not included in Case No. 12-0241GC based upon this previous decision.

The remaining Participants in Case No. 12-0241GC, Nos. 3, 4, 5, 6, 7, 8, 9, and 10, are subject to remand pursuant to CMS-1498-R. Enclosed please find the Board's remand under the standard procedure.

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, CPA
Jack Ahern, MBA

For the Board:

L. Sue Andersen
Chairperson

Enclosures: Standard Remand of SSI Fraction for Case No. 12-0241GC
Schedule of Providers
Jurisdictional Decision, Case No. 02-1329 (March 20, 2015)
42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Wilson C. Leong, Federal Specialized Services (w/ Enclosures)

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Refer to: 15-2949G
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FEB 09 2017

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Brooke F. McClurg
Federal Specialized Services
1710 South Racine Avenue
Chicago, IL 60608

RE: Squire Patton Boggs 2013 Medicare Outlier Group
Provider Nos. Various
FY 2013
PRRB Case No. 15-2949G

Dear Mr. Nash and Ms. McClurg:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' January 12, 2017 request for expedited judicial review (EJR) (received January 13, 2017) in the above-referenced appeal. The Board's jurisdictional determination and determination with respect to the request for EJR are set forth below.

Issue under Dispute

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

> Whether the specific regulations governing Outlier Case Payments as set forth in the two regulatory sources—the Outlier Payment Regulations[1] and the fixed loss threshold ("FLT") Regulations[2] (collectively, the "Medicare Outlier Regulations") — as promulgated by the Secretary of Health and Human Services ("HHS" [or the "Secretary"]) and the Centers for Medicare [&] Medicaid Services ("CMS"), and as in effect for the appealed years, are contrary to the Outlier Statute and/or are otherwise substantively or procedurally invalid?[3]

[1] *See* Providers' January 12, 2017 EJR request at 1 n.2 (the outlier regulations are found at 42 C.F.R. §§ 412.80 and 412.860).
[2] *Id.*
[3] *Id.* at 2 n.3.

Providers' Request for EJR

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

The Providers note that from 1997 through 2003, a number of hospitals were reported to have inflated their charge–masters, an action which the Department of Justice (DOJ) termed "turbo-charging." This practice greatly inflated cost to charge ratios which greatly increased the cost per case. The DOJ termed this action a false claim and this also resulted in the Secretary greatly increasing the FLT so that payments for outliers would remain at 5.1 percent of DRG payments. More specifically, beginning in or around Federal fiscal year (FFY) 1998, the Secretary began making upward adjustments to the FLTs which were in excess of the rate of inflationary indices routinely used, such as the Consumer Price Index for medical care or the Medicare Market Basket.[8]

In 2002, the Secretary disclosed that he was aware of "turbo-charging" and that he would be amending the outlier regulations to fix "vulnerabilities" in the regulations.[9] In the March 5, 2003[10] and June 9, 2003[11] Federal Registers, the Secretary acknowledged three flaws in the outlier payment regulations and stated that the vulnerabilities would be subject to reconciliation.[12] The Providers maintain that the data used to correct the vulnerabilities had always been available and should have been used to calculate outlier reimbursement. The Secretary explained that although he has the authority to revise the outlier threshold given the manipulation of the outlier payments, he elected not to exercise this authority because of the relatively small difference between the current threshold and the revised estimate and the short amount of time remaining in the FFY.[13] The Providers allege that the Secretary was aware of the problem months

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[4] *See* 42 U.S.C. § 1395ww(d)(5).
[5] Providers' January 12, 2017 EJR request at 3.
[6] *Id.* at 4.
[7] *Id.*
[8] *Id.* at 4-5.
[9] *Id.* at 5.
[10] 68 Fed. Reg. 10,420, 10,423 (Mar. 5, 2003) ("Recent analysis indicates that some hospitals have taken advantage of two vulnerabilities in our methodology to maximize their outlier payments . . . [1] the time lag between the current charges on a submitted bill and the cost-to-charge ratio taken from the most recently settled cost report [and 2] in some cases hospitals may increase their charges so far above costs that their cost-to-charge ratios fall below 3 standard deviations from the geometric mean of cost-to-charge ratios and a higher statewide average cost-to-charge ratio is applied.")
[11] 68 Fed. Reg. 34,494, 34,501 (June 9, 2003) ("[3] [e]ven though the final payment would reflect a hospital's true cost experience, there would still be the opportunity for a hospital to manipulate its outlier payments by dramatically increasing charges during the year in which the discharge occurs. In this situation, the hospital would receive excessive outlier payments, which, although the hospital would incur an overpayment and have to refund the money when the cost report is settled, would allow the hospital to obtain excess payments from the Medicare Trust Fund on a short-term basis.")
[12] Providers' January 12, 2017 EJR request at 5-6.
[13] *Id.* at 6.

before the final rule was published, as demonstrated by Provider Exhibit 9, a copy of an interim final rule submitted to the Office of Management and Budget on February 12, 2003.[14] In *Banner Health v. Sebelius*,[15] the D.C. District Court stated that the February 12, 2003 interim final rule was virtually identical to the final proposed rule, with the exception that the later proposed rule, published on March 5, 2003, did not recommend reduction of the FLT in the supporting analysis.[16]

The Providers state that they did not learn of the February 12, 2003 unpublished, interim final rule until their counsel obtained it through a Freedom of Information Act request made to the Office of Management and Budget in 2012. They believe the interim final rule for FYs 2007-2015 continues to be relevant because the Secretary's methodology for establishing each fiscal year's FLT regulation is necessarily a function of, and applies, the payment regulation. The Providers contend that the Secretary repeatedly set the FLT at levels which paid out significantly less than the agency's stated target of 5.1 percent of the total IPPS payments. As a result, they assert that providers did not receive the full amount of outlier payments to which they were entitled under the statute.[17]

Further, in the June 28, 2012 Office of Inspector General (OIG) report, the Inspector General noted that seven years after the 2003 publication of the regulation requiring reconciliation of outlier payments, CMS had not reconciled any of the cost reports screened and reported by Medicare Administrative Contractors (MACs).[18] In a later, 2013 report,[19] OIG noted that although nearly all hospitals receive outlier payments, a small percentage of hospitals receive a significantly higher proportion of payments. The hospitals receiving this higher portion of payments charged Medicare more for the same Medical Severity--DRGs, yet had similar lengths of stay and cost-to-charge ratios. The Providers contend that this is another example of CMS' failure to correct the distribution of outlier payments.[20]

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

1) The FLTs, established by the FLT regulations, are substantively invalid because, both as written and implemented, they represent agency action that violated the Administrative Procedures Act in that it was arbitrary and capricious, exceeded statutory authority and frustrated the intent of Congress as reflected in the outlier statute.

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

    a) fails to "examine the relevant data and articulate a satisfactory explanation for its action including a rational connection between the facts found and the choice made," and/or ignored "new and better data." *Dist. Hosp. Partners v. Burwell,* 786 F.3d 46, 57-58 (D.C. Cir. 2015) (internal citations omitted).

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[14] The Providers furnished no evidence that this document was ever published in the Federal Register.
[15] 2013 U.S. Dist. Lexis 69889 (D.D.C. May 16, 2013).
[16] Providers' January 12, 2017 EJR request at 6-7 n.15.
[17] *Id.* at 9-10.
[18] *Id.* at 11. Providers' Exhibit 10, OIG Report: The Centers for Medicare & Medicaid Services Did Not Reconcile Medicare Outlier Payments in Accordance with Federal Regulations and Guidance, Report A-07-10-02764 at 7-9 (June 2012).
[19] *Id.* at 11-12. Providers' Exhibit 11, Medicare Hospital Outlier Payments Warrant Increased Scrutiny, Report OEI-06-10-00520 (Nov. 2013).
[20] *Id.* at 12.

b) fails to consider one or more important aspects of the problems(s); and/or

c) offers explanation(s) for its decision(s) that run counter to the evidence.[21]

The Providers believe EJR is appropriate because the Board is required to apply the outlier regulations establishing the FLT for the FYs at issue. The Providers assert that the Board lacks the authority to grant the relief sought: retroactive correction of the FLT.

Jurisdictional Challenge

Appeals Support Contractor's Position

The Appeals Support Contractor (Federal Specialized Services (FFS)) filed a jurisdictional challenge with respect to the following Providers:

#3 Charleston Area Medical Center (provider number 51-0022)
#4 Denver Health Medical Center (provider number 06-0011)
#5 Halifax Medical Center (provider number 10-0017)
#6 Jupiter Medical Center (provider number 10-0253)
#7 Sarasota Memorial Hospital (provider number 10-0087)
#9 West Virginia University Hospital (provider number 51-0001)
#11 Grady Memorial Hospital (provider number 11-0079)

FSS points out that the Providers submitted amended cost reports; as a result, their as-filed cost reports were not their "perfected" cost reports and not the cost reports subject to audit. Pursuant to 42 C.F.R. § 405.1835(c)(1)(2014), the Providers' appeal rights are derived from perfected cost reports, and the cost report on the Schedule of Providers (the dates of the originally filed cost reports) do not form a basis for establishing appeal rights.[22]

Providers' Position

The Providers state that because the [as-filed] cost reports were perfected, they provided the foundation to file an appeal based on the Medicare Contractor's failure to timely issue a final determination.[23] They contend that the fact the Providers' cost reports were later amended does not prevent them from filing an appeal based on their perfected cost reports. The Providers point out that the Secretary supported this position in the Federal Register when she stated that "[o]ur longstanding policy is that if the contractor does not issue an NPR within 12 months after the date of its receipt of the provider's perfected or amended cost report, the Provider may appeal to the Board . . . ."[24] Further, the Providers note, Board Rule 7.4 acknowledges that a perfected and amended cost report are distinct items and that each provides ground to file an appeal based on a contractor's failure to issue and NPR.[25]

In their EJR request, the Providers claim that the Board does not need to address the merits of the jurisdictional challenge for #5 Halifax Medical Center, #6 Jupiter Medical Center, or #7 Sarasota Memorial Hospital because their appeal requests were not premature. The appeals for those Providers

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[21] *Id.* at 14.
[22] FSS' November 17, 2016 Juris. Br. at 2.
[23] Providers' November 15, 2016 Juris. Br. at 2.
[24] 80 Fed. Reg. 70,298, 70,566-67 (Nov. 13, 2015).
[25] The Board's Rules are found on the internet at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB_Instructions.html.

were based on the dates of their amended cost reports. For example, Halifax submitted its appeal on August 20, 2015, more than a year after its amended cost report was received on June 9, 2014. Similarly, Jupiter Medical Center submitted its appeal on August 24, 2015, more than one year after its amended cost report was received on July 3, 2014. Lastly, Sarasota Memorial Hospital submitted its appeal on August 7, 2015, more than one year after its amended cost report was received on June 27, 2014. The Providers assert that because the appeal requests were jurisdictionally proper when submitted, they cannot be dismissed from the group because of an event that post-dated the appeal request.

With respect to #3 Charleston Area Medical Center, #4 Denver Health Medical Center and #9 West Virginia University Hospital, the original as-filed cost reports were accepted by the respective Medicare Contractors. The Providers believe that acceptance of a provider's cost report establishes its perfection (citing to the Board's decision in PRRB Case Number 13-3738G, Exhibit A to the Providers' Jurisdictional Brief) and the Provider Reimbursement Manual (PRM) (CMS Pub. 15-1) § 2931.2A (a cost report may also be considered final when initially delivered to the intermediary although the intermediary may not have performed its desk review, and if necessary, an audit). The Providers claim that because the cost reports were perfected, they provide the foundation to file an appeal based on a contractor's failure to timely issue a final determination. The Providers point out that upon review of the jurisdictional documents, the Lead Medicare Contractor noted that although certain Providers had filed amended cost reports, the Providers were not at fault for the delay in issuing the final determinations.[26]

Decision of the Board

#3 Charleston Area Medical Center, #4 Denver Health Medical Center, and #9 West Virginia University Hospital

These Providers' appeals were filed under the provisions of 42 C.F.R. § 405.1835(c)(2014). This regulation permits providers which have not received final determinations to file appeals with the Board where:

> (1) A final contractor determination for the provider's cost reporting period is not issued **(through no fault of the provider)** within 12 months after the date of receipt by the contractor of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of this chapter). The date of receipt by the contractor of the provider's perfected cost report or amended cost report is presumed to be the date the contractor stamped "Received" on such cost report unless it is shown by a preponderance of the evidence that the contractor received the cost report on an earlier date.
>
> (2) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the expiration of the 12 month period for issuance of the final contractor determination (as determined in accordance with paragraph (c)(1) of this section); and
>
> (3) The amount in controversy (as determined in accordance with § 405.1839) is $10,000 or more. (Emphasis added.)

[26] Providers' EJR request at 31.

Similarly, PRM §§ 2920 and 2905.1, reiterates the requirement that the provider may not be the cause of the delay in the issuance of a final determination. Section 2920 states that a provider may file an appeal with the Board where a "[Medicare Contractor] has failed to issue a Notice of Program Reimbursement (NPR) within 12 months of receiving your [i.e., the provider's] perfected (final) or amended cost report, and **the cause of the delay was not occasioned by you** [i.e., the provider], but was due to the [Medicare Contractor's] failure to act timely." (Emphasis added.) Section 2905.1 permits an appeal in the same circumstances where "**the cause of such delay does not lie with the provider.**" (Emphasis added.)

In this case, Charleston Area Medical Center filed cost reports that were received by the Medicare Contractor on May 29, 2014 and October 27, 2014, and filed its appeal to the Board with copies of those cost reports on October 26, 2015, which is 364 days after the amended cost report. Denver Health Medical Center cost reports were received on May 30, 2014 and March 23, 2015 and filed its appeal to the Board with copies of those cost reports on October 26, 2015 which was 213 days after it filed its amended cost report. West Virginia University Hospital cost reports were received on May 29, 2014 and February 6, 2015 and filed its appeal on November 12, 2015 which was 179 days after its amended cost report.

It is apparent that these 3 providers filed their appeals based on the original cost report (*i.e.,* filing within 180 days after the expiration of 12 months from the filing of the cost report) rather than the amended cost report notwithstanding the fact that an amended cost report once filed and accepted by the Medicare Contractor replaces and supersedes any previously filed cost report. Accordingly, the Board concludes that Charleston Area Medical Center, Denver Health Medical Center and West Virginia University Hospital caused the delay in issuing final determinations within 12 months of the cost reports being appealed because prior to the expiration of the 12 month period of the submission of the first cost report, amended cost reports were accepted by the Medicare Contractor. Accordingly, the appeals for Charleston Area Medical Center, Denver Health Medical Center, and West Virginia University Hospital were premature when filed with the Board. Since the appeals did not comply with the requirements of 42 C.F.R. § 405.1835(c) (2014), the Board hereby dismisses the Providers from the case. Further, jurisdiction over a provider is a prerequisite to granting a request for EJR; consequently, the request for EJR for Charleston Area Medical Center, Denver Health Medical Center, and West Virginia University Hospital is hereby denied. *See* 42 C.F.R. § 405.1842(a). The Providers may file an appeal with the Board upon receipt of their respective final determinations pursuant to 42 C.F.R. § 405.1835.

#5 Halifax Medical Center

In the appeal request filed with the Board, Halifax Medical Center identified a cost report filed on February 28, 2014 as the cost report being appealed. However, rather than attaching a copy of the alleged February 28, 2014 cost report, the Provider submitted a copy of an unsigned cost report certification page with a run date of March 3, 2014. Further, the Medicare Contractor's September 9, 2016 e-mail indicated that the Provider filed an amended cost report on June 9, 2014. The regulation at 42 C.F.R. § 405.1835(b)(3) specifies that providers must submit "[a] copy of . . . any documentary evidence . . . necessary to satisfy the hearing request requirements of paragraph[] . . . (b)(1)" which specifies that the provider must demonstrate in the appeal request that it satisfies the requirement for a hearing request. Accordingly, Halifax was required to demonstrate in its appeal request that it met the basis for its appeal, namely that it had filed its appeal within 180 days of the expiration of 12 months from the perfected cost report. However, Halifax did not submit either a copy of the original cost report or the amended cost report along with proof of the Medicare Contractor's acceptance. Based on the above, the Board hereby dismisses the Halifax Medical Center from the case. Further, because jurisdiction over a

provider is a prerequisite to granting a request for EJR, the Board denies the request for EJR as it relates to Halifax Medical Center. *See* 42 C.F.R. § 405.1842(a). The Provider may file an appeal with the Board upon receipt of its final determination pursuant to 42 C.F.R. § 405.1835.

#11 Grady Memorial Hospital

In the case of Grady Memorial Hospital, the Provider filed its appeal with the Board on November 9, 2015, based on the Medicare Contractor's receipt of its as-filed cost report on June 2, 2014. Subsequently, the Provider filed an amended cost report with the Medicare Contractor on February 5, 2016. The Board concludes that the appeal of the original as-filed cost report is no longer a valid claim upon which an appeal can be based because once the amended cost report has been accepted by the Medicare Contractor, the amended cost report replaces and supersedes the originally filed cost report (*e.g.*, if the provider drops a cost or a protested item in the amended cost report that had been in the original, then the provider's rights relative to that cost or protested item are extinguished). To this end, the Medicare Contractor will only issue a final determination on the most recently filed and accepted cost report. So where a provider files an amended cost report that is accepted, the Medicare Contractor will not issue a final determination for any previously filed cost report.[27]

The Board's finding is supported by the regulation 42 C.F.R. § 405.1803(a) which requires that "[u]pon receipt of a provider's cost report, or amended cost report where permitted or required, the contractor must within a reasonable period of time (as described in [§ 405.1835(c)(1)]), furnish the provider . . . a written notice reflecting the contractor's determination of the total amount of reimbursement . . . ." Section 405.1835(c)(1) provides for a right to appeal where "[a] final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of this chapter)." If a provider files (and the Medicare contractor accepts) an amended cost report, then the provider is clearly at "fault" for the Medicare Contractor's inability to issue a final determination on the relevant cost reporting period.

Since the appeal did not comply with the requirements of 42 C.F.R. § 405.1835(c) (2014), the Board hereby dismisses Grady Memorial Hospital from the case. Further, jurisdiction over a provider is a prerequisite to granting a request for EJR; consequently, the request for EJR for Grady Memorial Hospital is hereby denied. See 42 C.F.R. § 405.1842(a). The Provider may file an appeal with the Board upon receipt of its final determination.

EJR Determination for: #1 Billings Clinic, #2 Cabell Huntington Hospital, #6 Jupiter Medical Center, #7 Sarasota Memorial Hospital, #8 Valley View Hospital and #10 Good Samaritan Hospital

The Board has reviewed the submissions of the remaining 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

[27] Note that filing an amended cost report occurs before a final determination is issued. If a final determination has been issued and a provider seeks a change to its reimbursement, it must file a request to reopen under the provisions of 42 C.F.R. § 405.1885 and the Medicare Contractor must agree to reopen the provider's cost report. This is a separate process from filing an amended cost report.

regulations, 42 C.F.R. §§ 412.80 - 412.86.[28] The Intermediaries did not oppose the request for EJR. The documentation shows that in each case the estimated amount in controversy exceeds $50,000 threshold for Board jurisdiction over group appeals and the appeals were timely filed under the provisions of 42 C.F.R. § 405.1835(c)(2014). The Board finds that:

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

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

3) it is bound by the regulations; and

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

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

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Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

FOR THE BOARD

L. Sue Andersen
Chairperson

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

cc: Laurie Polson, Palmetto GBA c/o NGS (Certified Mail w/Schedule of Providers
Wilson Leong, FSS (w/Schedule of Providers)

[28] Providers' EJR request at 1-2 n.2 (The Outlier Payment Regulations are the base regulations that establish the method for calculating a hospital's imputed costs for a patient case, which are set forth at 42 C.F.R. §§ 412.80 - 412.86. The Payment Regulations were first enacted in 1985 and have been revised periodically over the years . . . .).

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Refer to: 15-2872G
Certified Mail

FEB 09 2017

Stephen P. Nash, Esq.
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Denver, CO 80202

RE: Squire Patton Boggs 2010 Outliers NPR Optional Group II
Provider Nos. Various
FY 2010
PRRB Case No. 15-2872G

Dear Mr. Nash:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' January 12, 2017 request for expedited judicial review (EJR) (received January 13, 2017) in the above-referenced appeal. The Board's jurisdictional determination and determination with respect to the request for EJR are set forth below.

Issue under Dispute

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

> Whether the specific regulations governing Outlier Case Payments as set forth in the two regulatory sources—the Outlier Payment Regulations[1] and the fixed loss threshold ("FLT") Regulations[2] (collectively, the "Medicare Outlier Regulations") — as promulgated by the Secretary of Health and Human Services ("HHS" [or the "Secretary"]) and the Centers for Medicare [&] Medicaid Services ("CMS"), and as in effect for the appealed years, are contrary to the Outlier Statute and/or are otherwise substantively or procedurally invalid?[3]

[1] *See* Providers' January 12, 2017 EJR request at 1, n.2 (the outlier regulations are found at 42 C.F.R. §§ 412.80 and 412.860).
[2] *Id.* at n. 2.
[3] *Id.* at 2, n.3.

Providers' Request for EJR

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

The Providers note that from 1997 through 2003, a number of hospitals were reported to have inflated their charge–masters, an action which the Department of Justice (DOJ) termed "turbo-charging." This practice greatly inflated cost to charge ratios which greatly increased the cost per case. The DOJ termed this action a false claim and this also resulted in the Secretary greatly increasing the FLT so that payments for outliers would remain at 5.1 percent of DRG payments. More specifically, beginning in or around Federal fiscal year (FFY) 1998, the Secretary began making upward adjustments to the FLTs which were in excess of the rate of inflationary indices routinely used, such as the Consumer Price Index for medical care or the Medicare Market Basket.[8]

In 2002, the Secretary disclosed that he was aware of "turbo-charging" and that he would be amending the outlier regulations to fix "vulnerabilities" in the regulations.[9] In the March 5, 2003[10] and June 9, 2003[11] Federal Registers, the Secretary acknowledged three flaws in the outlier payment regulations and stated that the vulnerabilities would be subject to reconciliation.[12] The Providers maintain that the data used to correct the vulnerabilities had always been available and should have been used to calculate outlier reimbursement. The

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[4] *See* 42 U.S.C. § 1395ww(d)(5).
[5] Providers' January 12, 2017 EJR request at 3.
[6] *Id.* at 4.
[7] *Id.*
[8] *Id.* at 4-5.
[9] *Id. at 5.*
[10] 68 Fed. Reg. 10,420, 10,423 (Mar. 5, 2003) ("Recent analysis indicates that some hospitals have taken advantage of two vulnerabilities in our methodology to maximize their outlier payments . . . [1] the time lag between the current charges on a submitted bill and the cost-to-charge ratio taken from the most recently settled cost report [and 2] in some cases hospitals may increase their charges so far above costs that their cost-to-charge ratios fall below 3 standard deviations from the geometric mean of cost-to-charge ratios and a higher statewide average cost-to-charge ratio is applied.")
[11] 68 Fed. Reg. 34,494, 34,501 (June 9, 2003) ("[3] [e]ven though the final payment would reflect a hospital's true cost experience, there would still be the opportunity for a hospital to manipulate its outlier payments by dramatically increasing charges during the year in which the discharge occurs. In this situation, the hospital would receive excessive outlier payments, which, although the hospital would incur an overpayment and have to refund the money when the cost report is settled, would allow the hospital to obtain excess payments from the Medicare Trust Fund on a short-term basis.")
[12] Providers' January 12, 2017 EJR request at 5-6.

Secretary explained that although he has the authority to revise the outlier threshold given the manipulation of the outlier payments, he elected not to exercise this authority because of the relatively small difference between the current threshold and the revised estimate and the short amount of time remaining in the FFY.[13] The Providers allege that the Secretary was aware of the problem months before the final rule was published, as demonstrated by Provider Exhibit 9, a copy of an interim final rule submitted to the Office of Management and Budget on February 12, 2003.[14] In *Banner Health v. Sebelius*,[15] the D.C. District Court stated that the February 12, 2003 interim final rule was virtually identical to the final proposed rule, with the exception that the later proposed rule, published on March 5, 2003, did not recommend reduction of the FLT in the supporting analysis.[16]

The Providers state that they did not learn of the February 12, 2003 unpublished, interim final rule until their counsel obtained it through a Freedom of Information Act request made to the Office of Management and Budget in 2012. They believe the interim final rule for FYs 2007-2015 continues to be relevant because the Secretary's methodology for establishing each fiscal year's FLT regulation is necessarily a function of, and applies, the payment regulation. The Providers contend that the Secretary repeatedly set the FLT at levels which paid out significantly less than the agency's stated target of 5.1 percent of the total IPPS payments. As a result, they assert that providers did not receive the full amount of outlier payments to which they were entitled under the statute.[17]

Further, in the June 28, 2012 Office of Inspector General (OIG) report, the Inspector General noted that seven years after the 2003 publication of the regulation requiring reconciliation of outlier payments, CMS had not reconciled any of the cost reports screened and reported by Medicare Administrative Contractors (MACs).[18] In a later, 2013 report,[19] OIG noted that although nearly all hospitals receive outlier payments, a small percentage of hospitals receive a significantly higher proportion of payments. The hospitals receiving this higher portion of payments charged Medicare more for the same Medical Severity--DRGs, yet had similar lengths of stay and cost-to-charge ratios. The Providers contend that this is another example of CMS' failure to correct the distribution of outlier payments.[20]

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

1) The FLTs, established by the FLT regulations, are substantively invalid because, both as written and implemented, they represent agency action that violated the Administrative Procedures Act in that it was arbitrary and

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[13] *Id at 6.*
[14] The Providers furnished no evidence that this document was ever published in the Federal Register.
[15] 2013 U.S. Dist. Lexis 69889 (D.D.C. May 16, 2013).
[16] Providers' January 12, 2017 EJR request at 6-7, n.15.
[17] *Id* at 9-10.
[18] *Id.* at 11. Providers' Exhibit 10, OIG Report: The Centers for Medicare & Medicaid Services Did Not Reconcile Medicare Outlier Payments in Accordance with Federal Regulations and Guidance, Report A-07-10-02764 at 7-9 (June 2012).
[19] *Id.* at 11- 12. Providers' Exhibit 11, Medicare Hospital Outlier Payments Warrant Increased Scrutiny, Report OEI-06-10-00520 (Nov. 2013).
[20] *Id.* at 12.

capricious, exceeded statutory authority and frustrated the intent of Congress as reflected in the outlier statute.

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

   a) fails to "examine the relevant data and articulate a satisfactory explanation for its action including a rational connection between the facts found and the choice made," and/or ignored "new and better data." *Dist. Hosp. Partners v. Burwell,* 786 F.3d 46, 57-58 (D.C. Cir. 2015) (internal citations omitted).

   b) fails to consider one or more important aspects of the problems(s); and/or

   c) offers explanation(s) for its decision(s) that run counter to the evidence.[21]

The Providers believe EJR is appropriate because the Board is required to apply the outlier regulations establishing the FLT for the FYs at issue. The Providers assert that the Board lacks the authority to grant the relief sought: retroactive correction of the FLT.

Decision of the Board

The Board concludes that it lacks jurisdiction over the appeal because it is bound by the regulation at 42 C.F.R. § 405.1835(a)(1)(ii) and dismisses the case. Since jurisdiction over an appeal is a prerequisite to granting a request for EJR the Providers' request for EJR is hereby denied. *See* 42 C.F.R. § 405.1842(a). The regulation, 42 C.F.R. § 405.1835(a)(1)(ii), states that:

a) *Right to hearing on final contractor determination.* 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 final contractor or Secretary determination 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

[21] *Id.* at 14.

> (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 contractor lacks discretion to award the reimbursement the provider seeks for the item(s)).

In this case, the Providers received Notices of Program Reimbursement (NPRs) for cost reports that were filed after December 31, 2008. In the jurisdictional documents accompanying the Schedule of Providers, each Provider included a statement under Tab D that advising that:

> The provider did not self-disallow the outlier issue in its as-filed cost report. However, self-disallowance is not required. *See Banner Heart Hosp. v. Burwell*, [No. 14-CV-01195(APM), 2016 WL 4435174 (D.D.C. August 19, 2016)] ("under *Bethesda* [*Hospital Association v. Bowen*, 485 U.S. 399 (1988)]—and at *Chevron* Step One—the Secretary's self-disallowance regulation, as applied to the Plaintiffs' specific regulatory challenge, conflicts with the plain text of [42 U.S.C.] section 1395oo. The Board therefore erred in ruling that it lacked jurisdiction to hear the Plaintiff's challenge to the outlier regulations.")

The Court in *Banner* specifically addressed whether it was invalidating 42 C.F.R. § 405.1835(a)(1)(ii) in footnote 4 of the decision.[22] The D.C. District Court stated that:

> In their Complaint, Plaintiffs asked the court to "[i]nvalidat[e]" the self-disallowance regulation. Compl. At 20. The court, however, declines to do so, because its decision is limited only to the regulation's application to providers who, like Plaintiffs, seek to assert a legal challenge to a regulation or policy that cannot be addressed by a fiscal intermediary. The question is whether the self-disallowance regulation is lawful in all its applications is not before the court and, for that reason, the court will not vacate the regulation.

Since the Secretary has not taken action to remove the regulation from the Code of Federal Regulations, the Board is bound by the regulations by 42 C.F.R. § 405.1867. This regulation states that:

> In exercising its authority to conduct proceedings under this subpart, the Board must comply with all the provisions of Title XVIII of the Act and regulations issued thereunder, as well as

[22] No. 14-CV-01195(APM), 2016 WL 4435174 (D.D.C. August 19, 2016) at 10-11.

> CMS Rulings issued under the authority of the Administrator as described in § 401.108 of this subchapter. The Board shall afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS.

Although the D.C. District Court said its decision applied to Providers asserting a legal challenge to a regulation or policy that cannot be addressed by a fiscal intermediary, the Secretary has not acquiesced to this decision. Further, the Board cannot overlook a regulation binding compliance with regulatory requirements. In this case, 42 C.F.R. § 405.1867 requires the Board comply with the regulations issued under Title XVIII of the Social Security Act, of which 42 C.F.R. § 405.1835(a)(1)(ii) is one.

Since this is the only issue under dispute in this case, the Board closes the case. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating

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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

cc: Barb Hinkle, Cahaba GBS c/o NGS
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FEB 09 2017

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RE: Record Hearing and Jurisdictional Review
PRRB Case Number: 13-1025
Rochester General Hospital
Provider Number : 33-0125
FYE: 12/31/2007

Dear Mr. Lucas and Mr. Lau,

The Provider Reimbursement Review Board ("Board") has reviewed the parties request for hearing on the record. The pertinent facts of the case and the Board's determination related to jurisdiction over the sole issue remaining in the appeal are set forth below.

Background

The Board established Case No. 13-1025 for Rochester General Hospital ("Rochester" or "Provider") on March 11, 2013. The parties submitted Stipulations and a request for hearing on the record on January 18, 2017. The issue for Case No. 13-1025 is stated as follows:

> "Whether the Indirect Medical Education (IME) reimbursement as calculated on the Medicare cost report on Worksheet E, Part A, Lines 3.21 and 3.22, are properly stated as a result of the MAC's adjustment to decrease the penultimate year resident count."[1]

Pertinent Facts

Rochester states that "For various cost reporting years beginning from FYE 12/31/1996 ... on-going dispute regarding Rochester General's Intern and Resident FTE count. ... In each of those years, the MAC reduced the Intern and Resident Cap by 3.7 FTEs to adjust for Psychiatric Residents from Strong Memorial hospital who completed rotations at Rochester ..."[2]

[1] Parties Stipulations at 2. (January 18, 2017).
[2] *Id.*

For Rochester's FY 2006 cost report, the Medicare Contractor, for the first time allowed the Psychiatric Resident rotations. Rochester argues that the 1996 Intern and Resident Cap should be adjusted for the Penultimate Year (FYE 12/31/2005) calculations included in the 2007 cost report.

Rochester asserts that the Medicare Contractor's refusal to correct the 1996 Intern and Resident Cap FTEs for the penultimate year in the current appeal year is at odds with the D.C. Circuit Court of Appeals decision in *Kaiser Foundation Hospitals v. Sebelius*, 708 F.3d 226 (D.C.Cir. 2013).[3]

The Medicare Contractor contends that the Provider's appeal requests that the "predicate facts" be updated.[4] The increase to the base period IME FTE cap for 12/31/1996 was recognized for the first time during the FYE 12/31/2006 audit. The Medicare Contractor asserts that the 12/31/2005 cost report (penultimate FTE count for FYE 2007) is administratively final, as it is beyond the three year reopening period and the Provider did not file an appeal for this cost reporting period.[5]

The Medicare Contractor also argues that the Provider cannot use the FYE 12/31/2007 appeal to change the "predicate facts" that were established on a prior year cost report. The Medicare Contractor cites to the December 10, 2013 Federal Register that clarified the reopening rules and to the Board's recent decision in *H. Lee Moffitt Cancer Center v. First Coast Service Options, Inc.*, PRRB Dec. No. 2016-D27. The Medicare Contractor maintains the aforementioned decision is relevant, as the Provider in this case, is dissatisfied with its FYE 12/31/2005 cost report determination or "predicate facts" from an administratively final cost report.

Board's Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Board finds that it does not have jurisdiction over the calculation of Rochester's penultimate FTE count (1996 base year Interns and Residents FTE cap from the Provider's FY 2005 cost report) on the Provider's FY 2007 cost report. The Provider's FY 2005 cost report is administratively final. This issue is a "predicate fact" and, by regulation, Rochester is barred from claiming dissatisfaction with a predicate fact that was established in an earlier fiscal period. Without a valid claim of dissatisfaction, the Board has no jurisdiction.

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[3] Rochester's Final Position Paper at 6; Exhibit P-9.

[4] Parties Stipulations ¶ 8 at 3. (January 18, 2017). The parties state that "the Provider seeks to have the "predicate facts" corrected for the IME FTE count for the FYE 12/31/2005 (penultimate year) cost reporting period ..."

[5] Medicare Contractor's Final Position Paper at 4.

Responding to the District of Columbia Circuit Court decision in *Kaiser Found. Hosps. v. Sebelius* ("*Kaiser*"),[6] the Secretary promulgated revisions to 42 C.F.R. § 405.1885 in the final rule published on December 10, 2013 ("2013 Final Rule").[7] These revisions barred reopening of a contractor determination with respect to specific findings or factual determinations, *i.e.*, "predicate facts" that were made in a different fiscal period than the cost reporting period under review and, once determined, was used to determine an aspect of the provider's reimbursement for one or more later cost reporting periods.[8]

In the preamble to the 2013 Final Rule,[9] the Secretary explained that, when the specific matter at issue is a predicate fact that first arose in (or was determined for) an earlier fiscal period, "our longstanding interpretation and practice is that the pertinent provisions of the statute and regulations provide for review and potential redetermination of such predicate fact *only by a timely appeal* or reopening of: (1) *[t]he NPR for the cost reporting period in which the predicate fact first arose or was first determined*; or (2) the NPR for the period for which such predicate fact was first used or applied by the intermediary to determine reimbursement."[10] The Secretary further explained that reimbursement for a given provider's cost report should not be based on one determination regarding the predicate fact in the base period and a different determination about the same predicate fact in a later cost reporting period.[11] The Secretary concluded that, "[u]nder our longstanding interpretation and practice, once the 3-year reopening period has expired, *neither the provider nor the intermediary is allowed to revisit a predicate fact* that was not changed through the appeal or reopening of the cost report for the fiscal period in which such predicate fact first arose or for the fiscal period for which such fact was first determined by the intermediary."[12] Accordingly, the Board concludes that the regulatory change precludes a provider from appealing a predicate fact in a fiscal year subsequent to when it first arose or was first determined by a Medicare contractor and that the Board lacks jurisdiction and is without authority to review predicate facts in such instances.

The Secretary specified that the changes to 42 C.F.R. § 405.1885 were effective for appeals or reopening requests pending on or after the effective date of the 2013 Final Rule even if the Medicare contractor's determination preceded the effective date of the rule, January 27, 2014.[13] The Secretary also stated that, if the revisions to § 405.1885 were deemed retroactive, she would consider the retroactive application necessary to comply with the statutory requirements and failing to take such action would be contrary to the public interest.[14]

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[6] 708 F.3d 226 (D.C. Cir. 2013). In *Kaiser*, the D.C. Circuit found that the Board had jurisdiction to hear an appeal of predicate facts. Specifically, the D.C. Circuit found that the providers could appeal predicate facts even though such predicate facts were not timely appealed or reopened for the periods where they first arose or were first applied to determine the providers' reimbursement.
[7] 78 Fed. Reg. 74826 (Dec. 10, 2013).
[8] 42 C.F.R. § 405.1885(a)(1)(iii).
[9] 78 Fed. Reg. 74826 (Dec. 10, 2013).
[10] *Id.* at 75163-74 (emphasis added).
[11] *Id.* at 75164.
[12] *Id.* at 75164 (emphasis added).
[13] *Id.* at 75195.
[14] *Id.*

In this case, Rochester appeals its IME base year cap for 1996 in connection with its FY 2007 Medicare Cost Report. The Board finds that this 1996 IME base year cap is a predicate fact because the 1996 IME base year cap was established in a prior cost reporting period and it was used to determine an aspect of Rochester's later cost report years. Therefore, in accordance with the regulation at 42 CFR § 405.1885, the Board concludes that Rochester has no appeal rights relative to that predicate fact and, accordingly, the Board lacks jurisdiction over Rochester's appeal of its 1996 IME base year cap in 2007. The Board, hereby, dismisses and closes Case No. 13-1025.

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

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Refer to: 13-1024

FEB 09 2017

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RE: Record Hearing and Jurisdictional Review
PRRB Case Number: 13-1024
Rochester General Hospital
Provider Number: 33-0125
FYE: 12/31/2006

Dear Mr. Lucas and Mr. Lau,

The Provider Reimbursement Review Board ("Board") has reviewed the parties request for hearing on the record. The pertinent facts of the case and the Board's determination related to jurisdiction over the sole issue remaining in the appeal are set forth below.

Background

The Board established Case No. 13-1024 for Rochester General Hospital ("Rochester" or "Provider") on March 1, 2013. The parties submitted Stipulations and a request for hearing on the record on January 18, 2017. The issue for Case No. 13-1024 is stated as follows:

> "Whether the Indirect Medical Education (IME) reimbursement as calculated on the Medicare cost report on Worksheet E, Part A, Lines 3.21 and 3.22, and the prior year resident to bed ratio on Worksheet E, Part A, Line 3.19, are properly stated, as a result of the MAC's adjustment to decrease the prior year and penultimate year resident count."[1]

Pertinent Facts

Rochester states that "For various cost reporting years beginning from FYE 12/31/1996 ... on-going dispute regarding Rochester General's Intern and Resident FTE count. ... In each of those

[1] Parties Stipulations at 2. (January 18, 2017).

years, the MAC reduced the Intern and Resident Cap by 3.7 FTEs to adjust for Psychiatric Residents from Strong Memorial hospital who completed rotations at Rochester ..."[2]

For Rochester's FY 2006 cost report, the Medicare Contractor, for the first time allowed the Psychiatric Resident rotations. Rochester argues that the 1996 Intern and Resident Cap should be adjusted for the Prior and Penultimate Years (FYE 12/31/2004 and FYE 12/31/2005) calculations included in the 2006 cost report.

Rochester asserts that the Medicare Contractor's refusal to correct the 1996 Intern and Resident Cap FTEs for the prior and penultimate years in the current appeal year is at odds with the D.C. Circuit Court of Appeals decision in *Kaiser Foundation Hospitals v. Sebelius*, 708 F.3d 226 (D.C.Cir. 2013).[3]

The Medicare Contractor contends that the Provider's appeal requests that the "predicate facts" be updated.[4] The increase to the base period IME FTE cap for 12/31/1996 was recognized for the first time during the FYE 12/31/2006 audit. The Medicare Contractor asserts that the 12/31/2004 and 12/31/2005 cost reports (prior and penultimate FTE counts for FYE 2006) is administratively final, as it is beyond the three year reopening period and the Provider did not file an appeal for these cost reporting periods.[5]

The Medicare Contractor also argues that the Provider cannot use the FYE 12/31/2006 appeal to change the "predicate facts" that were established on a prior year cost report. The Medicare Contractor cites to the December 10, 2013 Federal Register that clarified the reopening rules and to the Board's recent decision in *H. Lee Moffitt Cancer Center v. First Coast Service Options, Inc.*, PRRB Dec. No. 2016-D27. The Medicare Contractor maintains the aforementioned decision is relevant, as the Provider in this case, is dissatisfied with its FYE 12/31/2004 and FYE 12/31/2005 cost report determinations or "predicate facts" from administratively final cost reports.

Board's Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Board finds that it does not have jurisdiction over the calculation of Rochester's 1996 IME Base Year Cap for its FY 2004 and 2005 cost reports as it pertains to the prior and penultimate FTE count on the Provider's FY 2006 cost report. This issue is a "predicate fact" and, by

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[2] *Id.*
[3] Rochester's Final Position Paper at 6; Exhibit P-9.
[4] Parties Stipulations ¶ 7 at 3. (January 18, 2017). The parties state that "the Provider seeks to have the "predicate facts" corrected for the FYE 12/31/2006 ... IME FTE count ... for the FYE 12/31/2005 (prior year) and FYE 12/31/2004 (penultimate year) cost reporting period ..."
[5] Medicare Contractor's Final Position Paper at 4.

regulation, Rochester is barred from claiming dissatisfaction with a predicate fact that was established in an earlier fiscal period. Without a valid claim of dissatisfaction, the Board has no jurisdiction.

Responding to the District of Columbia Circuit Court decision in *Kaiser Found. Hosps. v. Sebelius* ("*Kaiser*"),[6] the Secretary promulgated revisions to 42 C.F.R. § 405.1885 in the final rule published on December 10, 2013 ("2013 Final Rule").[7] These revisions barred reopening of a contractor determination with respect to specific findings or factual determinations, *i.e.*, "predicate facts" that were made in a different fiscal period than the cost reporting period under review and, once determined, was used to determine an aspect of the provider's reimbursement for one or more later cost reporting periods.[8]

In the preamble to the 2013 Final Rule,[9] the Secretary explained that, when the specific matter at issue is a predicate fact that first arose in (or was determined for) an earlier fiscal period, "our longstanding interpretation and practice is that the pertinent provisions of the statute and regulations provide for review and potential redetermination of such predicate fact *only by a timely appeal* or reopening of: (1) *[t]he NPR for the cost reporting period in which the predicate fact first arose or was first determined*; or (2) the NPR for the period for which such predicate fact was first used or applied by the intermediary to determine reimbursement."[10] The Secretary further explained that reimbursement for a given provider's cost report should not be based on one determination regarding the predicate fact in the base period and a different determination about the same predicate fact in a later cost reporting period.[11] The Secretary concluded that, "[u]nder our longstanding interpretation and practice, once the 3-year reopening period has expired, *neither the provider nor the intermediary is allowed to revisit a predicate fact* that was not changed through the appeal or reopening of the cost report for the fiscal period in which such predicate fact first arose or for the fiscal period for which such fact was first determined by the intermediary."[12] Accordingly, the Board concludes that the regulatory change precludes a provider from appealing a predicate fact in a fiscal year subsequent to when it first arose or was first determined by a Medicare contractor and that the Board lacks jurisdiction and is without authority to review predicate facts in such instances.

The Secretary specified that the changes to 42 C.F.R. § 405.1885 were effective for appeals or reopening requests pending on or after the effective date of the 2013 Final Rule even if the Medicare contractor's determination preceded the effective date of the rule, January 27, 2014.[13] The Secretary also stated that, if the revisions to § 405.1885 were deemed retroactive, she would

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[6] 708 F.3d 226 (D.C. Cir. 2013). In *Kaiser*, the D.C. Circuit found that the Board had jurisdiction to hear an appeal of predicate facts. Specifically, the D.C. Circuit found that the providers could appeal predicate facts even though such predicate facts were not timely appealed or reopened for the periods where they first arose or were first applied to determine the providers' reimbursement.
[7] 78 Fed. Reg. 74826 (Dec. 10, 2013).
[8] 42 C.F.R. § 405.1885(a)(1)(iii).
[9] 78 Fed. Reg. 74826 (Dec. 10, 2013).
[10] *Id.* at 75163-74 (emphasis added).
[11] *Id.* at 75164.
[12] *Id.* at 75164 (emphasis added).
[13] *Id.* at 75195.

consider the retroactive application necessary to comply with the statutory requirements and failing to take such action would be contrary to the public interest.[14]

In this case, Rochester appeals its IME base year cap for 1996 in connection with its FY 2006 Medicare Cost Report. The Board finds that this 1996 IME base year cap is a predicate fact because the 1996 IME base year cap was established in a prior cost reporting period and it was used to determine an aspect of Rochester's later cost report years. Therefore, in accordance with the regulation at 42 CFR § 405.1885, the Board concludes that Rochester has no appeal rights relative to that predicate fact and, accordingly, the Board lacks jurisdiction over Rochester's appeal of its 1996 IME base year cap in 2006. The Board, hereby, dismisses and closes Case No. 13-1024.

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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[14] *Id.*

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RE: Jurisdictional Determination
Lima Memorial Hospital
Provider Nos.: 36-0009
FYE: 12/31/2006
PRRB Case No.: 13-1930

Dear Ms. Goron and Ms. Cummings:

This case involves Lima Memorial Hospital's ("Lima's") appeal of its Medicare reimbursement for the fiscal year ending ("FYE") on December 31, 2006. Upon review, the Provider Reimbursement Review Board ("PRRB" or "Board") acknowledges Lima's request to dismiss one issue contained within Lima's request for hearing ("RFH"); dismisses two of Lima's issues for lack of jurisdiction; combines two of Lima's issues that challenge the same underlying data; grants Lima's request to transfer two issues to appropriate group appeals; and closes the instant appeal, as explained below.

BACKGROUND

On April 26, 2013, the Board received Lima's RFH that challenges Lima's November 28, 2012 revised notice of program reimbursement ("RNPR") for the FYE December 31, 2006 cost reporting period. Within its RFH, Lima presents the following 6 issues:

1. Supplemental Security Income ("SSI") Systemic Errors;
2. SSI Provider-Specific;
3. Medicaid Eligible Days;
4. Medicare Part C Days;
5. Dual Eligible Days; and
6. Rural Floor Budget Neutrality Adjustment ("RFBNA").

Subsequently, Lima requested that the Board transfer some of its issues into various optional group appeals:

- Medicare Part C Days to PRRB Case No. 14-0367G;
- Disproportionate Share Hospital ("DSH")/SSI Percentage" (i.e., Issue 1) to PRRB Case No. 14-0364G; and
- Dual Eligible Days to PRRB Case No. 14-0416G.

On December 31, 2013, the Board received the first page of Lima's preliminary position paper ("PPP"). The cover letter accompanying Lima's PPP states that "[a]ll other issues have been transferred to various groups[,] therefore, we are only briefing [RFBNA] and SSI Provider Specific." Shortly thereafter, in a March 26, 2014 letter, Lima asked the Board to transfer its RFBNA issue to PRRB Case No. 14-3108G.

The Board received an April 18, 2014 Jurisdictional Challenge filed by the Medicare Contractor in which the Contractor argues that the Board lacks jurisdiction to hear four of Lima's issues (Issues 3, 5 and 6, and a portion of Issue 4) contained within this appeal because the corresponding cost reporting items were not adjusted in Lima's November 28, 2012 RNPR.

Lima filed a May 20, 2014 Jurisdictional Response with the Board in which Lima requests that the Board dismiss Issue 3, Medicaid Eligible Days, and presents arguments in support of Board jurisdiction for its remaining issues.

BOARD'S DECISION

APPLICABLE REGULATIONS

Under 42 C.F.R. § 405.1835(a) (2012), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more ($50,000 for a group) and the request for hearing is filed within 180 days of the receipt of the final determination.

However, if a provider seeks to appeal a revised determination, such as an RNPR, the scope of an appeal before the Board is narrowed. Under 42 C.F.R. § 405.1889(a)-(b)(1) (2012), if, after a determination is reopened, a revision is made to an intermediary's determination, the revision is considered a separate and distinct determination. Only those matters that are specifically revised in a revised determination are within the scope of any appeal of such a determination.

ANALYSIS AND JURISDICTIONAL DETERMINATION

Issue 1, SSI Systemic Errors and Issue 2, SSI Provider-Specific

Within its RFH, Lima includes the following issue statement for Issue 1 "[t]he Provider contends that the SSI Percentages calculated by [the Centers for Medicare & Medicaid Services ("CMS")] and used by the [Medicare Contractor] to settle their Cost Report was incorrectly computed because of the following reasons[:]"

1. Availability of MedPar and Social Security Administration ("SSA") records;
2. Paid v. eligible days;
3. Not in agreement with Provider's records;
4. Fundamental problems in the SSI% calculation;
5. Covered v. total days;
6. Non-covered days;
7. CMS Ruling 1498-R;
8. Matching methodology pursuant to CMS Ruling 1498-R; and
9. Failure to adhere to required notice and comment rulemaking procedures.[1]

Lima's issue statement for Issue 2 states that "[t]he Provider contends that its[ ] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation." Lima goes on to explain that "[t]he Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period . . ."[2]

In its issue statement for Issue 1, Lima has recited a fairly comprehensive list of patient scenarios in which particular inpatient days may not have been included in the SSI percentage calculation. In addition, Lima also lists a number of arguments (e.g., availability of records, records not in agreement, matching methodology) as to why it may not have a complete list of SSI-eligible patients.

When comparing the issue statements for Lima's Issue 1 and Issue 2, Lima appears to have appealed the same issue twice, as both issue statements challenge the accuracy of the SSI percentage calculation. While the second part of Lima's issue statement for Issue 2 also claims that Lima is reserving its right to request a recalculation of its SSI percentage based upon its cost reporting year, the Board notes that a provider's request to realign its SSI percentage with a particular cost reporting year is an *election* that a provider may select,[3] but such an election is not an appealable issue before the Board.

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[1] RFH at Tab 3.
[2] *Id.*
[3] 42 C.F.R. § 412.106(b)(3) (2007).

The Board finds that Lima's SSI percentage was adjusted on Lima's RNPR[4] and that it has jurisdiction to hear Issue 1 as set out in the instant appeal. The Board also finds that Lima's Issue 2 comprises the same challenge to the SSI percentage accuracy as Issue 1, therefore, the Board is combining the two issues and granting the transfer of Issue 1 to PRRB Case No. 14-0364G.

Issue 3, Medicaid Eligible Days

Within its May 20, 2014 Jurisdictional Response, Lima requests that the Board dismiss this issue from the instant appeal. Accordingly, the Board hereby grants Lima's request.[5]

Issue 4, Medicare Part C Days

Lima's issue statement for its Issue 4 states that "[t]he Provider contends that the Secretary's construction of the statute is invalid, and MA days should be excluded from their Medicare fractions, and included instead in the Medicaid fraction of their DSH calculations." Within its Jurisdictional Challenge, the Medicare Contractor claims that Lima's issue statement contains two distinct parts: "a) [Medicare Advantage ("MA")] days should be excluded from their Medicare fractions, and b) MA days should be included in the Medicaid fraction of their DSH calculations."[6] The Contractor's Jurisdictional Challenge argues that that Board lacks jurisdiction over the "Medicaid fraction portion" of Issue 4 because the Medicare Contractor did not make an adjustment to Lima's Medicaid fraction in its appealed RNPR.[7]

Within its Jurisdictional Response, Lima argues that the Board has jurisdiction to hear its entire Issue 4 because "the protesting/presentment requirement is not valid, . . . [Lima's] DSH [payment] was adjusted in [Lima's] Cost Report and . . . DSH is not an item that must be adjusted or even claimed on a cost report."[8]

The Board notes that on June 22, 2012, CMS notified providers that it had "posted the SSI ratios for [fiscal years] 2006, 2007, 2008 and 2009 to the CMS website."[9] CMS goes on to state that "[t]hese SSI ratios include Medicare Advantage (MA) patient days and are calculated in the manner prescribed by CMS-1498-R."[10] Within this June 22, 2012 notice, CMS states that it "will be working to final settle the backlog of cost reports that have been held, awaiting revised SSI ratios."[11] Lima's original NPR for this appealed cost reporting period is dated August 21, 2008,

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[4] November 28, 2012 RNPR at 1.
[5] Jurisdictional Response at unnumbered page 1.
[6] Jurisdictional Challenge at unnumbered page 4.
[7] *Id.* at 5.
[8] Jurisdictional Response at unnumbered page 6.
[9] Department of Health and Human Services, CMS, MLN Matters Number: SE1225 at 1, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1225.pdf.
[10] On April 28, 2010, CMS issued CMS-1498-R that addresses three Medicare DSH issues, including CMS' processes for both matching Medicare and SSI eligibility data and calculating providers' SSI fractions.
[11] Department of Health and Human Services, CMS, MLN Matters Number: SE1225 at 3, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-

while the Medicare Contractor issued Lima's appealed RNPR on November 28, 2012. Based on CMS' June 22, 2012 notice, the Board concludes that the Medicare Contractor utilized Lima's revised SSI ratio[12] to settle its November 28, 2012 RNPR. Per CMS' June 22, 2012 notice, the revised SSI ratios include MA—or Part C—patient days. As such, the Board finds that Lima's Medicare Part C days were specifically revised within Lima's Medicare fraction in the November 28, 2012 RNPR and that the Board has jurisdiction to hear Lima's appeal of this issue.

The Board also finds, however, that the Medicare Contractor did not adjust Lima's Medicaid fraction in its November 28, 2012 RNPR. Despite Lima's arguments within its Jurisdictional Response, the regulations governing Board appeals filed from a provider's RNPR clearly state that "[o]nly those matters that are specifically revised in a revised determination are within the scope of any appeal of such a determination." The Medicare Contractor did not specifically revise Lima's Medicaid fraction when the Contractor reopened Lima's 2006 cost report and, as such, the Board finds that it lacks jurisdiction to hear Lima's challenge to the Medicaid fraction as set out in Lima's Issue 4. Therefore, the "Medicaid fraction portion" of Lima's Issue 4 is dismissed from the instant appeal.

The Board received Lima's request to transfer the Medicare ratio portion of its Part C patient days issue from the instant appeal to PRRB Case No. 14-0367G on December 12, 2013. The Board hereby grants the transfer as requested.

Issue 5, Dual Eligible Days,

Lima's issue statement for its Issue 5 states the following:

> Whether patient days associated with Medicare Part A and Title XIX eligible patients should be included in the Medicaid percentage of the Medicare [DSH] calculation. Further whether the [Medicare contractor] should have included in the Medicaid fraction of the DSH calculation patient days applicable to patients who were eligible for both Medicare and Medicaid where Medicare Part A did not make a payment.

The Board notes that this issue statement concerns Lima's challenge to the inclusion of dual eligible days within its Medicaid fraction only. As noted prior, the Medicare Contractor did not adjust Lima's Medicaid fraction within the reopening that forms the basis of this appeal. Therefore, pursuant to the regulations that govern a provider's appeal from an RNPR, the Board does not have jurisdiction to hear Lima's appeal with respect to the underlying components of that fraction. As such, the Board dismisses Issue 5 from Lima's appeal.

MLN/MLNMattersArticles/downloads/SE1225.pdf.

[12] The terms "SSI fraction," "SSI ratio," "Medicare ratio" and "Medicare fraction" are synonymous in this appeal and used interchangeably.

Issue 6, RFBNA

Lima has not shown, and the Board finds no evidence to suggest, that Lima's RFBNA was specifically revised within its reopening. Accordingly, for the reasons set out prior, the Board finds that it lacks jurisdiction to hear this issue and dismisses it from the instant appeal.[13]

As there are no issues remaining in the appeal, it is now closed. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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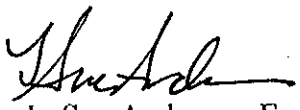
For the Board:



L. Sue Andersen, Esq.
Chairperson

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

cc: Wilson Leong, Federal Specialized Services

[13] The Board notes that following Lima's request to transfer Issue 6 to PRRB Case No. 14-3108G, Lima withdrew PRRB Case No. 14-3108G in its entirety.