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

Refer to: 17-0537GC
Certified Mail

MAR 0 2 2017

Gary A. Rosenberg, Esq.
Verrill Dana, LLP
One Boston Place
Suite 1600
Boston, MA 02108-4407

RE: Baystate Health 2017 Wage Index Group
Provider Nos. Various
FFY 2017
PRRB Case No. 17-0537GC

Dear Mr. Rosenberg:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' February 3, 2017 request for expedited judicial review (EJR) (received February 6, 2017). The Board's decision regarding the request for EJR is set forth below.

Issue

The Providers alleged that:

> The Centers for Medicare [&] Medicaid Services (CMS) incorrectly calculated the FY [Federal Year] 2017 Wage Index rural floor for Massachusetts by failing to correct identified errors in wage index data submitted by the state's only rural hospital, thereby significantly reducing the Providers' Medicare payment for FY 2017.[1]

Providers' Request for EJR

Wage Index Background

The Providers explain that the Medicare statute[2] requires, that as part of the methodology for determining prospective payments to hospitals, the Secretary[3] adjust the standardized amounts[4]

[1] Providers' November 18, 2016 Hearing Request, Tab 2.
[2] 42 U.S.C. § 1395ww(d)(3)(E).
[3] of the Department of Health and Human Services.
[4] The standardized amount is a figure representing the average price per case for all Medicare cases during the year. The standardized amount is the sum of: (1) a labor component which represents labor cost variations among

for the area wages based on the geographical location of the hospital compared to the national average hospital wage level. This adjustment is known as the wage index. CMS updates the wage index annually using wage and wage-related cost data by acute care hospitals on previously submitted Medicare cost reports, usually from four years prior. For FY 2017, the Secretary used data from Medicare cost reports submitted in fiscal year 2013.[5]

The Balanced Budget Act of 1997 contained a provision whereby the wage index for any hospital located in an urban area of any state may not be less than the area wage index applicable to any hospital located in a rural area.[6] This concept is known as the "rural floor." In other words, a state's rural hospitals establish the floor for the wage index that is applicable to all other hospitals in the state.[7]

Factual Background

Nantucket Cottage Hospital (NCH) is the only hospital in the Commonwealth of Massachusetts that meets the definition of a rural hospital. Accordingly, NCH sets the rural floor for the state's wage index.[8]

NCH timely filed its Medicare cost report for the fiscal year ending September 30, 2013 (2013 cost report). On its 2013 cost report, NCH inadvertently made several reporting errors on its wage index worksheet. These reporting errors resulted in a significant reduction in the average hourly wage attributed to NCH. Although the hospital's Medicare Contractor reviewed the 2013 cost report for wage index purposes, it did not correct the reporting errors.[9]

NCH later discovered the reporting errors and notified the Medicare Contractor and CMS that incorrect data had been used to calculate its average hourly wage for 2013. NCH supplied the corrected information and requested that the corrected information be used to recalculate its average hourly wage. However, CMS rejected NCH's request and notified the hospital that their requested correction fell outside the scope of the 2017 Wage Index Time Table for wage data corrections. Consequently, CMS would not incorporate the corrected data into the FY 2017 wage index.[10]

Because NCH is the only rural hospital in Massachusetts, CMS' issuance of the allegedly improper wage index for NCH had the impact of further reducing the rural floor for the whole

---

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 a wage index. *See* Medicare Hospital Prospective Payment System - Office of Inspector Report on the internet at https://oig.hhs.gov/oei/reports/oei-09-00-00200.pdf

[5] *See* 81 Fed. Reg. 56,762, 56,932 (August 22, 2016) (Federal year 2013 wage data was used to create the 2017 wage index).

[6] A rural area is defined in 42 U.S.C. § 1395ww(d)(2)(D).

[7] Providers' EJR Request at 2.

[8] *Id.*

[9] *Id.*

[10] *Id.*

state. This resulted in the area wage levels for many of the state's non-rural hospitals being set at an incorrect level. In the case of the hospitals in this appeal, the Providers will receive an estimated $19,907,000 less in Medicare payments than if CMS had used the corrected data furnished by NCH. The Providers contend that CMS' action is arbitrary and capricious and, otherwise, not in accordance with the law.[11]

Providers' EJR Request

The Providers assert that they are dissatisfied with the final determination of the Secretary as to the amount of payment under 42 U.S.C. § 1395ww(d). Specifically, the Providers are dissatisfied with the Secretary's publication of the FY 2017 wage index in the Federal Register, 81 Fed. Reg. 56761 (Aug. 22, 2016) (the FY 2017 Final Rule) which is a final determination appealable to the Board.[12]

The Providers contend that although the Board has jurisdiction over the appeal, it lacks the authority to grant a remedy. The FY 2017 Final Rule sets forth the administrative process a provider must follow to request changes to its own wage index calculation. However, the FY 2017 Final Rule does not establish a process for providers to challenge the calculation of another hospital's wage index calculation. Accordingly, the Board does not have the authority to grant the remedy the Providers seek: an update of the FY 2017 wage index with NCH's corrected data. Additionally, because the FY 2017 Final Rule does not establish an administrative process for providers to challenge the calculation of another hospital's wage index, there is no administrative remedy the Providers can pursue to challenge the Secretary's final decision.[13] EJR is appropriate where the Board lacks the ability to grant the relief sought.[14]

Decision of the Board

The Board has reviewed the Providers' request 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) .

---

[11] *Id. at 2-3.*

[12] *See, 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.)

[13] *See e.g. Chicago 98-00 MSA Wage Index v. Mutual of Omaha*, PRRB Dec. 2006-D7, 2005 WL 3741482 (PRRB) (Dec. 5, 2005) ("[T]he administrative process described in the July 30, 1999 Federal Register fails to provide a remedy for other hospitals in the same MSA which are harmed by the hospital that failed to furnish correct data. The Board concludes that it does have jurisdiction over the 81 Providers other than Reese, but lack[s] the authority to grant the remedy sought: update of the Chicago MSA wage index with Reese Hospital['s] corrected data.")

[14] Providers' EJR Request at 4.

The Board concludes that the Providers timely filed their request for hearing from the issuance of the August 22, 2016 Federal Register[15] and the amount in controversy exceeds the $50,000 threshold necessary for a group appeal.[16] Consequently, the Board has determined that it has jurisdiction over Providers' appeal.[17] This issue involves a challenge to the calculation of the Providers' wage index, which is published in the Federal Register. Further, the Board finds that it lacks the authority to decide the legal question of whether the Providers' wage index is correctly calculated; 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 calculation of their wage index, there are no findings of fact for resolution by the Board;

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

4) it is without the authority to decide the legal question of whether the Secretary's calculation of the Providers' wage index is valid.

Accordingly, the Board finds that the wage index 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

---

[15] *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).

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

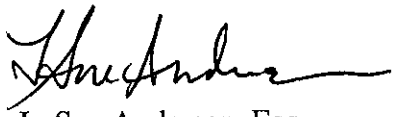
[17] The Board notes that one or more of the participants in this consolidated group appeal have cost report periods beginning on or after January 1, 2016, which would subject their appeals to the newly-added 42 C.F.R. § 405.1873 and the related revisions to 42 C.F.R. § 413.24(j) regarding submission 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 yet to be filed cost report included an appropriate claim for the specific item under appeal. *See* 80 Fed. Reg. at 70556.

institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

Board Members Participating

L. Sue Andersen, Esq.
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA, CHFP

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
Schedule of Providers

cc: Byron Lamprecht, WPS
Wilson Leong, FSS

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

Refer to: 13-1911GC **CERTIFIED MAIL** MAR 08 2017

Stephen Price, Esq.
Wyatt, Tarrant & Combs, LLP
500 W. Jefferson Street, Ste. 2800
Louisville, KY 40202

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

RE: Jurisdictional Determination
Appalachian Regional Healthcare 2007 DSH Medicaid Ratio Dual Eligible Days CIRP Group
Provider Nos.: Various
FYE: 06/30/2007
PRRB Case No.: 13-1911GC

Dear Mr. Price and Ms. Cummings:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above-referenced appeal in response to the Medicare Contractor's October 15, 2014 Jurisdictional Challenge ("Jurisdictional Challenge"). In its Jurisdictional Challenge, the Medicare Contractor argues that it did not adjust the group participants' dual eligible days in their respective revised notices of program reimbursement ("RNPRs"), therefore this issue is not within the Board's jurisdiction for the instant appeal. Upon review, the Board finds that it does not have jurisdiction over the issue and dismisses the appeal, as explained below.

Pertinent Facts

On May 1, 2013, the Board received Appalachian Regional Healthcare's ("ARH's") common issue-related party ("CIRP") group appeal request. The CIRP group is comprised of four participants,[1] each appealing their respective cost report adjustments from the fiscal year ending ("FYE") on June 30, 2007. ARH's group appeal request challenges the Medicare Contractor's adjustments from the participants' RNPRs dated November 1, 2012. The issue statement within the appeal request questions "[w]hether the Dual Eligible and Medicare Non-Covered days were properly included and excluded from the Medicaid and Medicare fractions."

In a May 7, 2013 email, the Board notified the parties that it had bifurcated the appeal "to cover the distinct legal questions of the [Disproportionate Share Hospital ("DSH")] Dual Eligible Days issue described in the initial hearing request[ ]" and to ensure that ARH's hearing request met the appeal requirements set out in 42 C.F.R. § 405.1837(a)(2) (2012). As such, ARH's appeal of the Medicare Contractor's treatment of dual eligible days in the Medicare fraction is now within

[1] The four participants are Williamson ARH (18-0069), Beckley ARH (51-0062), Harlan ARH (18-0050) and Hazard ARH (18-0029).

PRRB Case No. 13-1910GC, while the instant appeal covers ARH's appeal of the Medicare Contractor's treatment of dual eligible days in the Medicaid fraction.
The Board received the Medicare Contractor's October 15, 2014 Jurisdictional Challenge[2] in which the Contractor claims that the Board does not have jurisdiction over the issue in the instant appeal because the Medicare Contractor did not adjust the disputed dual eligible days[3] on the participants' respective RNPRs. The Medicare Contractor asserts that, pursuant to the applicable regulations pertaining to appeals of RNPRs, "[o]nly those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision."[4] The Contractor goes on to state that the ARH providers had "an ample amount of time to file appeals of [their] initial [Notices of Program Reimbursement ("NPRs")] if they felt that dual eligible days were improperly included in the [Supplemental Security Income ("SSI")] fraction[5] of the DSH calculation[,]" however, since "[n]one of the Providers in this group filed such appeals[,]" they must have been "happy with the placement of the dual eligible days in the SSI fraction."

On November 14, 2014, the Board received ARH's response ("ARH's Response") to the October 15, 2014 Jurisdictional Challenge in which ARH argues the following: (1) its participants' original NPRs were not final determinations because the cost reports were reopened almost immediately; (2) the Board has jurisdiction to hear its participants' group appeal because the participants' entire SSI percentage was recalculated; (3) the adjustment to the participants' SSI percentage relates to the appealed issue; and (4) ARH's two appeals, bifurcated by the Board, cannot be considered separately.

Board's Analysis

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-1841 (2012), a group of providers has a right to a hearing before the Board with respect to costs claimed on timely filed cost reports if the providers are dissatisfied with their respective final determinations of the intermediary, the amount in controversy is $50,000 or more and the request for a hearing is filed within 180 days of the providers' receipt of their final determinations.

Under 42 C.F.R. § 405.1889 (2012), a revised NPR is considered a separate and distinct determination from which providers may appeal. A provider's appeal of an RNPR is limited to those matters that are specifically revised and any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of

---

[2] On August 22, 2014, the Board received an initial jurisdictional challenge that was filed by the Medicare Contractor. As the October 15, 2014 Jurisdictional Challenge includes the same arguments, the Board is addressing only the October 15, 2014 Jurisdictional Challenge.
[3] It appears that the Medicare Contractor uses the term "dual eligible days" to refer to both dual eligible days and Medicare non-covered days. For brevity and clarity sake, the Board will also use the term "dual eligible days" to refer to both types of days mentioned in ARH's appeal request.
[4] Jurisdictional Challenge at 3, quoting from 42 C.F.R. § 405.1889(b)(1).
[5] The terms "SSI Fraction," "Medicare Fraction," "SSI ratio" and "SSI percentage" are all synonymous.

the revised determination or decision. As such, a provider's appeal of an RNPR does not extend further to all determinations underlying the original NPR.[6]

ARH's appeal request seeks Board review of the Medicare Contractor's exclusion of certain Medicare non-covered patient days—such as dual-eligible, Medicare exhausted and Medicare as second payor days—from the Medicaid fraction. The Medicare Contractor argues that it did not adjust those patient days within the participants' RNPRs and, because ARH has filed its CIRP group appeal from its participants' RNPRs, the Board does not have jurisdiction over this issue. In response, ARH argues that even if the Medicare Contractor did not adjust the disputed Medicare days in the reopening, the Contractor recalculated the "entire SSI percentage" and the recalculation relates to the issue on appeal such that the Medicaid fraction issue cannot be viewed in isolation from the Medicare fraction issue.

Despite ARH's argument that the two bifurcated dual eligible days appeals cannot be considered separately, the Centers for Medicare & Medicaid Services' regulation that governs Board jurisdiction expressly limits the scope of a provider's appeal filed from an RNPR. Under 42 C.F.R. § 405.1889 (2012), a provider's appeal of an RNPR is limited to those matters that are specifically revised and any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision. In the instant case, the Board notes that ARH's participants' Medicaid fractions were not specifically revised on their respective RNPRs that serve as the basis for this appeal and, as such, the Board does not have jurisdiction to hear the instant appeal

In addition, as the Board lacks jurisdiction to hear the sole issue in the instant CIRP group appeal, the Board hereby dismisses the appeal and closes this case.

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

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

For the Board:

L. Sue Andersen, Esq.
Chairman

cc: Wilson C. Leong, Esq., CPA; Federal Specialized Services

[6] *See, HCA Health Services of Oklahoma, Inc. v. Shalala*, 27 F.3d 614 (D.C. Cir 1994).

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

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

CERTIFIED MAIL

MAR 1 0 2017

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

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

RE: Longmont United Hospital
Provider No.: 06-0033
FYE: 12/31/07
PRRB Case No.: 13-1786

Dear Mr. Ravindran and Mr. Tisdale,

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 April 15, 2013, based on a Notice of Program Reimbursement ("NPR") dated October 17, 2012. The hearing request included eight issues, six of which were subsequently transferred to group appeals and one of which was withdrawn. One issue remain in the appeal as follows: Issue 1 – Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific).

Two of the issues that the Provider included in its hearing request were the DSH SSI % - Systemic and DSH SSI % - Provider Specific issues. The Provider requested that the DSH SSI% - Systemic issue be transferred directly to Group Case No. 13-2679G – QRS 2007 DSH SSI Percentage Group (2) by a request dated December 9, 2013. The Board has considered the DSH SSI % - Provider Specific and DSH SSI% - Systemic issues to be the same issue as both are based on SSI data. As such, the issue cannot be in two cases at the same time.

Board's Decision

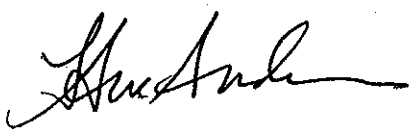
Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 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. Additionally, PRRB Rule 4.5 states that a Provider may not appeal an issue from a final determination in more than one appeal.

The Board concludes that it does not have jurisdiction over Issue 1 – Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific), and dismisses it from the appeal, as it is the same issue that the Provider is appealing in PRRB Case No. 13-2679G – QRS 2007 DSH SSI Percentage Group (2).

As no issues remain PRRB Case no. 13-1786, 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:
L. Sue Andersen, Esq.
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA, CHFP
Gregory H. Ziegler

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

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

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

Refer to: 17-1001
Certified Mail

MAR 1 0 2017

Christopher L. Keough, Esq.
Akin, Gump, Strauss, Hauer & Feld, LLP
Robert S. Strauss Building
1333 New Hampshire Avenue, N.W.
Washington, D.C. 20036-1564

RE: Roswell Park Cancer Institute
Provider No. 33-0354
FYE 3/31/2012
PRRB Case No. 17-1001

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's February 10, 2017 request for expedited judicial review (EJR) (received February 13, 2017) in the above referenced appeal. The decision of the Board is set forth below.

Issue

The issue under dispute is:

> Whether the Medicare Administrative Contractor ("MAC") improperly failed to apply the cancer hospital payment adjustment required under [42 U.S.C. 1395(t)(18)]. . . in determining payments due the Provider under the outpatient prospective payment system ("OPPS") for services furnished on or after January 1, 2011.[1]

Provider's Request for EJR

The Provider explains that Section 3138 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 ("ACA") amended the OPPS statute, by adding a new paragraph 18, requiring that a payment adjustment for certain cancer hospitals "as described in [42 U.S.C. § 1895ww]" be developed. The Provider is one of these 11 cancer hospitals.

As amended by ACA, the statute required the Secretary[2] to perform a study of the costs incurred by the 11 comprehensive cancer centers to determine if their costs of services paid under OPPS exceed the costs incurred by other hospitals for those services.[3]

---

[1] Provider's February 10, 2017 Hearing Requests, Tab 3 at 1.
[2] of the Department of Health and Human Services.
[3] 42 U.S.C. § 1395(t)(18)(A).

The statute requires that the Secretary "shall provide for an appropriate adjustment" to the OPPS payments to the 11 comprehensive cancer centers, including the Provider, if and to the extent that "the Secretary determines that their costs exceed the costs incurred by other hospitals for outpatient services paid under OPPS."[4] The statute mandates that the adjustment must be "effective for services furnished on or after January 1, 2011."[5]

The Provider notes that in 2010, the Secretary performed a study, determined that the 11 comprehensive cancer centers' costs exceeded the cost incurred by the other hospitals, and proposed a payment adjustment that would raise the OPPS payments to the comprehensive cancer centers to a level equal to 91% of their costs, which is on par with the average OPPS payment-to-cost ratio that the Secretary identified based on the study for other hospitals that were paid under OPPS.[6] The Secretary did not finalize the agency's proposal to apply the payment adjustment effective as of January 1, 2011, as required by the statute.[7] Instead, the Secretary delayed implementation of the payment adjustment until January 2, 2012.[8] The Provider contends that the delay was contrary to the law and should be corrected.

Further, the Provider asserts that the Secretary's failure to make the cancer center payment adjustment effective as of January 1, 2011, is contrary to the plain language and manifest intent of the statute, 42 U.S.C. § 1395(t)(18). The Provider points out that the statute mandates an effective date of January 1, 2011, not January 2, 2012, and the Secretary is not free to selectively comply with some statutory commands and ignore others. The Provider believes that the Secretary's failure to make the payment adjustment effective January 1, 2011 is also arbitrary, capricious, not based upon substantial evidence and otherwise contrary to law. There is no rational basis for the agency's failure to comply with the statutory mandate.[9]

Jurisdiction

The Provider did not protest the failure of the agency to make a timely cancer center payment adjustment effective January 1, 2011 on its 2012 cost report. The Provider attempted to file an amended cost report protesting the issue, but in e-mail correspondence dated July 7, 2016, the MAC refused to accept the amended cost report.[10]

---

[4] 42 U.S.C. § 1395t)(18)(B).
[5] *Id.*
[6] *See* 75 Fed. Reg. 71,800, 71,886 (Nov. 24, 2010) ("[W]e proposed and adjustment for cancer hospitals to reflect these higher costs, effective January 1, 2011"); *see also* 76 Fed. Reg. 74,122, 74,202-06 (Nov. 30, 2011).
[7] *Id. at 71,887* (The many public comments we received have identified a broad range of very important issues and concerns associated with the proposed cancer hospital adjustment. After consideration of these public comments, we have determined that further study and deliberation related to these issues is critical. This process, however, will take a longer period of time than is permitted in order for us to meet the publication deadline of this final rule with comment period. Therefore, we are not finalizing an adjustment for certain cancer hospitals identified in [42 U.S.C. § 1395ww(d)(1)(B)(v)]at this time.)
[8] *See* 76 Fed. Reg. at 74,583.
[9] Provider's Hearing Request, Tab 3 at 2.
[10] Provider's February 10, 2017 EJR Request, Tab P-1.

The Provider argues that the Board has jurisdiction over the appeals based on the decision in *Bethesda Hospital Ass'n v. Bowen* (*Bethesda*).[11] In *Bethesda,* the Supreme Court found that filing a cost report for the periods at issue in compliance with the Secretary's rules did not waive the Provider's dissatisfaction with the rule. The Provider asserts that CMS' 2008 self-disallowance regulation, 42 C.F.R. § 405.1835(a)(1)(ii), cannot trump the statute conferring jurisdiction over the appeal. The Providers point out that the recent decision in *Banner Heart Hosp. et al. v. Burwell*[12] reinforced this position when it ruled that the self-disallowance policy conflicts with the statute conferring jurisdiction, 42 U.S.C. § 1395oo, and as a result runs afoul of the Supreme Court's decision in *Bethesda.*[13]

Finally, the Provider asserts that it put the MAC on notice concerning its dissatisfaction with the Secretary's rule before the MAC issued its final payment determination for FYs 2012. The Provider contends that the request to amend the cost reports satisfied the state purposes of the self-disallowance policy, namely to allow MACs to better estimate their appeal workloads and provide notice to CMS about potential amount in controversy in future appeals.[14]

Decision of the Board

The Board concludes that it lacks jurisdiction over the Provider's appeal because the Provider failed to protest the failure to include a payment adjustment for cancer hospitals on its as-filed cost report. Consequently the Board hereby dismisses the case 17-0001. Since jurisdiction over an appeal is a prerequisite to granting a request for EJR, the Board hereby denies the Provider's request for EJR. *See* 42 C.F.R. § 405.1842(a)(1).

In this case, the Provider is challenging the MAC's failure to apply the cancer hospital payment adjustment required under 42 U.S.C. 1395(t)(18). In case number 17-1001, the Provider did not protest the MAC's failure to include the additional payment on its as-filed cost report as required by 42 C.F.R. § 405.1835(a)(1)(ii). This regulation states that:

> 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—

---

[11] 485 U.S. 399, 404 (1988).
[12] 2016 WL 4435174 (D.D.C. Aug. 19, 2016).
[13] *Id.* at 7. ("But where the intermediary has no authority to address a claim, such as when a pure legal challenge to a regulation is at issue, a provider cannot be deemed to be 'satisfied' simply because such challenge is not reflected in the cost report. Satisfaction cannot be imputed from a provider's silence when everyone knows it would be futile to present such claim to the intermediary.")
[14] 73 Fed. Reg. 30,190, 30,198 (May 23, 2008).

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

In this case, the Provider received a Notice of Program Reimbursement (NPRs) for a cost report that was filed after December 31, 2008. The Provider argues that *Bethesda* allows providers to appeal to the Board where they complied with the Secretary's rules and regulations in filing their cost report; they are not barred from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. However, although this statement is correct, it ignores addition language in *Bethesda* which states that "providers who bypass a clearly prescribed exhaustion requirement or who fail to request from the [MAC] reimbursement for all costs to which they are entitled under applicable rules" stand on different ground than those providers who are in compliance with the regulations.[15] Subsequent, to the decision in *Bethesda*, the Secretary did enact the regulatory protest requirement 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."[16] For the Board to find that it has jurisdiction over a provider's appeal, a provider must comply with the protest requirement of the regulation by protesting the lack of additional payment for cancer hospitals as required by 42 U.C.S. 1395(t)(18).

Further, the Provider points out that the Court in Banner stated that the self-disallowance policy of the regulation conflicts with the statute, 42 U.S.C. § 1395oo, conferring Board jurisdiction, and as a result runs afoul of the Supreme Court's decision in *Bethesda.* However, this does not abrogate the Board's responsibilities under the current regulatory scheme. 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.[17] 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

---

[15] *Bethesda* at 404-405.
[16] 42 C.F.R. § 405.1835(a)(1)(ii).
[17] No. 14-CV-01195(APM), 2016 WL 4435174 (D.D.C. August 19, 2016) at 10-11.

> before the court and, for that reason, the court will not vacate the regulation.

Since the Secretary has not removed 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 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 MAC, 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 there are no other issues under appeal in these cases, the Board hereby closes the case number 17-1001. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875-405.1877.

Board Members Participating

L. Sue Andersen, Esq.
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA, CHFP
Gregory H Ziegler

FOR THE BOARD:

L. Sue Anderson/D.U.Z.

L. Sue Andersen
Chairperson

Enclosures: 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875-405.1877

cc: Pam VanArsdale, NGS
Wilson Leong, FSS

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

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

Refer to: 17-1000
Certified Mail

MAR 1 0 2017

Christopher L. Keough, Esq.
Akin, Gump, Strauss, Hauer & Feld, LLP
Robert S. Strauss Building
1333 New Hampshire Avenue, N.W.
Washington, D.C. 20036-1564

RE: Roswell Park Cancer Institute
Provider No. 33-0354
FYE 3/31/2011
PRRB Case No. 17-1000

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's February 10, 2017 request for expedited judicial review (EJR) (received February 13, 2017) in the above referenced appeal. The decision of the Board is set forth below.

Issue

The issue under dispute is:

> Whether the Medicare Administrative Contractor ("MAC") improperly failed to apply the cancer hospital payment adjustment required under [42 U.S.C. 1395(t)(18)]. . . in determining payments due the Provider under the outpatient prospective payment system ("OPPS") for services furnished on or after January 1, 2011.[1]

Provider's Request for EJR

The Provider explains that Section 3138 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 ("ACA") amended the OPPS statute, by adding a new paragraph 18, requiring that a payment adjustment for certain cancer hospitals "as described in [42 U.S.C. § 1895ww]" be developed. The Provider is one of these 11 cancer hospitals.

As amended by ACA, the statute required the Secretary[2] to perform a study of the costs incurred by the 11 comprehensive cancer centers to determine if their costs of services paid under OPPS exceed the costs incurred by other hospitals for those services.[3]

The statute requires that the Secretary "shall provide for an appropriate adjustment" to the OPPS payments to the 11 comprehensive cancer centers, including the Provider, if and to the extent that "the Secretary determines that their costs exceed the costs incurred by other hospitals for outpatient services

---

[1] Provider's February 10, 2017 Hearing Request, Tab 3 at 1.
[2] of the Department of Health and Human Services.
[3] 42 U.S.C. § 1395(t)(18)(A).

paid under OPPS."[4] The statute mandates that the adjustment must be "effective for services furnished on or after January 1, 2011."[5]

Through an August 3, 2010 proposed regulation, the Secretary put forward her methodology to implement the adjustment, specifying that Roswell would receive a 16.3% payment adjustment to the "wage adjusted payments for all items except for items and services paid at charges adjusted to cost or devices receiving pass through status defined in 42 C.F.R. § 419.66."[6] Subsequently in a final rule published November 24, 2010, in response to numerous comments regarding a host of issues with the payment adjustment, CMS determined that "further study and deliberation" was needed and "we are *not finalizing* an adjustment for certain cancer hospitals...at this time."[7] CMS revisited this issue again on November 30, 2011, and finalized the rule as proposed with an effective date of January 1, 2012.[8]

The Provider did not protest the agency's failure to pay the adjustment beginning January 1, 2011, on its 2011 cost report. The Provider asserts that the Secretary's failure to make the cancer center payment adjustment effective as of January 1, 2011, is contrary to the plain language and manifest intent of the statute, 42 U.S.C. § 1395(t)(18). The Provider points out that the statute mandates an effective date of January 1, 2011, not January 1, 2012, and the Secretary is not free to selectively comply with some statutory commands and ignore others. The Provider believes that the Secretary's failure to make the payment adjustment effective January 1, 2011 is also arbitrary, capricious, not based upon substantial evidence and otherwise contrary to law. There is no rational basis for the agency's failure to comply with the statutory mandate.[9]

Jurisdiction

The Board majority finds that the Board has jurisdiction over this appeal. The Board Members disagree on the issue of whether the Provider's failure to protest the agency's determination to delay the implementation of the payment adjustment deprives the Board of jurisdiction in this case. The Board majority concludes that because of the unique facts in this case, the Provider was unable to determine, at the time of the filing of its costs report in August, 2011, both the amount and timing of the payment of the adjustment with sufficient certainty to claim or protest the amount of reimbursement on its FYE 2011 cost report as required by federal regulation, 42 C.F.R. § 405.1835(a)(1).[10]

At the time the Provider's cost report was due on August 31, 2011, the Secretary had not yet promulgated a final rule establishing the amount nor the timing of the payment adjustment. The Secretary had published a proposed rule on August 3, 2010 establishing a proposed methodology and indicating that Roswell Park Cancer Institute could receive a 16.3% payment increase. As it was only a proposed rule, however, this methodology was not finalized.[11] The Secretary promulgated a final regulation on November 24, 2010 but, once again, chose not to finalize the payment adjustment—neither finalizing the actual amount of the adjustment nor when the adjustment would take effect. Finally, with the publication

---

[4] 42 U.S.C. § 1395t)(18)(B).
[5] *Id.*
[6] 75 Fed. Reg. 46,170, 46,236 (Aug. 3, 2010).
[7] 75 Fed. Reg. 71,800, 71,887 (Nov. 24, 2010).
[8] 76 Fed. Reg. 74,122, 74,202 (Nov. 30, 2011). It should be noted that section 4 on page 74202 is entitled "Proposed CY 2011 Cancer Hospital Payment Adjustment Was Not Finalized."
[9] Provider's Hearing Request, Tab 3 at 2.
[10] Roswell filed its appeal on February 10, 2017. Effective for cost reports filed on or after January 1, 2016, the self-disallowance requirement was moved from requirement establishing a right to a hearing before the Board found at 42 C.F.R. § 405.1835(a)(1) to a cost reporting requirement found at 42 C.F.R. § 413.24(j).
[11] 75 Fed. Reg. 46,170, 46,236 (Aug. 3, 2010).

of the November 30, 2011 Final Rule, the Provider was advised of the actual amount of the payment adjustment and that this adjustment would not be effective until January 1, 2012—almost three months *after* the deadline for filing its FYE 2011 cost report. While the Provider attempted to file an amended cost report, the Medicare Contractor refused to accept the amended cost report through email correspondence dated July 7, 2016.[12]

Decision of the Board

The Board majority agrees that the Provider is not barred from its appeal because it did not protest the timing of the payment adjustment on its 2011 cost report. As it was not certain of the final determination of the amount or the payment adjustment nor when the adjustment would become effective because the regulation had not yet been finalized, the Provider could not yet, in August, 2011, determine that it would be "dissatisfied with a final determination of...its fiscal intermediary...as to the amount of total program reimbursement due the provider...for the period covered by such report" as required by 42 U.S.C. 1395oo(a)(1)(A)(i). Consistent with the holding in *Bethesda Hospital Ass'n v. Bowen*, 108 S. Ct. 1255 (1988), the Provider's failure to protest on its cost report does not bar it from claiming dissatisfaction with the delay in implementing the payment adjustment that was published, in final, on November 30, 2011.

Further, even if the Provider knew that the agency intended to delay the payment adjustment, it would have been futile for the Provider to protest this delay on its cost report because the Medicare Contractor was without the power to award the payment adjustment effective as of January, 2011 as the ACA statute requires. As reiterated in a recent D.C. District Court case, *Banner Heart Hospital v. Burwell*,[13] which the agency has chosen not to appeal, the Court stated:

> ...when a provider fails to present a claim in its cost report that an intermediary can address, it can be deemed 'satisfied' with the amounts requested in the cost report and awarded by the intermediary. But where the intermediary has no authority to address a claim, such as when a pure legal challenge to a regulation is at issue, a provider cannot be deemed to be 'satisfied' simply because such challenge is not reflected in the cost report. Satisfaction cannot be imputed from a provider's silence when everyone knows that it would be futile to present such a claim to the intermediary.[14]

Consistent with this opinion, the Board majority finds it has jurisdiction in this matter but does not have the authority to declare the delayed effective date of the payment adjustment contrary to the statute and it is, therefore, appropriate to grant EJR in this matter.

EJR

The Board has reviewed the Provider's request 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. §§ 405.1835 and 405.1840(a). The Board concludes that the Provider timely filed its request for hearing and the amount in controversy exceeds the $10,000 threshold necessary for an

---

[12] Provider's February 10, 2017 EJR Request, Tab P-1.
[13] *Banner Heart Hospital v. Burwell*, No. 14-cv-01195, 2016 WL 4435174 (D.D.C. Aug. 19, 2016).
[14] *Id.* at 9.

individual appeal.[15] Consequently, the Board majority has determined that it has jurisdiction over Provider's appeal. This issue involves a challenge to the cancer hospital payment adjustment which was to be implemented in CY 2011. Further, the Board finds that it lacks the authority to decide whether the delay in the implementation of the cancer hospital payment adjustment is appropriate; therefore, EJR is appropriate for the issue under dispute in this case.

The Board majority finds that:

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

2) based upon the Provider's assertions regarding the cancer hospital payment adjustment issue, there are no findings of fact for resolution by the Board;

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

4) it is without the authority to decide the legal question of whether the Secretary's delay in implementing the cancer hospital payment adjustment is valid.

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

Board Members Participating

L. Sue Andersen, Esq.
Clayton J. Nix, Esq. (dissenting)
Charlotte F. Benson, CPA (dissenting)
Jack Ahern, MBA, CHFP
Gregory H. Ziegler

FOR THE BOARD:

L. Sue Andersen

L. Sue Andersen
Chairperson

Enclosures: 42 U.S.C. § 1395oo(f)

cc: Pam VanArsdale, NGS
Wilson Leong, FSS

[15] *See* 42 C.F.R. § 405.1835(a)(2).

Clayton J. Nix, Esq. and Charlotte F. Benson, CPA, *dissenting*

The undersigned respectfully disagree with the majority's decision to find that the Board has jurisdiction over the Provider's appeal of its fiscal year ending March 31, 2011 ("FYE 2011"). It is clear from the record that the Provider neither claimed nor protested the Medicare reimbursement at issue on its FYE 2011 cost report. As explained below, we respectfully disagree with the majority's conclusion that the Provider had no obligation to protest the Medicare reimbursement at issue under 42 C.F.R. § 405.1835(a)(1) because "the Provider was unable to determine, at the time of the filing of its costs report in August, 2011, both the amount and timing of the payment of the adjustment with sufficient certainty to claim or protest the amount of reimbursement on its FYE 2011 cost report as required by federal regulation, 42 CFR § 405.1835(a)(1)." CMS'[Centers for Medicare & Medicaid Services] standard for protesting under § 405.1835(a)(1)(ii) is only whether the reimbursement at issue "***may*** not be allowable"[1] and does not require that a provider be certain of the unallowability. As explained more fully below, we would find that, pursuant to 42 C.F.R. § 405.1835(a)(1)(ii), the Provider had an obligation to protest the reimbursement at issue because the final rule published on November 24, 2010 ("2010 Final Rule")[2] and the proposed rule published on July 18, 2011 ("2011 Proposed Rule") made it clear that the Medicare reimbursement at issue "***may*** not be allowable." Accordingly, we would conclude that the Board lacks jurisdiction over this appeal due to the failure to claim or protest the Medicare reimbursement at issue and, thereby, should also deny the request for expedited judicial review ("EJR").

A. OBLIGATION TO PROTEST UNDER 42 C.F.R. § 405.1835(A)(1)(II)

42 C.F.R. § 405.1835(a)(1)(ii) is controlling in this case and states:

> 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 aware the reimbursement the provider seeks for the item(s)).[3]

CMS promulgated this regulation in final rule published on May 23, 2008.[4] In the preamble to this rule, CMS provides a detailed discussion and confirms that the regulatory obligation to protest exists where a provider "has a good faith belief that the item may not be allowable under Medicare policy."[5] Similarly, CMS acknowledged that, if a provider is unsure what the amount in controversy is for a protest item, the provider may explain why it is unable to determine whether payment is correct as a result of not having access to underlying information.[6] Finally, CMS discusses the provider appeal rights based on the concept of futility as discussed in *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988) ("*Bethesda*") and confirms that CMS promulgated § 405.1835(a)(1)(ii) to respond to *Bethesda*.[7] Accordingly, unlike the

---

[1] (Emphasis added.)
[2] 75 Fed Reg. 71800, 71885-71887 (Nov. 24, 2010).
[3] (Emphasis added.)
[4] 73 Fed. Reg. 30190 (May 23, 2008).
[5] *Id.* at 30196.
[6] *Id.* at 30194.
[7] *Id. at* 30195.

majority, we conclude that both the regulation and this preamble discussion make it clear that *Bethesda* is not relevant to this case and that the standard for applying the obligation to protest is only whether the provider was on notice that the Medicare reimbursement at issue "may not be allowable."[8]

B. APPLICATION OF THE OBLIGATION TO PROTEST TO THIS APPEAL

This case involves the "Authorization of Adjustment for Cancer Hospitals" under § 3138 of the Patient Protection and Affordable Care Act of 2010 for services furnished on or after January 1, 2011.[9] This authorization is conditioned on: (1) the Secretary conducting a study on certain hospital costs described in 42 U.S.C. § 1395ww(d)(1)(B)(v); and (2) the Secretary finding that those costs for cancer hospitals exceeded those for hospitals subject to the inpatient prospective payment system. If those conditions were met, then § 3138 states that "the Secretary shall provide for an appropriate adjustment . . . to reflect those higher costs effective for services furnished on or after January 1, 2011." We shall refer to this adjustment as the "§ 3138 Adjustment."

We acknowledge that CMS did not finalize its proposal not to have a § 3138 Adjustment for any outpatient services furnished during calendar year ("CY") 2011 until it published the final rule on November 30, 2011 ("2011 Final Rule").[10] Notwithstanding, we would find that the Provider's obligation to protest under 42 C.F.R. § 1835(a)(1)(ii) was triggered because the Provider had more than ample notice that the Medicare reimbursement at issue "may not be allowable" and that the reimbursement issue would have a significant impact on the Provider based on the following facts:

1. In the preamble to the 2010 Final Rule, CMS confirmed that it was "not finalizing an adjustment [*i.e.*, a § 3138 Adjustment for CY 2011] ... at this time" because of "a broad range of very important issues and concerns" identified by comments that warranted CMS to conduct "further study and deliberation related to these issues."[11] In this regard, one of the issues identified by the commenters was that "the CMS analysis is inadequate to conclude that costs are higher in cancer hospitals and that an adjustment is warranted."[12] The commenter asserted that "the CMS analysis did not control for the many factors that might explain differences in costliness or assess to what extent cost differences could be explained by differences in efficiency."[13] Thus, the preamble discussion suggests that one of the conditions precedent to authorization for a § 3138 Adjustment may not have been met and, accordingly, was still under consideration for CY 2011.

2. CMS also acknowledged in the preamble to 2010 Final Rule that CMS' proposed adjustment methodology would have resulted in a 41.2 percent aggregate increase in OPPS payments for cancer hospitals for CY 2011.[14] As a result, cancer hospitals were on notice that a § 3138 Adjustment for CY 2011 had the potential to have a huge impact on their Medicare reimbursement.

---

[8] We also recognize that the Majority cites to *Banner Heart Hosp. v. Burwell*, No. 14-cv-01195, 2016 WL 4435174 (D.D.C. Aug. 19, 2016) in support of its decision. However, we note that this decision is not binding on the Board and that CMS has not rescinded 42 C.F.R. § 405.1835(a)(1)(ii). Accordingly, pursuant to 42 C.F.R. § 405.1867, the Board is still bound by § 405.1835(a)(1)(ii).
[9] Pub. L. No. 111-148, § 3138, 124 Stat. 119, 439 (2010).
[10] 76 Fed. Reg. 74122 (Nov. 30, 2011).
[11] 75 Fed. Reg. 71800, 71887 (Nov. 24. 2010).
[12] *Id.* at 71886.
[13] *Id.* at 71886-71887.
[14] *Id.* at 71886.

3. In the 2011 Proposed Rule, CMS confirmed that, if the proposed rule were finalized, CMS would only make a § 3138 Adjustment for outpatient services furnished on or after January 1, 2012 and that CMS would *not* make such an adjustment for any services furnished during CY 2011.[15] CMS did in fact finalize this in the 2011 Final Rule.

4. The due date for the Provider's FYE 2011 cost report was on September 1, 2011 which is more than a month after CMS had published the 2011 Proposed Rule and more than 9 months after CMS had published the 2010 Final Rule.

In summary, we would find that the Board lacks jurisdiction over this appeal because the Provider failed to either claim or protest the Medicare reimbursement at issue as required under 42 C.F.R. § 405.1835(a)(1). As such, we would also deny the Provider's EJR request.

Clayton J. Nix, Esq.
Board Member

Charlotte F. Benson, CPA
Board Member

[15] 76 Fed. Reg. 42170, 42216-42221, 42392 (July 18, 2011).

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

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

Refer to: 16-1022GC

MAR 1 3 2017

Certified Mail

Kenneth R. Marcus, Esq.
Honigman, Miller, Schwartz and Cohn, LLP
2290 First National Bank Building
660 Woodward Ave.
Detroit, MI 48226-3506

RE: BMHCC 2013 DSH Medicaid Eligible Days Group
Provider Nos. Various
FYE 2013
PRRB Case No. 16-1022GC

Dear Mr. Marcus:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' February 16, 2017 request for expedited judicial review (EJR) (received February 17, 2017). The decision of the Board with respect to this request is set forth below.

Issue

The issue under appeal in this case is:

> Whether all Medicaid eligible days were included in the computation of the DSH [disproportionate share hospital] Adjustment Medicaid Fraction?[1]

The Providers explain that they are appealing the failure of the Medicare Administrative Contractor (MAC) to include all Medicaid eligible days in the computation of the DSH adjustment. Specifically, they are challenging the MAC's computation of the "Medicaid Proxy." In this fraction, the numerator of which is the number of hospital patient days for patients who were eligible for medical assistance under a State plan approved under Title XIX for such period, but not entitled to benefits under Medicare Part A. The denominator of the fraction is the total number of the hospital's patient days for such period.[2,3] The Providers are seeking to include all DSH Medicaid eligible days in the Medicaid fraction of the DSH adjustment.[4]

In their EJR request the Providers identify the issue as:

> Whether the Board has jurisdiction where the Providers self-disallowed their appeal of the MAC's failure to include all

---

[1] Providers' February 11, 2016 Hearing Request, Tab 2.
[2] *Id.*
[3] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi) and 42 C.F.R. § 412.106(b)(4).
[4] Providers' February 16, 2017 EJR Request at 1.

> Medicaid eligible days in the Medicaid fraction of the [DSH] adjustment for the Providers' FYE's 9/30/2013?[5]

Providers' Request for EJR

Jurisdiction Over the Issue

Jurisdiction over an issue is a prerequisite to granting a request for EJR.[6] In this case, the Providers admit that they did not file protested amounts for the Medicaid eligible days issue on their cost reports as required by 42 C.F.R. § 405.1835(a)(1)(ii).[7] The Providers note that the Board is bound by this regulation and must issue an order for EJR on the validity of the self-disallowance regulation.[8] They state, that for purposes of this EJR request, the issue is whether the Board has jurisdiction where the Providers did not comply with the self-disallowance regulation in their appeal of the MAC's failure to include all Medicaid eligible days in the Medicaid fraction of the DSH adjustment.[9] The Providers believe that the request for EJR should be granted as the result of the challenge to 42 C.F.R. § 405.1835(a)(1)(ii).

The Providers argue that the Board has jurisdiction based on the self-disallowance principle[10] over its appeal of the MAC's failure to include all Medicaid eligible days in the Medicaid fraction of the DSH adjustment. The Providers assert that they are entitled to have all Medicaid eligible days included in the DSH adjustment based on well-established law set forth in the Health Care Financing Administration (HCFA) Ruling 97-2.[11]

EJR

The Providers state that the issue for which EJR is requested is whether the Board has jurisdiction where the Medicaid eligible days were self-disallowed by the Providers and the MAC failed to include all of the Medicaid eligible days in the Medicaid fraction of the DSH adjustment. The Providers admit that they did not claim the Medicaid days on their cost reports. Because the Board interprets the self-disallowance regulation as requiring the filing of protested amounts, the Providers challenge the legal validity of the regulation. The Providers point out

---

[5] *Id.* at 5.
[6] *See* 42 C.F.R. § 405.1842(a)(1) (a provider has the right to seek EJR of a legal question at issue if there is Board jurisdiction to conduct a hearing).
[7] Providers' EJR Request at 1.
[8] *Id.* at 3.
[9] *Id.* at 2-3.
[10] *See Bethesda Hospital Ass'n v. Bowen*, 485 U.S. 399, 404 (1988). (the submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations, does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations. No statute or regulation expressly mandates that a challenge to the validity of a regulation be submitted first to the fiscal intermediary).
[11] 1997 WL 835500 (Feb. 27, 1997) HCFA Ruling 97-2 was, at the time, a new interpretation of the DSH adjustment which changed the calculated to include all inpatient days for medical assistance under a State Medicaid plan in the Medicaid fraction whether or not a hospital received payment for those inpatient hospital services. To receive payment under the Ruling, providers were required to have jurisdictionally proper appeals pending.

that the Board does not have the authority to grant the relief sought, so resolution of the legal issue requires adjudication by the courts.

The Providers argue that the Board has jurisdiction because the Providers are dissatisfied with the final determination of the Secretary as to the amount of payment.[12] In addition, in *Bethesda* the Supreme Court ruled that a provider had the right to appeal any item covered by the cost report in compliance with the law regarding that item. Finally, the Providers point out, that the Court in *Banner Health v. Sebelius*,[13] observed that the Secretary's self-disallowance regulation . . . conflicts with the plain text of [42 U.S.C. §] 1395oo and, therefore, the Board erred in ruling that it lacked jurisdiction to hear the Plaintiffs' challenge.[14]

Decision of the Board

The Board concludes that it lacks jurisdiction over the Providers appeal because they failed to protest the additional Medicaid eligible days they were seeking on their as filed cost reports as required by 42 C.F.R. § 405.1835(a)(1)(ii). 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). Since the Board lacks jurisdiction over the appeal, it hereby dismisses the case.

The Providers did not protest the MAC's failure to include the additional Medicaid days on their as-filed cost reports as required by 42 C.F.R. § 405.1835(a)(1)(ii). This regulation states that:

> 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
>
> (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)).

---

[12] 42 U.S.C. § 1395oo(a)(ii).
[13] 2013 U.S. Dist. Lexis 69889 (D.D.C. May 16, 2013).
[14] Providers' EJR Request at 9.

In this case, the Providers received Notices of Program Reimbursement (NPRs) for cost reporting periods ending on or after December 31, 2008. The Providers assert that *Bethesda* allows providers to appeal to the Board where they are claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Although this statement is correct, it ignores additional language in *Bethesda* which states that "providers who bypass a clearly prescribed exhaustion requirement or who fail to request from the [MAC] reimbursement for all costs to which they are entitled under applicable rules" stand on different ground than those providers who are in compliance with the regulations.[15] Subsequent, to the decision in *Bethesda*, the Secretary did enact the regulatory protest requirement 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."[16] For the Board to find that it has jurisdiction over a provider's appeal, a provider must comply with the protest requirement of the regulation.

Further, the Providers point out that the Court in *Banner* stated that the self-disallowance policy of the regulation conflicts with the statute, 42 U.S.C. § 1395oo, and as a result the Board erred in finding that it lacked jurisdiction to hear the Providers' challenge. Consequently, the Court in *Banner* concluded the Board dismissal ran afoul of the Supreme Court's decision in *Bethesda.* However, this does not abrogate the Board's responsibilities under the current regulatory scheme. 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.[17] 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 removed 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 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

---

[15] *Bethesda* at 404-405.
[16] 42 C.F.R. § 405.1835(a)(1)(ii).
[17] No. 14-CV-01195(APM), 2016 WL 4435174 (D.D.C. August 19, 2016) at 10-11.

> 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 MAC, the Secretary has not acquiesced to this decision.[18] 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 there are no other issues under appeal in this case, the Board hereby closes the case number 16-1022GC. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875-405.1877.

Board Members Participating

L. Sue Andersen, Esq.
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA, CHFP
Gregory H. Ziegler

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

Enclosures: 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875-405.1877

cc: Barb Hinkle, Cahaba GBA c/o NGS
Wilson Leong, FSS

[18] In *Banner*, the Court concluded that the Board "violate[d] the administrative appeal provision of the Medicare statue and the key Supreme Courts precedent interpreting it, *Bethesda*." *Bethesda* emphasizes the futility of presenting a legal challenge to [a MAC] when the [MAC] does not have authority to entertain or decide such challenges. The Court in Bethesda also noted that providers who bypass a clearly prescribed exhaustion requirement or who fail to request from the [MAC] reimbursement for all costs to which they are entitled under applicable rules stand on different ground than those providers who are in compliance with the regulations. Here, the Provider has not documented that it would have been futile to claim reimbursement for additional Medicaid eligible days. Therefore, the Board concludes that the Medicaid eligible days issue would stand on different ground than issues for which it was futile (i.e. the provider was barred by a statute or regulation) to make a claim. Under 42 C.F.R. § 405.1835(a)(1)(ii), the Board is not able to find that it has jurisdiction over the Medicaid eligible days issue.

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

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

Refer to: 17-1051GC
Certified Mail

MAR 13 2017

Kenneth R. Marcus, Esq.
Honigman, Miller, Schwartz and Cohn, LLP
2290 First National Bank Building
660 Woodward Ave.
Detroit, MI 48226-3506

RE: BMHCC 2012 DSH Medicaid Eligible Days Group
Provider Nos. Various
FYE 2012
PRRB Case No. 17-1051GC

Dear Mr. Marcus:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' February 20, 2017 request for expedited judicial review (EJR) (received February 22, 2017). The decision of the Board with respect to this request is set forth below.

Issue

The issue under appeal in this case is:

> Whether all Medicaid eligible days were included in the computation of the DSH [disproportionate share hospital] Adjustment Medicaid Fraction?[1]

The Providers explain that they are appealing the failure of the Medicare Administrative Contractor (MAC) to include all Medicaid eligible days in the computation of the DSH adjustment. Specifically, they are challenging the MAC's computation of the "Medicaid Proxy." In this fraction, the numerator of which is the number of hospital patient days for patients who were eligible for medical assistance under a State plan approved under Title XIX for such period, but not entitled to benefits under Medicare Part A. The denominator of the fraction is the total number of the hospital's patient days for such period.[2,3] The Providers are seeking to include all DSH Medicaid eligible days in the Medicaid fraction of the DSH adjustment.[4]

In their EJR request the Providers identify the issue as:

> Whether the Board has jurisdiction where the Providers self-disallowed their appeal of the MAC's failure to include all

[1] Providers' February 17, 2017 Hearing Request, Tab 2.
[2] *Id.*
[3] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi) and 42 C.F.R. § 412.106(b)(4).
[4] Providers' February 20, 2017 EJR Request at 1.

> Medicaid eligible days in the Medicaid fraction of the [DSH] adjustment for the Providers' FYE's 9/30/2012?[5]

Providers' Request for EJR

Jurisdiction Over the Issue

Jurisdiction over an issue is a prerequisite to granting a request for EJR.[6] In this case, the Providers admit that they did not file protested amounts for the Medicaid eligible days issue on their cost reports as required by 42 C.F.R. § 405.1835(a)(1)(ii).[7] The Providers note that the Board is bound by this regulation and must issue an order for EJR on the validity of the self-disallowance regulation.[8] They state, that for purposes of this EJR request, the issue is whether the Board has jurisdiction where the Providers did not comply with the self-disallowance regulation in their appeal of the MAC's failure to include all Medicaid eligible days in the Medicaid fraction of the DSH adjustment.[9] The Providers believe that the request for EJR should be granted as the result of the challenge to 42 C.F.R. § 405.1835(a)(1)(ii).

The Providers argue that the Board has jurisdiction based on the self-disallowance principle[10] over its appeal of the MAC's failure to include all Medicaid eligible days in the Medicaid fraction of the DSH adjustment. The Providers assert that they are entitled to have all Medicaid eligible days included in the DSH adjustment based on well-established law set forth in the Health Care Financing Administration (HCFA) Ruling 97-2.[11]

EJR

The Providers state that the issue for which EJR is requested is whether the Board has jurisdiction where the Medicaid eligible days were self-disallowed by the Providers and the MAC failed to include all of the Medicaid eligible days in the Medicaid fraction of the DSH adjustment. The Providers admit that they did not claim the Medicaid days on their cost reports. Because the Board interprets the self-disallowance regulation as requiring the filing of protested amounts, the Providers challenge the legal validity of the regulation. The Providers point out

---

[5] *Id.* at 5.
[6] *See* 42 C.F.R. § 405.1842(a)(1) (a provider has the right to seek EJR of a legal question at issue if there is Board jurisdiction to conduct a hearing).
[7] Providers' EJR Request at 1.
[8] *Id.* at 3.
[9] *Id.* at 2-3.
[10] *See Bethesda Hospital Ass'n v. Bowen*, 485 U.S. 399, 404 (1988). (the submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations, does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations. No statute or regulation expressly mandates that a challenge to the validity of a regulation be submitted first to the fiscal intermediary).
[11] 1997 WL 835500 (Feb. 27, 1997) HCFA Ruling 97-2 was, at the time, a new interpretation of the DSH adjustment which changed the calculated to include all inpatient days for medical assistance under a State Medicaid plan in the Medicaid fraction whether or not a hospital received payment for those inpatient hospital services. To receive payment under the Ruling, providers were required to have jurisdictionally proper appeals pending.

that the Board does not have the authority to grant the relief sought, so resolution of the legal issue requires adjudication by the courts.

The Providers argue that the Board has jurisdiction because the Providers are dissatisfied with the final determination of the Secretary as to the amount of payment.[12] In addition, in *Bethesda* the Supreme Court ruled that a provider had the right to appeal any item covered by the cost report in compliance with the law regarding that item. Finally, the Providers point out, that the Court in *Banner Health v. Sebelius*,[13] observed that the Secretary's self-disallowance regulation . . . conflicts with the plain text of [42 U.S.C. §] 1395oo and, therefore, the Board erred in ruling that it lacked jurisdiction to hear the Plaintiffs' challenge.[14]

Decision of the Board

The Board concludes that it lacks jurisdiction over the Providers' appeal because they failed to protest the additional Medicaid eligible days they were seeking on their as filed cost reports as required by 42 C.F.R. § 405.1835(a)(1)(ii). 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). Since the Board lacks jurisdiction over the appeal, it hereby dismisses the case.

The Providers did not protest the MAC's failure to include the additional Medicaid days on their as-filed cost reports as required by 42 C.F.R. § 405.1835(a)(1)(ii). This regulation states that:

> 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
>
> (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)).

[12] 42 U.S.C. § 1395oo(a)(ii).
[13] 2013 U.S. Dist. Lexis 69889 (D.D.C. May 16, 2013).
[14] Providers' EJR Request at 9.

In this case, the Providers received Notices of Program Reimbursement (NPRs) for cost reporting periods ending on or after December 31, 2008. The Providers assert that *Bethesda* allows providers to appeal to the Board where they are claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Although this statement is correct, it ignores additional language in *Bethesda* which states that "providers who bypass a clearly prescribed exhaustion requirement or who fail to request from the [MAC] reimbursement for all costs to which they are entitled under applicable rules" stand on different ground than those providers who are in compliance with the regulations.[15] Subsequent, to the decision in *Bethesda*, the Secretary did enact the regulatory protest requirement 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."[16] For the Board to find that it has jurisdiction over a provider's appeal, a provider must comply with the protest requirement of the regulation.

Further, the Providers point out that the Court in *Banner* stated that the self-disallowance policy of the regulation conflicts with the statute, 42 U.S.C. § 1395oo, and as a result the Board erred in finding that it lacked jurisdiction to hear the Providers' challenge. Consequently, the Court in *Banner* concluded the Board dismissal ran afoul of the Supreme Court's decision in *Bethesda.* However, this does not abrogate the Board's responsibilities under the current regulatory scheme. 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.[17] 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 removed 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 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

---

[15] *Bethesda* at 404-405.
[16] 42 C.F.R. § 405.1835(a)(1)(ii).
[17] No. 14-CV-01195(APM), 2016 WL 4435174 (D.D.C. August 19, 2016) at 10-11.

> 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 MAC, the Secretary has not acquiesced to this decision.[18] 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 there are no other issues under appeal in this case, the Board hereby closes the case number 17-1051GC. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875-405.1877.

Board Members Participating

L. Sue Andersen, Esq.
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA, CHFP
Gregory H. Ziegler

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

Enclosures: 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875-405.1877

cc: Barb Hinkle, Cahaba GBA c/o NGS
Wilson Leong, FSS

[18] In *Banner*, the Court concluded that the Board "violate[d] the administrative appeal provision of the Medicare statue and the key Supreme Courts precedent interpreting it, *Bethesda*." *Bethesda* emphasizes the futility of presenting a legal challenge to [a MAC] when the [MAC] does not have authority to entertain or decide such challenges. The Court in Bethesda also noted that providers who bypass a clearly prescribed exhaustion requirement or who fail to request from the [MAC] reimbursement for all costs to which they are entitled under applicable rules stand on different ground than those providers who are in compliance with the regulations. Here, the Provider has not documented that it would have been futile to claim reimbursement for additional Medicaid eligible days. Therefore, the Board concludes that the Medicaid eligible days issue would stand on different ground than issues for which it was futile (i.e. the provider was barred by a statute or regulation) to make a claim. Under 42 C.F.R. § 405.1835(a)(1)(ii), the Board is not able to find that it has jurisdiction over the Medicaid eligible days issue.