



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](http://www.cms.gov/PRRBReview) FAX: 410-786-5298

Refer to:

00-2445G

Certified Mail

AUG 02 2013

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

Re: ReedSmith NJ 95 SSI Group Appeal, Case No. 00-2445G  
(*Specifically Palisades General Hospital, Provider No. 31-0003, FYE 12/31/95*)

Dear Mr. Rotella:

The Provider Reimbursement Review Board (Board) has reviewed the Schedule of Providers and the associated jurisdictional documents for the above-referenced group pursuant to CMS Ruling CMS-1498-R. On its own motion, the Board notes a jurisdictional impediment with regard to one of the participants in the group. The pertinent facts and the Board's jurisdictional decision are set forth below.

**Pertinent Facts**

The Board received the Schedule of Providers for case number 00-2445G on May 31, 2013. The Board notes that Palisades General Hospital timely appealed from a revised Notice of Program Reimbursement (NPR) dated November 21, 1997. The Provider's appeal request states that the original NPR, dated May 5, 1997, was re-opened to adjust Medicaid eligible days. No additional information regarding the reopening was provided. The documentation submitted does not indicate that the SSI percentage was addressed in the re-opening, and the Schedule of Providers does not include the additional documentation, mandated under Rule 7.1 of the Provider Reimbursement Review Board Rules, required to make a determination of jurisdiction.

**Board Determination**

Based on the evidence available, the Board finds that it lacks jurisdiction over Palisades General Hospital.

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

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

42 C.F.R. § 405.1889(b)(1) explains the effect of a cost report revision: "Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision."

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

Additionally, effective March 1, 2013 the Board issued new rules which apply to all appeals pending as of, or filed on or after March 1, 2013. Rule 7.1 requires that when a Provider appeals a revised NPR, the Provider must submit a copy of the following documentation:

- the NPR that is immediately preceding the revised NPR under appeal,
- the revised NPR,
- the Reopening Request that preceded the revised NPR (if applicable),
- the Reopening Notice issued by the Intermediary,
- the revised NPR workpapers (for the issue(s) under appeal, and
- any applicable cost report worksheets (e.g., Worksheet E).

As noted, Palisades General Hospital is appealing from a revised NPR. Appeals from revised NPRs are limited to the specific matters revised in the revised determination. Having failed to provide the required documentation under Rule 7.1, there is no evidence to support an adjustment to the SSI percentage in the revised NPR. Consequently, the Board finds that it does not have jurisdiction over participant # 4, Palisades General Hospital, Provider No. 31-0003, FYE 12/31/95 and hereby dismisses the Provider from group case number 00-2445G.

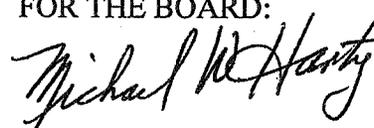
Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of this appeal.

Enclosed, please find the Board's notice regarding remand of the SSI issue under CMS Ruling CMS-1498-R for the remaining participants in the group and a copy of the Schedule of Providers.

Board Members Participating:

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

FOR THE BOARD:

  
Michael W. Harty  
Chairman

Enclosures

cc: Donna Silvio, Novitas Solutions, Inc.  
Kevin D. Shanklin, Executive Director, Blue Cross Blue Shield Association



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Refer to: 12-0095GC & 12-0096GC

CERTIFIED MAIL

AUG 08 2013

Ms. Corinna Goron  
President  
Healthcare Reimbursement Services  
17101 Preston RD, Suite 220  
Dallas, TX 75248-1372

Re: HRS 1987-2000 DSH/SSI Percentage Equitable Tolling Group, Provider Nos.: Various, FYEs:  
1987-2000, Case No. 12-0095G

HRS UHHS 1987-2000 Equitable Tolling CIRP Group, Provider Nos.: Various, FYEs: Various,  
Case No. 12-0096GC

Dear Ms. Goron:

The Provider Reimbursement Review Board (Board) has reviewed the hearing requests submitted in the attached appeals. The Providers asked the Board to consider equitable tolling to extend the time for filing an appeal with the Board. While the Providers have not furnished dates for the Notice of Program Reimbursement (NPR), the Providers stated on the Schedules of Providers that the Providers filed the appeals more than three years after the dates of their NPRs for the relevant fiscal periods. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

The Providers in the above cases requested equitable tolling because they argue that they could not have reasonably obtained the requisite information to exercise their appeal rights regarding the Supplemental Security Income (SSI) percentages used in calculating their Disproportionate Share Hospital (DSH) adjustment. The issues noted are:

- 1) whether DSH payments were incorrectly determined due to the systemic errors in the SSI percentages as identified in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008); and
- 2) whether CMS' refusal to provide the Provider Analysis and Review (MEDPAR) file to Providers deprived them of the ability to identify any non-systemic errors in the computation of their SSI percentages.

In the first case, HRS 1987-2000 DSH SSI Percentage Equitable Tolling Group, Case No. 12-0095G, the Intermediary filed a jurisdictional challenge charging that the appeals are untimely filed. The Intermediary noted that the case has 58 Providers that had not previously appealed the SSI percentage

issue and untimely added the SSI issue to the present case on December 21, 2011<sup>1</sup>. The Providers appealed cost reports with FYEs between June 30, 1987 and September 30, 2000, for which the MAC states the final determination was more than three years prior to the earliest request for hearing.<sup>2</sup>

The second case, HRS UHHS 1987-2000 Equitable Tolling CIRP Group, Case No. 12-0096GC, has 40 Providers.

Board Determination:

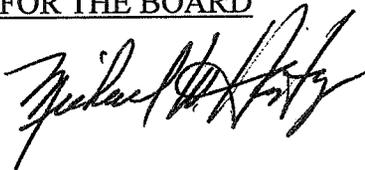
The Supreme Court recently addressed the question of whether the Board can consider equitable tolling and found that equitable tolling does not apply to appeals pending before the Board. *See Sebelius v. Auburn Regional Medical Center*, 133 S. Ct. 817 (2013). Since the appeals were not timely filed and the Board cannot consider equitable tolling to extend the time for filing, the Board hereby dismisses the equitable tolling issue within case numbers 12-0095G and 12-0096GC. As this is the sole issue in the appeals, the Board hereby closes the cases.

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  
Keith E. Braganza, CPA  
Clayton J. Nix, Esq.  
L. Sue Andersen, Esq.

FOR THE BOARD



Michael W. Harty  
Chairman

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

cc: Kevin D. Shanklin, Executive Director, BCBSA (w/Enclosures)  
Donna Silvio, Novitas Solutions, Inc. (w/Enclosures)  
Judith E. Cummings, CGS Administrators, LLC (w/Enclosures)  
James Ward, Noridian (AZ) (w/ Enclosures)  
Darwin San Luis, First Coast Service Options (CA) (w/Enclosures)  
Bryon Lamprecht, WPS (w/ Enclosures)

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<sup>1</sup> See, Intermediary Jurisdictional Challenge, Section II.

<sup>2</sup> *Id.*



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Refer to:

CERTIFIED MAIL

**AUG 13 2013**

Todd Prine  
Campbell Wilson  
15770 North Dallas Parkway  
Suite 500  
Dallas, TX 75248

Robin Sanders, Esq.  
Associate Counsel  
Blue Cross Blue Shield Association  
1310 G. Street, N.W. - 20th Floor  
Washington, DC 20005

RE: PRRB Case No. 11-0708G, Campbell Wilson 93-04 Nursing Home Group  
PRRB Case No. 03-1254G, Campbell Wilson 93-04 SSI Group

Dear Mr. Prine:

On July 24, 2013, the Provider Reimbursement Review Board (the Board) received the "Provider Response to PRRB Letter Dated June 24, 2013" for the above captioned appeals. Based on this correspondence, the revised Schedules of Providers, and the additional jurisdictional support submitted, the Board has completed its jurisdictional review of the participating Providers. The Board's findings are addressed below.

**PROVIDERS TO BE REMOVED FROM GROUP**

The Representative agreed that the seven Providers identified by the Board as having been previously dismissed or withdrawn from the groups should in fact be removed from the appeal. Similarly, the Representative agreed that the one Provider lacking proof of filing an individual appeal and proof of transfer to the group appeal should also be removed. Since these Providers have each been marked as "Removed" on the Schedule of Providers, no further action is necessary.

However, the Representative asked for clarification regarding the treatment of Grady Memorial Hospital and Nyack Hospital for FYE 12/31/2003. As the Board previously noted, both of these Providers were dismissed March 14, 2008 because the Providers had not filed a written request for hearing for the specific issue under appeal as required by 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841. The Representative properly excluded these Providers from Case No. 03-1254G as evidenced by the Schedule of Providers filed on June 12, 2008. However, the Representative continued to report these dismissed Providers as ongoing participants within Case No. 11-0708G as evidenced by the Schedule of Providers dated July 5, 2011. The Board noted this inconsistency and asked for the Providers to be removed from latter group as the documentation deficiency applies equally to both groups. The Board is unable to reconcile or provide a rationale for the Representative's inconsistent treatment of these Providers across the two groups.

### APPEALS FROM REVISED NPRS

The effect of a revised Notice of Program Reimbursement (NPR) on a provider's right to a Board hearing is addressed at 42 C.F.R. § 405.1889 (1998), which provides that:

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

The limit on issues that can be appealed from revised NPRs was discussed in *HCA Health Serv. of Okla. v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994). In that case, the Court concluded that when an intermediary reopens a determination regarding an amount of reimbursement that a Medicare provider is to receive, an appeal of the reopened cost report is limited to the specific issues revisited on reopening, and does not extend further to all determinations underlying the original reimbursement determination for the fiscal year in question.

The Board identified five Providers that filed appeals from revised NPRs. The Board requested supporting documentation from the Representative by letter dated March 14, 2008, and again on June 24, 2013, specifically to provide evidence the SSI/Nursing Home Days issue was adjusted on the revised NPRs for the respective Providers.<sup>1</sup> The Representative did not provide any new documentation in response to either request.<sup>2</sup> Instead, the Representative simply questioned the application of current Board Rules to previously established appeals and stated that it believes it met the standard for documentation as identified in Board Rule 7.1 (2009).

Consistent with 42 U.S.C. § 1395oo(e), the regulations governing Board appeals specify at 42 C.F.R. § 405.1868 that the Board has the power to establish rules governing hearings before the Board and that the Board has the authority to take "appropriate actions" in response to a party's failure to follow Board rules. It states in pertinent part:

- (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this

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<sup>1</sup> The Board Instructions at Part I, Section B(I)(a)(3) (2002), in effect at the time Case No. 03-1254G was filed, address Board jurisdiction over revised NPRs stating: "The Board accepts jurisdiction over appeals from a revised Notice of Program Reimbursement (NPR) where the issues(s) in dispute were specifically adjusted by that revised NPR. The Board typically follows the courts by limiting the scope of such an appeal to only the revised issue(s)."

<sup>2</sup> The Representative failed to respond to the first request. In response to the second request, the Representative resubmitted copies of the same prior jurisdictional documentation that had initially given rise to the Board's requests on this issue. The Representative did not identify any new documentation or provide clarification regarding the adjustments made within the revised NPRs.

*subpart. The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders. . . .*<sup>3</sup>

Board Rule 9 (2009, 2013) states:

You will receive an acknowledgement from the Board indicating that your appeal request has been received and the case number assigned ... An acknowledgement does not limit the Board's authority to require more information or dismiss the appeal if it is later found to be jurisdictionally deficient. The acknowledgment and subsequent correspondence will establish various deadlines and due dates. Failure by a party to comply with such deadlines ... may result in the Board taking any of the actions described in 42 C.F.R. § 405.1868.

While current Board Rules 7.1 and 21D (2013) reference specific supporting documentation that is required to be submitted for new appeals raised from a revised NPR, the Board finds that similar documentation is necessary to determine whether the jurisdictional and filing requirements have been met for certain Providers within Case Nos. 03-1254G and 11-0708G. The Board has routinely used development letters, such as those issued in March 2008 and June 2013, to request such supporting documentation.

Based on the Representative's failure to supply the requested documentation regarding the review performed and adjustments made from the revised NPR, the Board cannot determine whether the SSI Omitted Days and SSI Nursing Home issues were considered and adjusted by the Intermediary when the cost reports were revised. Therefore, in accordance with 42 C.F.R. §§ 405.1835(a) and 405.1889, the Board concludes that it lacks jurisdiction over these issues for the following Providers and hereby dismisses them from Case Nos. 03-1254G and 11-0708G:

<u>Book</u>	<u>Line</u>	<u>Provider Name</u>	<u>FYE</u>
1	1	Parkland Health & Hospital System	9/30/1993
1	17	Rush North Shore	6/30/1999
17	1	Freeman Health	3/31/1998
17	2	Freeman Health	3/31/1999
17	3	Freeman Health	3/31/2000

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<sup>3</sup> (Italics emphasis added.) Similarly, Board Rule 1.1 specifies that "[t]he Board has discretion to take action as outlined in 42 C.F.R. § 405.1868 if a party fails to comply with these rules."

**INCONSISTENT DATA & TYPOGRAPHICAL ERRORS**

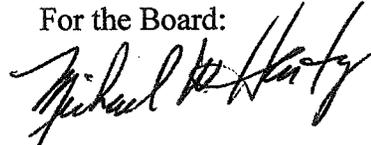
The Board has sufficient supporting documentation to support the Providers previously identified as having inconsistent data and notes that the required corrections were made to address the typographical errors. The use of a single schedule for Case Nos. 03-1254G and 11-0708G with a separate column E for each group is also acceptable. No further documentation or clarification for these items is required.

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

**Board Members:**

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

For the Board:

  
Michael W. Harty  
Chairman

cc: Donna Silvio  
Medicare Reimbursement & Settlement  
Novitas Solutions, Inc.  
Union Trust Building  
501 Grant Street, Suite 600  
Pittsburgh, PA 15219

Kevin D. Shanklin  
Executive Director  
Senior Government Initiatives  
Blue Cross Blue Shield Association  
225 North Michigan Avenue  
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Refer to:

13-1633

CERTIFIED MAIL

**AUG 13 2013**

Nevada Regional Medical Center  
Judith Feuquay  
President/CEO  
800 South Ash  
Nevada, MO 64772

RE: Nevada Regional Medical Center  
FYE: 6/30/09  
Provider No. 26-0061  
PRRB Case No. 13-1633

Dear Ms. Feuquay:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's April 9, 2013 request for hearing which was received (filed)<sup>1</sup> by the Board on April 12, 2013. The Board's jurisdictional determination is set forth below.

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

Decision of the Board

In this case, the Board received the Provider's request for a hearing on April 12, 2013. This appeal was filed from a Notice of Program Reimbursement dated October 5, 2012. The Provider is deemed to have received the final determination 5 days after issuance, which would have been October 10, 2012. The request for hearing was not received by the Board within 180 days of the date of the receipt of the final determination as required; therefore, the Board hereby dismisses the appeal because it was not filed on a timely basis.

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.

<sup>1</sup> See, 42 C.F.R. § 405.1835(a)(3) (a provider has a right to hearing before the Board if, among other things, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the date of receipt by the intermediary's [final] determination.) 42 C.F.R. 405.1801(a)(2) (2008) (the date of receipt means the date stamped "Received" by the reviewing entity).

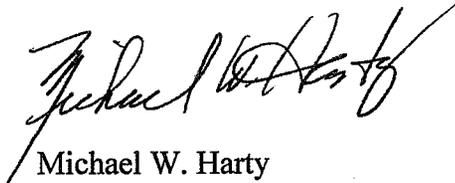
Provider Reimbursement Review Board  
Nevada Regional Medical Center

Case No. 13-1633

Board Members Participating

Michael W. Harty  
Clayton J. Nix, Esq.  
L. Sue Andersen, Esq.

FOR THE BOARD



Michael W. Harty  
Chairman

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

cc: Judith E. Cummings  
Accounting Manager  
CGS Administrators, LLC  
J15 Part A Audit & Reimbursement  
3021 Montvale Drive, Suite C  
Springfield, IL 62704

Kevin Shanklin  
Executive Director  
Senior Government Initiatives  
Blue Cross & Blue Shield Association  
225 North Michigan Avenue  
Chicago, IL 60601-7680



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FAX: 410-786-5298

Refer to:

13-2354

CERTIFIED MAIL

**AUG 13 2013**

Sisters of Mercy Willard  
Sheri Zimmerman  
Regional Director of Reimbursement  
2200 Jefferson Avenue  
Toledo, OH 43604

RE: Sisters of Mercy Willard  
FYE: 12/31/2010  
Provider No. 36-1310  
PRRB Case No. 13-2354

Dear Ms. Zimmerman:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's March 13, 2013 request for hearing which was received (filed)<sup>1</sup> by the Board on June 19, 2013. The Board's jurisdictional determination is set forth below.

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

Decision of the Board

In this case, the Board received the Provider's request for a hearing on June 19, 2013. This appeal was filed from a Notice of Program Reimbursement dated September 19, 2012. The Provider is deemed to have received the final determination 5 days after issuance, which would have been September 25, 2012. The request for hearing was not received by the Board within 180 days of the date of the receipt of the final determination as required; therefore, the Board hereby dismisses the appeal because it was not filed on a timely basis.

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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<sup>1</sup> See, 42 C.F.R. § 405.1835(a)(3) (a provider has a right to hearing before the Board if, among other things, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the date of receipt by the intermediary's [final] determination.) 42 C.F.R. 405.1801(a)(2) (2008) (the date of receipt means the date stamped "Received" by the reviewing entity).

Provider Reimbursement Review Board  
Sisters of Mercy Willard

Case No. 13-2354

Board Members Participating

Michael W. Harty  
Clayton J. Nix, Esq.  
L. Sue Andersen, Esq.

FOR THE BOARD



Michael W. Harty  
Chairman

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

cc: Judith E. Cummings  
Accounting Manager  
CGS Administrators, LLC  
J15 Part A Audit & Reimbursement  
3021 Montvale Drive, Suite C  
Springfield, IL 62704

Kevin Shanklin  
Executive Director  
Senior Government Initiatives  
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225 North Michigan Avenue  
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Refer to:

13-2271

CERTIFIED MAIL

**AUG 18 2013**

Lee Memorial Health System  
Ben Spence  
224 Santa Barbara Boulevard, Suite 203  
Cape Coral, FL 33991

RE: Lee Memorial Hospital  
FYE: 9/30/06  
Provider No. 10-0012  
PRRB Case No. 13-2271

Dear Mr. Spence:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's May 31, 2013 request for hearing which was received (filed)<sup>1</sup> by the Board on June 03, 2013. The Board's jurisdictional determination is set forth below.

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

Decision of the Board

In this case, the Board received the Provider's request for a hearing on June 03, 2013. This appeal was filed from a Notice of Program Reimbursement dated November 28, 2012. The Provider is deemed to have received the final determination 5 days after issuance, which would have been December 3, 2012. The request for hearing was not received by the Board within 180 days of the date of the receipt of the final determination as required; therefore, the Board hereby dismisses the appeal because it was not filed on a timely basis.

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.

<sup>1</sup> See, 42 C.F.R. § 405.1835(a)(3) (a provider has a right to hearing before the Board if, among other things, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the date of receipt by the intermediary's [final] determination.) 42 C.F.R. 405.1801(a)(2) (2008) (the date of receipt means the date stamped "Received" by the reviewing entity).

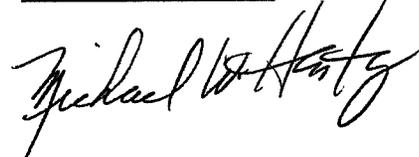
Provider Reimbursement Review Board  
Lee Memorial Hospital

Case No. 13-2271

Board Members Participating

Michael W. Harty  
Clayton J. Nix, Esq.  
L. Sue Andersen, Esq.

FOR THE BOARD



Michael W. Harty  
Chairman

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

cc: Geoff Pike  
First Coast Service Options, Inc. – FL  
Provider Audit and Reimbursement Department  
532 Riverside Avenue  
Jacksonville, FL 32231

Kevin Shanklin  
Executive Director  
Senior Government Initiatives  
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Refer to:

09-0542GC

Certified Mail

AUG 13 2013

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

Re: QRS BHCS 1997-2003 DSH LDR Days Group Appeal, Case No. 09-0542GC  
Specifically:

- Provider 1: Baylor University Medical Center, Provider No. 45-0021, FYE 6/30/1997, Original PRRB Case No. 07-0345
- Provider 2: Baylor University Medical Center, Provider No. 45-0021, FYE 6/30/1998, Original PRRB Case No. 07-0740
- Provider 4: Baylor All Saints Medical Center, Provider No. 45-0137, FYE 9/30/1999, Original PRRB Case No. 04-1683

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") recently reviewed the above-captioned appeal. The Disproportionate Share Hospital Labor Room Days issue is subject to CMS Ruling CMS-1498-R. The background regarding the above-captioned participants in the above-captioned group case and the Board's determination are set forth below.

**Background**

The Board received the initial request for appeal of the Labor Room Day issue for Group No. 09-0542GC on December 23, 2008 and received the most recent Schedule of Providers on August 1, 2011.

On June 21, 2013 the Board requested additional information to determine whether the jurisdictional and filing requirements were met for the group. The Board requested documentation from Providers 7, 9, and 10 regarding appeals from revised NPRs. The Board also requested documentation showing that Providers 1, 2, 3, 4, 5, 6, and 8 properly added the Labor Room Days issue to their individual appeals prior to transferring to this group, Case No. 09-0542GC.

The Providers' Representative responded to this request on July 22, 2013. The submission included the requested information regarding Providers 7, 9, and 10. Additionally, copies of Model Form C (Request to Add Issues to an Individual Appeal) were included for Providers 3, 5, 6, and 8 confirming that the Labor Room Days issue had been added to the individual appeals prior to their transfer to this group, Case No. 09-0542GC. The submission did not include such documentation for Providers 1, 2, and 4.

**Board Determination**

The August 2008 revisions to the regulations governing provider reimbursement appeals require that a relevant issue be timely added to an individual appeal prior to its transfer to a group appeal. Providers were given 60 days from the effective date of the revisions to add additional issues to pending appeals. See 73 Fed. Reg. 49356 (August 21, 2008).

Providers 1, 2, and 4 failed to provide evidence that the Labor Room Day issue was added to their individual appeals prior to the exhaustion of the 60 day add period.

The Board finds that the following Providers did not properly preserve the Labor Room Day issue, and therefore were not properly added to this group, Case No. 09-0542GC.

- Provider 1: Baylor University Medical Center, Provider No. 45-0021, FYE 6/30/1997, Original PRRB Case No. 07-0345
- Provider 2: Baylor University Medical Center, Provider No. 45-0021, FYE 6/30/1998, Original PRRB Case No. 07-0740
- Provider 4: Baylor All Saints Medical Center, Provider No. 45-0137, FYE 9/30/1999, Original PRRB Case No. 04-1683

The Board hereby dismisses Providers 1, 2, and 4 from Case No. 09-0542GC. Please find enclosed, the Board's notice regarding remand of the Labor Room Day issue under CMS Ruling CMS-1498-R for the remaining participants in the group and a copy of the Schedule of Providers.

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

**Board Members Participating:**

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

FOR THE BOARD:



Michael W. Harty  
Chairman

**Enclosures**

CC: Novitas Solutions, Inc.  
Donna Silvio  
Medicare Reimbursement and Settlement  
Union Trust Building  
501 Grant Street, Suite 600  
Pittsburgh, PA 15219

Blue Cross Blue Shield Association  
Kevin D. Shanklin  
Executive Director  
Strategic Government Initiatives  
225 North Michigan Avenue  
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CERTIFIED MAIL

**AUG 16 2013**

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

Re: QRS DSH/SSI Equitable Tolling Cases (See attached list.)

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (Board) has reviewed the Schedules of Providers and associated jurisdiction documents for the appeals on the attached list of cases. The Providers have asked the Board to consider equitable tolling to extend the time for filing an appeal with the Board. The Providers have not furnished dates for the Notices of Program Reimbursement (NPRs), however, given the fiscal years identified on the Schedules of Providers, it is assumed that all the NPRs are more than three years old. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

The Providers in these cases have requested equitable tolling because they argue that they could not have reasonably obtained the requisite information to exercise their appeal rights regarding the Supplemental Security Income (SSI) percentage used in calculating their disproportionate share hospital (DSH) adjustment. The issues noted are:

- 1) whether DSH payments were incorrectly determined due to the systemic errors in the SSI percentages as identified in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008); and
- 2) whether CMS' refusal to provide the Provider Analysis and Review (MEDPAR) file to Providers deprived them of the ability to identify any non-systemic errors in the computation of their SSI percentages.

One or more Intermediaries have filed a jurisdictional challenge in the cases listed below. The Intermediary argues that the following cases are untimely filed:

- QRS DCH 1987-2000 DSH SSI Equitable Tolling CIRP Group, Case No. 12-0011GC;
- Integris Health 1987-2000 DSH SSI Equitable Tolling CIRP Group Case No. 12-0016GC;
- QRS Via Christi Health 1987-2000 DSH/SSI Equitable Tolling Case No. 12-0019GC;
- QRS BJC Healthcare 1987-2000 DSH/SSI Equitable Tolling CIRP Group Case No. 12-0028GC;
- QRS Affinity Health 1987-2000 DSH/SSI Equitable Tolling CIRP Group Case No. 12-0051GC;
- QRS BHCS 1987-2000 DSH/SSI Equitable Tolling Case No. 12-0052GC;

- QRS Trinity Health 1987-2000 DSH/SSI Equitable Tolling CIRP Group Case No. 12-0090GC;
- QRS TMH 1987-2000 DSH/SSI Equitable Tolling CIRP GRP 12-0119GC; and
- QRS HMA 1987-2000 DSH SSI Equitable Tolling CIRP GRP Case No. 12-0131GC.
- QRS BMHCC 1987-1995 DSH SSI Equitable Tolling CIRP GRP Case No. 12-0230GC.

Board Determination:

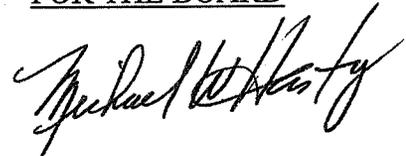
The Supreme Court recently addressed the question of whether the Board can consider equitable tolling and found that equitable tolling does not apply to appeals pending before the Board. *See Sebelius v. Auburn Regional Medical Center*, 133 S. Ct. 817 (2013). Since the appeals were not timely filed and the Board cannot consider equitable tolling to extend the time for filing, the Board hereby dismisses the appeals. This action closes the cases.

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  
Keith E. Braganza, CPA  
Clayton J. Nix, Esq.  
L. Sue Andersen, Esq.

FOR THE BOARD



Michael W. Harty  
Chairman

Enclosures: List of Cases

Schedules of Providers

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

cc: Kevin D. Shanklin, BCBSA (w/Enclosures)  
Renee Rhone, Cahaba Government Benefit Administrators (w/Enclosures)  
Donna Silvio, Novitas Solutions, Inc. (w/Enclosures)  
Bryon Lamprecht, Wisconsin Physicians Services (w/Enclosures)  
Geoff Pike, First Coast Service Options, Inc.- FL (w/Enclosures)  
Danene Hartley, National Government Services, Inc. (w/Enclosures)  
Cecile Huggins, Palmetto GBA (w/Enclosures)

**QRS DSH/SSI EQUITABLE TOLLING GROUP**

QRS DCH 1987-2000 DSH/SSI EQUITABLE TOLLING CIRP GROUP	12-0011GC
INTEGRIS HEALTH 1987-2000 DSH SSI EQUITABLE TOLLING CIRP GROUP	12-0016GC
QRS VIA CHRISTI HEALTH 1987-2000 DSH SSI EQUITABLE TOLLING	12-0019GC
QRS BROWARD HEALTH 1987-2000 DSH SSI EQUITABLE TOLLING CIRP GRP	12-0021GC
QRS BJC HEALTHCARE 1987-2000 EQUITABLE TOLLING CIRP GROUP	12-0028GC
QRS AFFINITY HEALTH 1987-2000 DSH/SSI EQUITABLE TOLLING CIRP GROUP	12-0051GC
QRS BHCS 1987-2000 DSH/SSI EQUITABLE TOLLING	12-0052GC
QRS TRINITY HEALTH 1987-2000 DSH/SSI EQUITABLE TOLLING CIRP GROUP	12-0090GC
QRS YNHHS 1987-2000 DSH/SSI EQUITABLE TOLLING CIRP GRP	12-0092GC
QRS WVUH 1987-2000 DSH SSI EQUITABLE TOLLING CIRP GRP	12-0093GC
QRS 1987-2000 DSH SSI EQUITABLE TOLLING GROUP	12-0117G
QRS TMH 1987-2000 DSH SSI EQUITABLE TOLLING CIRP GROUP	12-0119GC
QRS HMA 1987-2000 DSH SSI EQUITABLE TOLLING CIRP GRP	12-0131GC
QRS BMHCC 1987-1995 DSH SSI EQUITABLE TOLLING CIRP GRP	12-0230GC



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Refer to: 10-0395GC

CERTIFIED MAIL

AUG 16 2013

Petrak & Associates, Inc.  
Derek F. Petrak  
2255 Morrello Avenue  
Suite 201  
Pleasant Hill, CA 94523

Palmetto GBA c/o First Coast Service Options, Inc.  
Darwin San Luis  
Appeals Coordinator  
4880 Santa Rosa Road, Suite 170  
Camarillo, CA 93012-0951

Re: Marin General Hospital (05-0360), Participant #5  
Memorial Hospital Modesto (05-0557), Participant #6  
*As Participants in Sutter Health 2004 Disproportional Share Labor Room Days CIRP Group*  
FYE: 12/31/2004  
PRRB Case No.: 10-0395GC

Dear Mr. Petrak and San Luis:

The Provider Reimbursement Review Board (Board) has reviewed your appeal for Standard Remand in accordance with CMS-1498-R. Upon review the Board noted a jurisdictional impediment with regard to two participants in your group appeal. The pertinent facts regarding these participants and the Board's determination are set forth below.

**Pertinent Facts:**

Marin General Hospital (Marin), Participant #5 referenced dates from its 2005 FYE appeal on the Schedule of Providers. However, the documentation submitted is for FYE 12/31/2004. The Provider timely appealed the FYE 2004 final determination to the Board in an individual appeal and was assigned case no. 08-0465. Although the Labor Delivery Room Days (LDR) was included in the individual appeal, there is no record that Marin formally requested to transfer the LDR issue from its individual appeal to the group. The provider submitted no supporting documentation at Tab 5G. The group appeal request states:

Sutter Health will request to transfer this issue from the various established individual appeal cases into this new group once the new case number has been established.  
(emphasis added)

Memorial Hospital Modesto (05-0557), Participant #6, previously transferred the LDR issue from its individual appeal, case number 07-2815 to the Toyon 04 LDR Group, case no. 07-2719G. That group appeal received an Alternative Procedure Remand on February 28, 2011.

**Board Determination:**

The Board finds that it lacks jurisdiction over Marin in this group appeal as the issue was not properly transferred to the group appeal. As this group appeal was filed after the issuance of the Board's August 2008 Board Rules, there must be an actual request to transfer the issue from the Provider's individual appeal to the group appeal.

As Marin has a pending individual appeal, case no. 08-0465, the LDR issue will be remanded to the Intermediary pursuant to CMS-1498-R, under the individual case number.

With respect to Memorial Hospital Modesto the Board finds that the LDR issue has already been remanded in case 07-2719g, therefore it is dismissed from the group appeal, case no. 10-0395GC.

The remaining participant in the group appeal, Eden Medical Center (05-0488), is 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:**

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

For the Board:

  
Michael W. Harty  
Chairman

Enclosures: Standard Remand of LDR Days for case no. 10-0395GC  
Schedule of Providers  
Copy of Remand in case no. 07-2719G with Schedule of Providers

cc: Kevin D. Shanklin, Executive Director, BCBSA (w/ Enclosures)



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CERTIFIED MAIL

**AUG 15 2013**

12-0231GC

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

Re: QRS Pinnacle Health 1987-1995 DSH/SSI Equitable Tolling CIRP Group  
With Two Participants Harrisburg Hospital fka Polyclinic Medical Center (39-0067) and Harrisburg  
Hospital (39-0098)  
FYE: 1987-1995  
PRRB Case No. 12-0231GC<sup>1</sup>

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (Board) has reviewed the record in the above referenced group appeal. The Providers have asked the Board to consider equitable tolling to extend the time for filing an appeal with the Board. The Providers did not furnish dates for the Notices of Program Reimbursement (NPRs). However, given the fiscal years identified on the Schedule of Providers it is assumed that all NPRs are more than three years old. The Board's determination with respect to jurisdiction is set forth below.

Pertinent Facts:

The Providers in this case have requested equitable tolling because they argue their Disproportionate Share Hospital (DSH) Adjustment was incorrectly determined due to a significant error in the Supplemental Security Income percentage that the Intermediary used to determine the DSH adjustment.

The Intermediary has filed a jurisdictional challenge contending that the appeal is untimely filed as each "determination is more than three years prior to the earliest request for a hearing."

Board Determination:

The Supreme Court recently addressed the question of whether the Board can consider equitable tolling and found that equitable tolling does not apply to appeals pending before the board. *See Sebelius v.*

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<sup>1</sup> The two hospitals participating in this case previously participated in case number 08-2872G. The Providers asked to establish this group appeal through requests dated December 21, 2011 and transfer from 08-2872G to comply with the requirements of 42 C.F.R. § 405.1837(b)(ii) which addresses the requirements for group appeals involving commonly owned providers.

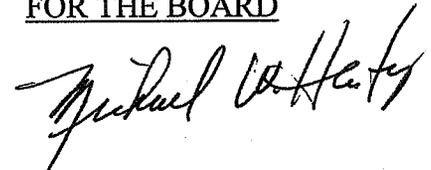
*Auburn Regional Medical Center*, 133 S.Ct. 817 (2013). The Court held that the Board cannot consider equitable tolling to extend the time for filing. Since the appeal was not timely filed and the Board cannot consider equitable tolling to extend the time for filing, the Board hereby dismisses the appeal. This action 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

Michael W. Harty  
Keith E. Braganza, CPA  
Clayton J. Nix, Esq.  
L. Sue Andersen, Esq.

FOR THE BOARD



Michael W. Harty  
Chairman

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

cc: Kevin D. Shanklin, Executive Director, BCBSA  
Donna Silvio, Novitas Solutions, Inc.



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CERTIFIED MAIL

**AUG 15 2013**

Toyon Associates, Inc.  
Glenn S. Bunting  
Vice President - Appeal Services  
1800 Sutter Street, Suite 600  
Concord, CA 94520 2546

RE: San Gabriel Valley Medical Center (#16), Provider No. 05-0132, FYE 09/30/2000  
Mercy Medical Center Dominican Campus (#17), Provider No. 05-0117, FYE 9/30/2000  
As participants in the Toyon CHW 2000 DSH General Assistance Days Group,  
PRRB Case No. 06-0088GC

Dear Mr. Bunting:

The Provider Reimbursement Review Board (the Board) reviewed the above-captioned DSH General Assistance Days group appeal which has been heard on the record. The Board notes a jurisdictional impediment with regard to two of the participants in the group. The pertinent facts with regard to these participants and the Board's determination are set forth below.

Pertinent Facts:

**San Gabriel Valley Medical Center**

On March 13, 2009 San Gabriel Valley Medical Center filed a timely request to join the subject group appeal from a revised NPR (RNPR) dated December 30, 2008. The Provider referenced audit adjustment number 4 from the adjustment report. This adjustment is for additional allowable DSH days. The information submitted from the RNPR does not support an adjustment to General Assistance Days.

**Mercy Medical Center Dominican Campus**

On June 21, 2005, Mercy Medical Center Dominican Campus filed a timely appeal from a RNPR dated January 3, 2005. The RNPR indicates it "incorporates the appeal decision for . . . the DSH Adjustment Management Fees" for case number 03-0515. (Case number 03-0515 was the Provider's original NPR appeal filed on January 24, 2003 from an NPR dated September 13, 2002. The case was withdrawn in October 2005.) In the RNPR appeal request, the Provider included the General Assistance Days issue but referenced audit adjustments from the original adjustment report (2, 6, 44 and 54). In column D of the Schedule of Providers, the Provider lists adjustment R2-002 and the audit adjustment page submitted at tab 17D reflects an adjustment to Hospital Adults & Peds - "to update the DSH adjustment to include additional payment for allowable days not included in the previous DSH calculation." The RNPR does not appear to adjust General Assistance Days.

This Provider initially transferred the General Assistance Days issue from the original NPR individual appeal (case number 03-0515) to group appeal case number 04-1816G - The QRS 00

DSH/General Assistance Days Group. On February 16, 2010, the Provider transferred from that group to a state specific group for the same issue, case number 09-2068G. Ultimately, the Provider transferred from the state specific group, case number 09-2068G to this CIRP group, case number 06-0088GC on September 24, 2010.

#### Jurisdiction – General Requirements

A provider has a right to a hearing before the Board, with respect to costs claimed on a timely filed cost report, if: (a) it is dissatisfied with the final determination of the intermediary, (b) the amount in controversy is \$10,000 or more (\$50,000 for a group), and (c) the request for a hearing is filed within 180 days of the date of receipt of the Notice of Program Reimbursement (NPR).<sup>1</sup>

Additionally, for Revised Notices of Program Reimbursement, the regulation that was in effect when the RNPRs were issued states:

Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in § 405.1885, such revision shall be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1835, 405.1875 and 405.1877 are applicable.<sup>2</sup>

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

#### Board Determination:

The Board finds that it does not have jurisdiction over San Gabriel Valley Medical Center and Mercy Medical Center Dominican Campus for the General Assistance Days issue pursuant to 42 U.S.C. § 1395oo(a)(1)(A) and 42 C.F.R. §§ 405.1835 and 405.1837, or alternatively 42 C.F.R. § 405.1889(b)(1).

Neither of these Providers appealed from RNPRs which adjusted General Assistance Days. In fact, the RNPR appealed by Mercy Medical Center Dominican Campus was issued to incorporate the appeal decision for PRRB case number 03-0515. Although the Board does not have a copy of the signed resolution, the Provider apparently agreed that the dissatisfaction had been resolved for the issues in case number 03-0515. The Board finds that the Provider resolved/withdrew its dissatisfaction with the issues appealed in that case when it withdrew the case before the Board. Had the Provider been only "partially" satisfied with the resolution, it had an open appeal and an opportunity to bring remaining issues before the Board for hearing.

---

<sup>1</sup> 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-1841.

<sup>2</sup> 42 C.F.R. § 405.1889.

Therefore, the Board finds that San Gabriel Valley Medical Center and Mercy Medical Center Dominican Campus cannot show the dissatisfaction necessary to appeal the RNPR as required by 42 U.S.C. §1395oo(a)(1)(A) and 42 C.F.R. §§405.1835 and 405.1837. Therefore, the Board finds that it lacks jurisdiction over these Providers for the General Assistance Days issue and dismisses participant #s 16 and 17 from the group.

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

Board Members Participating:

Michael W. Harty  
Clayton J. Nix, Esq.  
L. Sue Andersen, Esq.

For the Board:

  
Michael W. Harty  
Chairman

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

cc: Darwin San Luis, Palmetto GBA c/o First Coast Service Options, Inc.  
Kevin D. Shanklin, Executive Director, BCBSA



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**AUG 15 2013**

Toyon Associates, Inc.  
Glenn S. Bunting  
Vice President - Appeal Services  
1800 Sutter Street, Suite 600  
Concord, CA 94520 2546

RE: Alta Bates Medical Center (#1), Provider No. 05-0305, FYE 12/31/1998  
Mt. Diablo Medical Center (#5), Provider No. 05-0496, FYE 12/31/1998  
As participants in the Toyon 1998 DSH General Assistance Days Group #2  
PRRB Case No. 07-1425G

Dear Mr. Bunting:

The Provider Reimbursement Review Board (the Board) reviewed the above-captioned DSH General Assistance Days group appeal which has been heard on the record. The Board notes a jurisdictional impediment with regard to two of the participants in the group. The pertinent facts with regard to these participants and the Board's determination are set forth below.

Pertinent Facts:

**Alta Bates Medical Center**

On October 10, 2006 Alta Bates Medical Center filed a timely appeal from a revised NPR (RNPR) dated September 20, 2006. The RNPR indicates it "incorporates the appeal decision for . . . the DSH Medicaid Eligible Days Inpatient Part B 5.8% Reduction" for case number 02-1394. (Case number 02-1394 was the Provider's original NPR appeal filed on March 22, 2002 from an NPR dated September 28, 2001. The case was withdrawn in April 2006.)

In the RNPR appeal request, the Provider included the General Assistance Days issue, referencing adjustment numbers R4-003 and R4-006. The audit adjustment pages submitted at tab 1D reflect that adjustment R3-004 is for Hospital Adults & Peds - "To adjust the Medicaid Eligible and Total Patient Days as per audit findings." Adjustment R4-006 is for Allowable DSH "To revise the Allowable Disproportionate Share Percentage as per audit findings." It includes a memo adjustment which indicates "The Capital DSH payment will be revised on W/S L Part 1 of the cost report as flow through." The RNPR does not appear to adjust General Assistance Days.

The documentation submitted in the Schedule of Providers at tab 1G shows this Provider was used to form the group appeal on March 13, 2007. The RNPR individual appeal from which this Provider would have transferred the issue, however, was closed on December 29, 2006.

### **Mt. Diablo Medical Center**

This Provider timely filed its individual appeal from an original NPR and was assigned case number 02-0011.<sup>1</sup> The Provider did not submit evidence demonstrating the transfer of the General Assistance Days to the subject group appeal. The documentation submitted in the Schedule of Providers at Tab 5G is for a different Provider that is no longer participating in the group. According to the Board's tracking system, the Mt. Diablo Medical Center apparently transferred the General Assistance Days issue to group appeal case number 00-1863G – The Blumberg Ribner 92-01 AZ DSH General Assist Days/Charity Care Days Group on August 5, 2005. There is no documentation to support the transfer of Mt. Diablo Medical Center from case number 00-1863G to this group.

#### Jurisdiction – General Requirements

A provider has a right to a hearing before the Board, with respect to costs claimed on a timely filed cost report, if: (a) it is dissatisfied with the final determination of the intermediary, (b) the amount in controversy is \$10,000 or more (\$50,000 for a group), and (c) the request for a hearing is filed within 180 days of the date of receipt of the Notice of Program Reimbursement (NPR).<sup>2</sup>

Additionally, for Revised Notices of Program Reimbursement, the regulation that was in effect when the RNPRs were issued states:

Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in § 405.1885, such revision shall be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1835, 405.1875 and 405.1877 are applicable.<sup>3</sup>

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

#### Board Determination:

The Board finds that it does not have jurisdiction over Alta Bates Medical Center for the General Assistance Days issue pursuant to 42 U.S.C. §1395oo(a)(1)(A) and 42 C.F.R. §§405.1835 and 405.1837, or alternatively 42 C.F.R. § 405.1889(b)(1).

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<sup>1</sup> The case numbers referenced on the Schedule of Providers for this participant are incorrect for both the individual appeal and the first group to which it allegedly transferred prior to transferring to this group case.

<sup>2</sup> 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-1841.

<sup>3</sup> 42 C.F.R. § 405.1889.

The Provider appealed from a RNPR which did not adjust General Assistance Days. In fact, the RNPR appealed was issued to incorporate the appeal decision for PRRB case number 02-1394. Although the Board does not have a copy of the signed resolution, the Provider apparently agreed that the dissatisfaction had been resolved for the issues in case number 02-1394. Therefore, the Board finds that the Provider resolved/withdrew its dissatisfaction with the issues appealed in that case when it withdrew the case before the Board. Had the Provider been only "partially" satisfied with the resolution, it had an open appeal and an opportunity to bring remaining issues before the Board for hearing. Alternatively, the RNPR did not specifically adjust General Assistance Days and the Provider's individual appeal was closed at the time the subject group appeal was filed, making the transfer invalid. Based on these findings, the Board dismisses Alta Bates Medical Center as it cannot show the dissatisfaction necessary to appeal the RNPR as required by of 42 U.S.C. §1395oo(a)(1)(A) and 42 C.F.R. §§405.1835 and 405.1837.

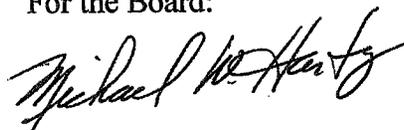
With regard to Mt. Diablo Medical Center, the Provider did not provide evidence to support the transfer of the General Assistance Days issue from its individual appeal to the subject group. Therefore, the Board lacks jurisdiction over Mt. Diablo Medical Center for the General Assistance Days issue, and dismisses it from the group.

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

Board Members Participating:

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

For the Board:

  
Michael W. Harty  
Chairman

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

cc: Darwin San Luis, Palmetto GBA c/o First Coast Service Options, Inc.  
Kevin D. Shanklin, Executive Director, BCBSA



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Refer to:

12-0213GC

Certified Mail

AUG 15 2013

Isaac Blumberg  
Blumberg Ribner, Inc  
315 South Beverly Drive  
Suite 205  
Beverly Hills, CA 90212

RE: Alta Health Systems RFBNA 1999-2011 Equitable Tolling Group<sup>1</sup>  
Provider Nos. Various  
FYE 1999-2011  
PRRB Case No. 12-0213GC

Dear Mr. Blumberg:

The Provider Reimbursement Review Board (Board) has reviewed the Schedule of Providers and associated jurisdictional documentation in the above-referenced appeal. The Board's jurisdictional decision is set forth below.

**Appeals filed Prior to the Issuance of Notices of Program Reimbursement (NPRs)**

In reviewing the record the Board noted that the Providers asked that the Board consider equitable tolling for late filing. However, a number of the Providers' appeals were filed prior to the issuance of their respective NPRs as was indicated in the February 13, 2012 hearing request.<sup>2</sup> The following appeals were filed prior to the issuance of the requisite final determination:

Brotman Medical Center, provider number 05-0166, FYEs 12/31/2007, 2008, 2009, 2010 and 2011;

<sup>1</sup> Hollywood Community Hospital (provider number 05-0135) and Los Angeles Community Hospital (provider number 05-0663), filed appeals of the fiscal years 12/31/2007 and 12/31/2008 in this case prior to the issuance of their respective NPRs and sought equitable tolling. Upon receipt of the NPRs for these fiscal year ends, Hooper, Lundy and Bookman filed group appeals for these fiscal years and included both Providers. The Providers were dismissed from this case through correspondence dated August 5, 2013, since they had appeals of the RFBNA issue pending in case numbers 13-0210GC (2007) and 13-2398GC (2008) and the Board's rules 4.5 precludes filing duplicate appeals. The appeals in this case had been premature since the Providers had not received final determinations of reimbursement.

<sup>2</sup> See Providers' February 13, 2012 hearing request, Tab 2 (Alta Health Systems is appealing under the Equitable Tolling Theory for FFYs 1999 through 2011 even though they have not yet received any notices of amount of program reimbursement for their fiscal years ending 2007 through 2011).

Hollywood Community Hospital, provider number 05-0135, FYEs 12/31/2009, 2010 and 2011; and

Los Angeles Community Hospital, provider number 05-0633, FYEs, 12/31/2009, 2010 and 2011.

#### Decision of the Board-Premature Appeals

The Board concludes that it lacks jurisdiction over these appeals because the Providers have not received final determinations of reimbursement as required by 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1837 (2008). Since a final determination is a prerequisite to Board jurisdiction over an appeal the Board finds that the appeals for the Providers and fiscal years referenced above are premature and dismisses the Providers and fiscal year ends above from the appeal.

#### Appeals that were not Timely Filed and For Which the Providers Requested the Board consider Equitable Tolling as a Justification for Late Filing

The appeals for the following fiscal years and Providers were not timely filed:

Brotman Medical Center, provider number 05-0144, FYEs 12/31/2005 and 2006;

Hollywood Community Hospital, provider number 05-0135, FYEs 12/31/1999, 2000, 2001, 2002, 2005 and 2006; and

Los Angeles Community Hospital, provider number 05-0663, FYEs 12/31/1999, 2000, 2001, 2002 and 2006.

The Providers assert that equitable tolling applies to their appeals of the Rural Floor Budget Neutrality Adjustment (RFBNA) issue because their failure to file timely appeals was the direct result of CMS' knowing and unlawful refusal to inform prospective payment system (PPS) hospitals that the inpatient PPS rates were incorrect and understated.

#### Decision of the Board Equitable Tolling

The Supreme Court recently addressed the question of whether the Board can consider equitable tolling and found that equitable tolling does not apply to appeals pending before the Board. *See Sebelius v. Auburn Regional Medical Center*, 133 S.Ct. 817 (2013). Since the appeals were not timely file and the Board cannot consider equitable tolling to extend the time for filing, the Board hereby dismisses the Providers referenced above from this appeal.

Since all of the Providers have been dismissed from this appeal, the Board hereby 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

Michael W. Harty  
Keith E. Braganza, CPA  
Clayton J. Nix, Esq.  
L. Sue Andersen, Esq.

FOR THE BOARD:



Michael W. Harty  
Chairman

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

cc: Darwin San Luis, First Coast Service Options (CA) (w/Schedule of Providers)  
Kevin Shanklin, BCBSA (w/Schedule of Providers)



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**CERTIFIED MAIL**

**AUG 16 2013**

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

RE: Forsyth Memorial Hospital  
Provider No. 34-0014  
FYE: 12/31/2003  
PRRB Case No. 11-0842

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeal upon receipt of additional jurisdictional documents submitted by the Provider. The Board's determination is outlined below.

**Pertinent Facts:**

On September 23, 2011, the Provider appealed its Revised Notice of Program Reimbursement ("RNPR"), which was issued on April 14, 2011. The Provider appealed the following issues:

1. DSH/SSI (Provider Specific)
2. DSH/SSI Percentage
3. DSH/Medicaid Eligible Days
4. DSH/Medicare Managed Care Part C Days
5. DSH/Dual Eligible Days
6. DSH/Exhausted Medicare Benefits Medicaid Dual Eligible Days
7. DSH/Medicaid Eligible Observation Bed Days
8. DSH/Medicaid Eligible North Carolina Charity Care Days
9. DSH/Exclusion of Part C Days from the Denominator of the Medicare Percentage

On October 23, 2012, the Board issued a letter to both parties requesting the following documents:

1. The original NPR DSH work papers;
2. A copy of Worksheet E, Part A from the original NPR;
3. The Reopening Request that preceded the revised NPR;
4. The Reopening Notice issued by the Intermediary and the revised NPR DSH work papers.

On December 7, 2012, the Provider submitted a copy of Worksheet E, Part A from the original NPR cost report and the Intermediary's Notice of Intent to Reopen the Cost Report dated April 14, 2011. The Provider stated it is still in the process of gathering the Revised NPR DSH work papers and requests a thirty day extension to provide them. No additional documentation was submitted.

**Board Determination:**

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

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

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

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

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

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

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

1. **DSH/SSI (Provider Specific) Issue**

In its description of the SSI Percentage issue, the Provider states:

The Provider seeks to reconcile its records with CMS data and identify records that CMS may have failed to include in their determination of the SSI percentage. *The Provider may exercise its' right to request* under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. (Emphasis added.)

The Board majority hereby denies jurisdiction over the SSI Realignment (Provider Specific) issue because the Provider has not yet requested that CMS recalculate their SSI percentage; therefore, the issue is premature and the Board dismisses it from this appeal.

2. **DSH/SSI Percentage Issue**

The SSI issue was adjusted by the Intermediary on the RNPR and, therefore, is valid.

3. **DSH/Medicaid Eligible Days**

The Audit Adjustment Report submitted with the Provider's appeal request, indicates that the Intermediary adjusted the Medicaid Eligible Days by adding an additional 2,083 days. In the Provider's calculation (Tab 5 of appeal request), it appears the Provider is requesting an additional 2,000 Medicaid Eligible Days. In the Intermediary's Notice of Intent to Reopen the Cost Report dated April 14, 2011, the Intermediary states they are reopening the cost report "To include Medicaid Eligible Days per provider request." The Board requested the Provider to submit the Revised NPR DSH work papers in order to verify these additional days were included in the RNPR. To date, the Provider has failed to submit these documents; therefore, the Board finds it does not have jurisdiction over this issue.

4.-9. **DSH/Medicare Managed Care Part C Days; DSH/Dual Eligible Days; DSH/Exhausted Medicare Benefits Medicaid Dual Eligible Days; DSH/Medicaid Eligible Observation Bed Days; DSH/Medicaid Eligible North Carolina Charity Care Days; and DSH/Exclusion of Part C Days from the Denominator of the Medicare Percentage**

These issues were included in the Provider's original appeal request; however, there is no evidence of any adjustment to these issues in the supporting documents. These issues were not included in the reopening request nor in the Notice of Reopening and the Provider has not provided work papers to support that a specific adjustment was made to these issues. Since this appeal was filed from a Revised NPR and the Medicare Managed Care Part C Days; DSH/Dual Eligible Days; DSH/Exhausted Medicare Benefits Medicaid Dual Eligible Days; DSH/Medicaid Eligible Observation Bed Days; DSH/Medicaid Eligible North Carolina Charity Care Days; and DSH/Exclusion of Part C Days from the Denominator of the Medicare Percentage issues were not adjusted on the RNPR, the appeal of this issue is contrary to the regulation. The Board finds it does not have jurisdiction over these issues.

**Conclusion:**

The SSI Percentage issue was adjusted by the Intermediary on the RNPR, therefore, the Board does have jurisdiction over this issue. Since the SSI issue is the only remaining issue in this appeal, the Board will remand the SSI issue in accordance with CMS Ruling 1498-R directly from this individual appeal (Case No. 11-0842) under separate cover.

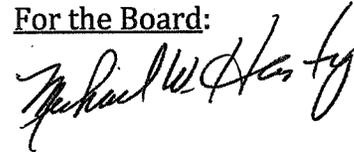
Since the Provider failed to provide the requested Revised NPR DSH work papers to determine if the Medicaid Eligible Days issue was jurisdictionally valid, the Board finds that it lacks jurisdiction over this issue and dismisses it from this appeal.

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

**Board Members Participating:**

Michael W. Harty  
Clayton J. Nix, Esq.  
L. Sue Andersen

**For the Board:**



Michael W. Harty  
Chairman

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

Kevin D. Shanklin  
Executive Director  
Senior Government Initiatives  
BC & BS Association  
225 North Michigan Avenue  
Chicago, IL 60601-7680



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CERTIFIED MAIL

**AUG 21 2013**

08-2872G, 10-0046GC & 10-0060GC

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

Re: QRS 1987-1996 DSH/SSI Equitable Tolling Group, FYEs 1987-1996, Provider Nos. Various,  
PRRB Case No. 08-2872G  
QRS St. John Health 1987-1996 DSH/SSI Equitable Tolling Group, FYEs 1987-1996, Provider  
Nos. Various, PRRB Case No. 10-0046GC  
QRS PHS 1996-1999 DSH/SSI Equitable Tolling Group, FYEs 1996-1999, Provider Nos. Various,  
PRRB Case No. 10-0060GC

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (Board) has reviewed the Schedules of Providers and associated jurisdictional documents submitted in the above-referenced appeals. All of the requests for hearing were from denials of reopening of the Providers' respective cost reports. The Providers have asked the Board to consider equitable tolling to extend the time for filing an appeal with the Board.

Pertinent Facts:

The Providers in these cases have requested equitable tolling because, they argue, they could not have reasonably obtained the requisite information to exercise their appeal rights regarding certain issues affecting their disproportionate share hospital (DSH) adjustments. The issue specifically appealed is whether the Providers' DSH adjustment was incorrectly determined due to a significant error in the Supplemental Security Income percentage that the Intermediary used to determine the Providers' DSH payment.

The Intermediary has filed a jurisdictional challenge in each of the cases. The Intermediary argues that the cases are untimely filed and the appeals result from the denial of reopening requests. It further notes that no request was made for "good cause" extension and asserts that equitable tolling is not applicable.

Board Determination:

Pursuant to 42 C.F.R. § 405.1885(a)(1)(2008), jurisdiction to reopen an intermediary determination rests exclusively with the intermediary as the last reviewing entity. Further, 42 C.F.R. § 405.1885(a)(6) states that a determination or decision to reopen or not to reopen a determination is not a final determination within the meaning of Subpart R of Title 42 of the Code of Federal Regulations and is not subject to further administrative or judicial review. Further, the Supreme Court in *Your Home Visiting Nurse*

*Services, Inc. v Shalala*, 525 U.S. 449, 457 (1999) has determined that an Intermediary's refusal to open the cost report is not reviewable. Consequently, the Board concludes it lacks jurisdiction over the appeals from denials of reopening.

Further, the Supreme Court recently addressed the question of whether the Board can consider equitable tolling and found that equitable tolling does not apply to appeals pending before the Board. *See Sebelius v. Auburn Regional Medical Center*, 133 S.Ct. 817 (2013). The Court held that the Board cannot consider equitable tolling to extend the time for filing.

Since the Board does not have jurisdiction over the Intermediaries' refusal to reopen the cost report and cannot consider equitable tolling to extend the time for filing, the Board hereby dismisses the appeals and closes the cases.

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  
Keith E. Braganza, CPA  
Clayton J. Nix, Esq.  
L. Sue Andersen, Esq.

FOR THE BOARD



Michael W. Harty  
Chairman

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

cc: Kevin D. Shanklin, Executive Director, BCBSA (w/Enclosures)  
Renee Rhone, Cahaba Government Benefit Administrators (w/Enclosures)  
Donna Silvio, Novitas Solutions, Inc. (w/Enclosures)  
Bryon Lamprecht, Wisconsin Physicians Services (w/Enclosures)  
Geoff Pike, First Coast Service Options, Inc. - FL (w/Enclosures)  
Danene Hartley, National Government Services, Inc. (w/Enclosures)  
Cecile Huggins, Palmetto GBA (w/Enclosures)  
James R. Ward, Noridian, (J-3) (w/Enclosures)



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CERTIFIED MAIL

AUG 22 2013

Toyon Associates, Inc.  
Glenn S. Bunting  
Vice President - Appeal Services  
1800 Sutter Street, Suite 600  
Concord, CA 94520 2546

RE: O'Connor Hospital, Provider No. 05-0153, FYE 06/30/1999  
(as a participant in Toyon Daughters of Charity 1999 General Assistance  
Days Group, PRRB Case No. 08-2322G)

Dear Mr. Bunting:

The Provider Reimbursement Review Board (the Board) reviewed the above-captioned DSH General Assistance Days group appeal which has been heard on the record. The Board notes a jurisdictional impediment with regard to one of the participants in the group. The pertinent facts with regard to this participant and the Board's determination are set forth below.

Pertinent Facts:

O'Connor Hospital (Participant #1) filed a timely appeal on June 9, 2006 from a revised NPR (RNPR) dated April 26, 2006. The RNPR indicates a Notice of Reopening (NOR) was issued on June 22, 2005 "[t]o incorporate the DSH Medicaid Eligible Days on the cost report."

The Board assigned case number 06-1848 to the individual appeal which included the General Assistance Days issue. On July 7, 2006, the Representative requested that this Provider be used in the formation of a new group appeal - The Toyon 1999 DSH General Assistance Days Group 2, to which the Board assigned case number 06-1941G. Subsequently, on July 15, 2008 the Provider was transferred from 06-1941G to a CIRP group - The Daughters of Charity 1999 DSH General Assistance Days Group to which the Board assigned case number 08-2322GC.

The Provider referenced adjustment #s R3-001 and R3-002 in column D on the Schedule of Providers. According to the adjustment page submitted, # R3-001 is for Hospital Adults & Peds "[t]o incorporate the Medi-Cal eligible days total and Medi-Cal labor & delivery room days on the cost report for the purpose of calculating the disproportionate share adjustment." The adjustment page for #R3-002 shows an adjustment to Allowable disproportionate share percentage "[t]o adjust the DSH payment percentage based on the revised calculation due to the incorporation of the Medi-Cal eligible days and the adjustment to total and Medi-Cal labor & delivery room days.

### Jurisdiction – General Requirements

A provider has a right to a hearing before the Board, with respect to costs claimed on a timely filed cost report, if: (a) it is dissatisfied with the final determination of the intermediary, (b) the amount in controversy is \$10,000 or more (\$50,000 for a group), and (c) the request for a hearing is filed within 180 days of the date of the Notice of Program Reimbursement (NPR).<sup>1</sup>

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

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

Pursuant to 42 C.F.R. § 405.1885(c), jurisdiction to reopen an intermediary determination rests exclusively with the intermediary. Further, 42 C.F.R. § 405.1885(a) (6) states that a determination or decision to reopen or not to reopen a determination is not a final determination within the meaning of Subpart R of Title 42 and is not subject to further administrative or judicial review. See also, *Your Home Visiting Nurse Services, Inc. v. Shalala*, 119 S.Ct. 930 (1999).

Additionally, for Revised Notices of Program Reimbursement, the regulation that was in effect when the RNPRs were issued states:

Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in § 405.1885, such revision shall be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1835, 405.1875 and 405.1877 are applicable.<sup>2</sup>

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

<sup>1</sup> 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-1841.

<sup>2</sup> 42 C.F.R. § 405.1889 (1998) (amended 2008).

Board Determination:

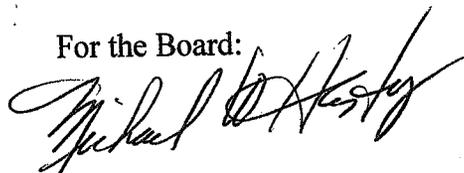
After reviewing the facts in this case, the Board finds that O'Connor Hospital appealed from a RNPR. There is nothing in the record that supports General Assistance Days was adjusted on the RNPR for this Provider. Therefore, the Board finds that it does not have jurisdiction over the General Assistance Days issue pursuant to 42 C.F.R. § 405.1889(b)(1) and dismisses O'Connor Hospital from the group appeal.

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

Board Members Participating:

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

For the Board:



Michael W. Harty  
Chairman

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

cc: Darwin San Luis, Palmetto GBA c/o First Coast Service Options, Inc.  
Kevin D. Shanklin, Executive Director, BCBSA



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2

Refer to: 13-1334  
Certified Mail

**AUG 23 2013**

Kenneth R. Marcus  
Honigman Miller Schwartz and Cohn LLP  
2290 First National Building  
660 Woodward Avenue  
Detroit, MI 48226

Re: NEA Baptist Memorial Hospital  
Provider No.: 04-0118  
FYE: 05/31/2009  
Case No. 13-1334

Dear Mr. Marcus:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's request for hearing which was received (filed)<sup>1</sup> on March 13, 2013. The Board's jurisdictional determination is set forth below.

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

Decision of the Board

The Board received the Provider's request for hearing on March 29, 2013, 186 days after the issuance of the Notice of Program Reimbursement (NPR) dated September 24, 2012. The NPR is presumed to have been received 5 days after the date of issuance by the intermediary.<sup>2</sup> In this case, the hearing request was received (filed) 181 days after the presumed date of receipt of the NPR.<sup>3</sup> The request for hearing was not received by the Board within 180 days of the date of the receipt of the NPR as required by 42 C.F.R. § 405.1835 and, therefore, was not timely filed. Consequently, the Board hereby dismisses the appeal because it was not filed on a timely basis.

<sup>1</sup> See 42 C.F.R. § 405.1835(a)(3) (a provider has a right to hearing before the Board if, among other things, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the date of receipt by the intermediary's [final] determination.) 42 C.F.R. 405.1801(a)(2) (2008) (the date of receipt means the date stamped "Received" by the reviewing entity).

<sup>2</sup> See 42 C.F.R. § 405.1801 (a)(1)(iii).

<sup>3</sup> See 42 C.F.R. § 405.1835(a)(3)(i).

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

Board Members Participating:

Michael W. Harty  
Clayton J. Nix, Esq.  
L. Sue Andersen, Esq.

For the Board:

  
Michael W. Harty  
Chairman

cc: Kevin D. Shanklin, BCBSA

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



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Refer to: 12-0386GC

CERTIFIED MAIL

**AUG 26 2013**

Ms. Corinna Goron  
President  
Healthcare Reimbursement Services  
17101 Preston RD, Suite 220  
Dallas, TX 75248-1372

Re: Central Maine Health Care 1999-2009; 2011 & 2012 RFBNA Equitable Tolling CIRP Group,  
Provider Nos.: Various, FYEs: 1999-2009; 2011 & 2012, Case No. 12-0386GC

Dear Ms. Goron:

The Provider Reimbursement Review Board (Board) has reviewed the hearing request submitted in the above appeal that was filed from the final publication inpatient PPS rule for each FFY in the Federal Register. The Providers have asked the Board to consider equitable tolling to extend the time for filing an appeal with the Board. The Providers furnished dates for the Notice of Program Reimbursement (NPR) which were not timely appealed in this group appeal.

**Pertinent Facts:**

By letter filed June 13, 2012, the Providers in the above case have requested equitable tolling because they contend they had no "reasonable means" to identify errors in the Secretary's computation of the rural floor budget neutrality adjustment. They proffer that when CMS' 2008 rulemaking established the prospective payment system (PPS) no information was provided regarding the purpose of the change. CMS did not indicate that errors had been made in its prior implementation of the budget neutrality provision and they are not published. Consequently they were unable to discern any error(s) and could not duplicate the Secretary's calculations. They seek a correction of all annual budget neutrality adjustments from 1999-2012 to allow full and complete relief.

**Board Determination:**

**Equitable Tolling**

The Supreme Court recently addressed the question of whether the Board can consider equitable tolling and found that equitable tolling does not apply to appeals pending before the Board. *See Sebelius v. Auburn Regional Medical Center*, 133 S.Ct. 817 (2013). This appeal was not timely and the Board cannot consider equitable tolling to extend the time for filing.

**Good Cause**

In this case, the Providers filed their appeal based on the publication of the final inpatient prospective payment rules in the Federal Register for the Federal fiscal years (FFYs) under dispute. Pursuant to 42

C.F.R. § 405.1836, a provider may request good cause for late filing if it can demonstrate that there are extraordinary circumstances beyond its control that prevented timely filing of an appeal and the request for hearing was made within three years of date of receipt of the final determination.<sup>1</sup> The Board notes that the Providers did not request or demonstrate good cause for late filing for those appeals that were filed within three years of the publication of the Federal Register notices. In this regard, the Board notes that the public was on notice of the issues surrounding the RFBNA well before the Providers filed this appeal in 2012. *See, e.g., Cape Cod Hospital v. Sebelius*, 677 F. Supp. 2d 18 (D.D.C. 2009).

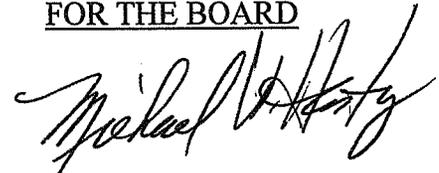
The Board hereby dismisses the appeals on the attached Schedule of Providers because they were not timely filed and hereby closes the case.

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

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

FOR THE BOARD



Michael W. Harty  
Chairman

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

cc: Kevin D. Shanklin, Executive Director, BCBSA (w/Enclosures)  
Danene Hartley, NHIC Corp. (w/Enclosures)

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<sup>1</sup> In *District of Columbia Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993) Medicare and Medicaid Guide (CCH) ¶ 41,025 the Administrator determined that publication of notices in the Federal Register constitutes a final determination that can be appealed to the Board. The five day period for mailing to enable receipt of a final determination by a provider is not applicable to Federal Register notices because 42 U.S.C. § 1395oo(a)(3) states that a provider must file an appeal 180 days after it receives notice of the Secretary's final determination. In this case, the date that a notice is published in the Federal Register is the date of notice. 44 U.S.C. §1507 states that "[publication in the Federal Register] is sufficient to give notice of the contents of the document to a person subject to or affect by it." Consequently, with publication of the Federal Register there is no five-day delay in notice to allow for the mailing period.



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
PROVIDER REIMBURSEMENT REVIEW BOARD

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Refer to: 12-0162G, 13-2796G

CERTIFIED MAIL

AUG 26 2013

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

Re: QRS FFYS 1998-2012 RFBNA Equitable Tolling Group  
FYE: 1998-2012  
Provider Nos.: Various  
PRRB Case No.: 12-0162G

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (Board) has reviewed the hearing request submitted in the group appeal which was not timely filed from Federal Register notices for the relevant fiscal periods. The Providers have asked the Board to consider equitable tolling to extend the time for filing an appeal with the Board.

The Providers appealed the Final PPS rules for their respective Federal Fiscal Years (FFYs) which were published in the Federal Register. The latest cost report period under appeal ends 6/30/12 during FFY 2012 and was appealed from the August 18, 2011 Federal Register.

**Pertinent Facts:**

The Providers in the above case have requested equitable tolling because they contend they had no "reasonable means" to identify errors in the Secretary's computation of the rural floor budget neutrality adjustment. They proffer that when CMS' FFY 2008 rulemaking established the prospective payment system (PPS) rules no information was provided regarding the purpose of the change. CMS did not indicate that errors had been made in its prior implementation of the budget neutrality provision and they are not published. Consequently, the Providers were unable to discern any error(s) and could not duplicate the Secretary's calculations. They seek a correction of all annual budget neutrality adjustments from 1999-2012 to allow full and complete relief.

**Jurisdiction Over Appeals filed for Federal Fiscal Year 2012:**

Several Providers included claims for parts of FFY 2012. Parts of the appeals for the FFY 2012 are timely; the remaining part of the case is being dismissed as untimely.

The following Providers filed appeals for cost reporting periods involving a portion of FFYs 2011 and 2012. The chart below sets forth the FYE under dispute and shows the entire length of the cost reporting period.

No.	Provider	FYE	Cost Reporting Period
27	Coalinga Regional Medical Center (05-0397)	6/30/2012	7/1/2011-6/30/2012
62	Montrose Memorial Hospital (06-0006)	12/31/2011	1/1/2011-12/31/2011
76	Denver Health Medical Center (06-0011)	12/31/2011	1/1/2011-12/31/2011
90	Parkview Medical Center (06-0020)	6/30/2012	7/1/2011-6/30/2012
104	Arkansas Valley Regional Center (06-0036)	3/31/2012	4/1/2011-3/31/2012

The following portions of the Providers cost reporting periods are part of FFY 2011 and are not timely filed from the publication of the final inpatient prospective payment rules in the August 16, 2010 Federal Register and are subject of the Board's jurisdictional determination set forth below:

No.	Provider	FYE	Untimely Period
27	Coalinga Regional Medical Center (05-0397)	6/30/2012	7/1/2011-9/30/2011
62	Montrose Memorial Hospital (06-0006)	12/31/2011	1/1/2011-9/30/2011
76	Denver Health Medical Center (06-0011)	12/31/2011	1/1/2011-9/30/2011
90	Parkview Medical Center (06-0020)	6/30/2012	7/1/2011-9/30/2011
104	Arkansas Valley Regional Center (06-0036)	3/31/2012	4/1/2011-9/30/2011

The following Providers have a portion of their cost reporting period which was timely filed from the August 18, 2011 publication date of the final inpatient prospective payment rules in the Federal Register notice for FFY 2012:

No.	Provider	FYE	Timely Period
27	Coalinga Regional Medical Center (05-0397)	6/30/2012	10/1/2011-6/30/2012
62	Montrose Memorial Hospital (06-0006)	12/31/2011	10/1/2011-12/31/2011
76	Denver Health Medical Center (06-0011)	12/31/2011	10/1/2011-12/31/2011
90	Parkview Medical Center (06-0020)	6/30/2012	10/1/2011-6/30/2012
104	Arkansas Valley Regional Center (06-0036)	3/31/2012	10/1/2011-3/31/2012

**Board Determination:**

**Creation of New Group**

The Board has placed the appeals of the partial cost reporting period that were timely filed from the issuance of the August 18, 2011 Federal Register in a new group appeal case, number 13-2796GC. The Providers and partial fiscal years to which this transfer applies are identified in the chart directly above.

Equitable Tolling

The Supreme Court recently addressed the question of whether the Board can consider equitable tolling and found that equitable tolling does not apply to appeals pending before the Board. *See Sebelius v. Auburn Regional Medical Center*, 133 S.Ct. 817 (2013). For the FFYs where the appeal was not timely, the Board cannot consider equitable tolling to extend the time for filing.

Good Cause

In this case, the Providers filed their appeal based on the publication of the final inpatient prospective payment rules in the Federal Register for the Federal fiscal years (FFYs) under dispute. Pursuant to 42 C.F.R. § 405.1836, a provider may request good cause for late filing if it can demonstrate that there are extraordinary circumstances beyond its control that prevented timely filing of an appeal and the request for hearing was made within three years of date of receipt of the final determination.<sup>1</sup> The Board notes that the Providers did not request or demonstrate good cause for late filing for those appeals that were filed within three years of the publication of the Federal Register notices. In this regard, the Board notes that the public was on notice of the issues surrounding the RFBNA well before the Providers filed this appeal in 2012. *See, e.g., Cape Cod Hospital v. Sebelius*, 677 F. Supp. 2d 18 (D.D.C. 2009)

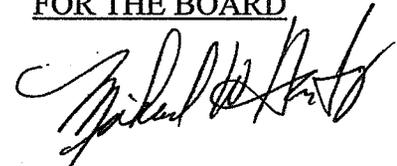
The Board hereby dismisses the appeals on the attached Schedule of Providers because they were not timely filed and hereby closes the case.

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

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

FOR THE BOARD



Michael W. Harty  
Chairman

Enclosures: Schedule of Providers  
Critical Due Dates Letter for case no. 13-2796G  
42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin D. Shanklin, Executive Director, BCBSA (w/Schedule of Providers)  
James R. Ward, Noridian Administrative Services (w/Schedule of Providers)

<sup>1</sup> In *District of Columbia Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993) Medicare and Medicaid Guide (CCH) ¶ 41,025 the Administrator determined that publication of notices in the Federal Register constitutes a final determination that can be appealed to the Board. The five day period for mailing to enable receipt of a final determination by a provider is not applicable to Federal Register notices because 42 U.S.C. § 1395oo(a)(3) states that a provider must file an appeal 180 days after it receives notice of the Secretary's final determination. In this case, the date that a notice is published in the Federal Register is the date of notice. 44 U.S.C. §1507 states that "[publication in the Federal Register] is sufficient to give notice of the contents of the document to a person subject to or affect by it." Consequently, with publication of the Federal Register there is no five-day delay in notice to allow for the mailing period.



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**CERTIFIED MAIL**

**AUG 26 2013**

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

RE: **Forsyth Memorial Hospital**  
Provider No. 34-0014  
FYE: 12/31/2001  
PRRB Case No. 11-0468

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeal upon receipt of additional jurisdictional documents submitted by the Provider. The Board's determination is outlined below.

**Pertinent Facts:**

On February 16, 2011, the Provider appealed its Revised Notice of Program Reimbursement ("RNPR"), which was issued on September 1, 2010. The Provider appealed the following issues:

1. DSH/SSI (Provider Specific)
2. DSH/SSI Percentage
3. DSH/Medicaid Eligible Days
4. DSH/Medicare Managed Care Part C Days
5. DSH/Dual Eligible Days
6. DSH/Exhausted Medicare Benefits Medicaid Dual Eligible Days
7. DSH/Medicaid Eligible North Carolina Charity Care Days
8. DSH/Exclusion of Part C Days from the Denominator of the Medicare Percentage

On June 27, 2011, the Provider submitted a Model Form D requesting to transfer the DSH/Medicaid Eligible North Carolina Charity Care Days issue to the Novant 2001-2002 DSH Medicaid Eligible North Carolina Charity Care Days CIRP Group, Case No. 11-0674GC.

On July 25, 2011, the Provider submitted two requests (Model Form D) requesting to transfer the DSH/SSI Percentage and the DSH/Medicare Managed Care Part C Days issues to the following CIRP groups:

1. QRS Novant 2001-2002 DSH SSI Percentage CIRP Group, Case No. 11-0761GC; and
2. QRS Novant 2001-2002 DSH Medicare Managed Care Part C Days CIRP Group, Case No. 11-0762GC.

On September 26, 2011, the Provider submitted two requests (Model Form D) requesting to transfer the DSH/Exhausted Medicare Benefits Medicaid Dual Eligible Days and the DSH/Exclusion of Part C Days from the Denominator of the MCR Percentage issues to the following CIRP groups:

1. QRS Novant 2001 DSH Exhausted Medicare Benefits Medicaid Dual Eligible Days CIRP Group, Case No. 11-0844GC; and
2. QRS Novant 2001 DSH Exclusion of Part C Days from Denom. Of the MCR Percentage CIRP Group, Case No. 11-0846GC.

On August 3, 2012, the Board granted QRS' request to transfer the DSH/SSI Percentage issue to the QRS Novant 2001-2002 DSH SSI Percentage CIRP Group, Case No. 11-0761GC, and the DSH/Medicare Managed Care Part C Days issue to the QRS Novant 2001-2002 DSH Medicare Managed Care Part C Days CIRP Group, Case No. 11-0762GC.

The Board also stated that Case Nos. 11-0844GC (QRS Novant 2001 DSH Exhausted Medicare Benefits Medicaid Dual Eligible Days Group) and 11-0846GC (QRS Novant 2001 DSH Exclusion of Part C Days from the Denominator of the MCR Percentage Group) were formed as a result of transferring the issues out of the Provider's FY 2001 appeal, Case No. 11-0468. Because Case Nos. 11-0844GC and 11-0864GC did not meet the requirements for a group appeal, in that each group only has the sole provider upon being fully formed, the Board advised the Provider that the DSH/Exhausted Medicare Benefits Medicaid Dual Eligible Days and DSH/Exclusion of Part C Days from the Denominator of the MCR Percentage issues were being transferred back to the Provider's FYE 2002 appeal, Case No. 11-0843. As a result, the Board closed Case Nos. 11-0844GC and 11-0846GC.

On October 23, 2012, the Board issued a letter to both parties requesting the following documents:

1. The original NPR DSH work papers;
2. A copy of Worksheet E, Part A from the original NPR;

3. The Reopening Request that preceded the revised NPR;
4. The Reopening Notice issued by the Intermediary and the revised NPR DSH work papers.

On December 7, 2012, the Provider submitted a copy of the 2001 DSH Days Review, a copy of Worksheet E, Part A from the original NPR cost report, and the Reopening Notice letter. The Provider stated it was still in the process of gathering the Revised NPR DSH work papers and requested a thirty day extension to provide them. No additional documentation has been submitted.

**Board Determination:**

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

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

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

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

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

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

**1. DSH/SSI (Provider Specific) Issue**

In its description of the SSI Percentage issue, the Provider stated:

The Provider seeks to reconcile its records with CMS data and identify records that CMS may have failed to include in their determination of the SSI percentage. *The Provider may exercise its' right to request* under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. (Emphasis added.)

The Board majority hereby denies jurisdiction over the SSI Realignment (Provider Specific) issue because the Provider has not yet requested that CMS recalculate their SSI percentage; therefore, the issue is premature and the Board dismisses it from this appeal.

**2. DSH/SSI Percentage Issue**

The SSI issue was adjusted by the Intermediary on the RNPR and, therefore, is valid. The Provider transferred this issue on April 27, 2012, to the QRS Novant 2001-2002 DSH SSI Percentage CIRP Group, Case No. 11-0761GC.

**3. DSH/Medicaid Eligible Days**

The Audit Adjustment Report submitted with the Provider's appeal request, indicates that the Intermediary adjusted the Medicaid Eligible Days by adding an additional 4,055 days. In the Provider's calculation (Tab 5 of appeal request), it appears the Provider is requesting an additional 763 Medicaid Eligible Days. The Board requested the Provider to submit the Revised NPR DSH work papers in order to verify these additional days were included in the RNPR. To date, the Provider has failed to submit these documents; therefore, the Board finds it does not have evidence to support that the DSH/Medicaid Eligible Days issue under appeal were the days requested/revised in the RNPR. The Board finds it does not have jurisdiction over this issue.

**4. and 7. DSH/Medicare Managed Care Part C Days and DSH/Medicaid Eligible North Carolina Charity Care Days**

Issues 4 and 8 were included in the Provider's reopening request and in the MAC's reopening notice, but there is no evidence in the record of any adjustment for these issues. 42 C.F.R. §405.1889(b)(2) specifically states:

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.

Without the work papers to support Adjustment #3, there is no evidence that these categories of days were revised. In addition, as both categories of days have been historically removed from the DSH calculation per CMS instruction, it is unlikely that the work papers would support that an adjustment was made to include any days that fall into these categories. Since this appeal was filed from a Revised NPR and there is no evidence that the Medicare Managed Care Part C Days issue DSH/Medicaid Eligible North Carolina Charity Care Days was adjusted on the RNPR, the appeal of these issues is contrary to the regulation. The Board finds it does not have jurisdiction over these issues. In addition, the Board denies the Provider's request to transfer this issue to the QRS Novant 2001-2002 DSH Medicare Managed Care Part C Days CIRP Group, Case No. 11-0762GC.

**5., 6. and 8. DSH/Dual Eligible Days; DSH/Exhausted Medicare Benefits Medicaid Dual Eligible Days; and DSH/Exclusion of Part C Days from the Denominator of the Medicare Percentage**

These issues were included in the Provider's original appeal request; however, there is no evidence of any adjustment to these issues in the supporting documents. These issues were not included in the reopening request, or in the Notice of Reopening, and the Provider has not provided work papers to support that a specific adjustment was made to these issues. Since this appeal was filed from a Revised NPR and the DSH/Dual Eligible Days; DSH/Exhausted Medicare Benefits Medicaid Dual Eligible Days; and the DSH/Exclusion of Part C Days from the Denominator of the Medicare Percentage issues were not adjusted on the RNPR, the appeal of these issues is contrary to the regulation. The Board finds it does not have jurisdiction over these issues.

**Conclusion:**

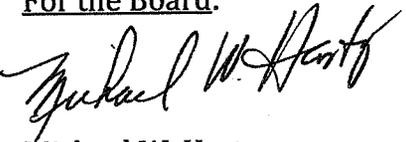
The SSI Percentage issue, which was adjusted by the Intermediary on the RNPR, has been transferred to Group Case No. 11-0761GC. Since the Provider failed to provide the requested Revised NPR DSH work papers to determine if the Medicaid Eligible Days issue was jurisdictionally valid, the Board finds that it lacks jurisdiction over this issue and dismisses it from this appeal. The Board also dismissed the SSI Realignment issue as premature and the other DSH day categories, as they were not adjusted as part of the RNPR. Since they are no remaining issues in this appeal, the Board hereby closes this appeal and removes it from the Board's docket.

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

**Board Members Participating:**

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

**For the Board:**

  
Michael W. Harty  
Chairman

**Provider Reimbursement Review Board  
Page 6 – PRRB Case No. 11-0468**

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

**Kevin D. Shanklin  
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**CERTIFIED MAIL**

**AUG 26 2013**

Alton Memorial Hospital  
Paul J. Bradshaw  
Reimbursement Manager  
3<sup>rd</sup> Floor, PFD Building  
113 Dunn Road  
St. Louis, MO 63136

RE: **Alton Memorial Hospital**  
Provider No. 14-0002  
FYE: 12/31/2003  
PRRB Case No. 10-0365

Dear Mr. Bradshaw:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeal upon receipt of additional jurisdictional documents submitted by the Provider. The Board's determination is outlined below.

**Pertinent Facts:**

On January 7, 2010, Mr. Paul J. Bradshaw, Reimbursement Manager for Alton Memorial Hospital filed an appeal from a Revised NPR (RNPR) dated July 14, 2009, which was assigned Case No. 10-0365. The Provider appealed the following issues:

1. DSH/SSI (Provider Specific)
2. DSH/SSI (Systemic Errors)
3. DSH/Medicaid Eligible Labor Room Days

On August 24, 2010, the Provider submitted two Model Form D requests to transfer the DSH/SSI issue to the QRS BJC 2000-2006 DSH/SSI Proxy CIRP Group, Case No. 09-0782GC; and the DSH/Medicaid Eligible Labor Room Days issue to the QRS BJC 2003 DSH/Medicaid Eligible Labor Room Days CIRP Group, Case No. 10-1306GC.

On June 14, 2012, the Intermediary submitted a jurisdictional challenge to the Board, and on July 16, 2012, the Provider submitted their Jurisdictional Response.

**Intermediary's Contentions:**

The Intermediary contends they did not make any adjustments to the three issues appealed by the Provider when it reopened the Provider's cost report. The Intermediary states the Provider's cost report was reopened to make adjustments to the Medicaid fraction. Prior to the reopening of the cost report, the Provider did not qualify for a DSH payment, as it did not meet the threshold factor (DPP) of 15 percent. After reviewing the Provider's submitted documentation, Medicaid Eligible Days and additional total patient days for the Provider did qualify for DSH reimbursement, as it met or exceeded the threshold factor.

In order to calculate the Provider's reimbursement, the Intermediary adjusted the Provider's Medicaid Eligible Days (592) and Total Patient Days (992). The Intermediary did not reopen or adjust the Provider's SSI Realignment, the SSI Systemic Errors, or the DSH/Medicaid Eligible Labor Room Days issues. The Intermediary contends since no adjustments were made to these issues on the Revised NPR, the Provider does not have a right to appeal.

**Provider's Contentions:**

The Provider states the Board has jurisdiction over the DSH/SSI issue because the SSI ratio was included and used to compute the DSH payment for a Provider who did not previously qualify for DSH until the issuance of their Revised Notice of Program Reimbursement (RNPR). In addition, the SSI ratio was not claimed or included in the original NPR and is only first included in the cost report of the RNPR, which is the subject of this appeal. As a result, the Provider requests that the Board find it does have jurisdictional over the DSH/SSI (Systemic Errors & Provider Specific) issues.

In addition, the Provider notes that it had previously transferred the DSH/SSI (Systemic Errors) issue to PRRB Case Number 09-0782GC. The Provider states the transfer was proper and the remaining DSH/SSI (Provider Specific) issue is also properly raised in this appeal.

The Provider also contends the Board has jurisdiction over the DSH/Medicaid Eligible Labor Room Days issue. The Provider states the Intermediary not only adjusted the Medicaid Proxy and the DSH adjustment factor, but also adjusted Total Days. The Intermediary argues that because the Provider appealed from a Revised NPR that adjusted DSH/Medicaid Eligible Days, the Provider cannot appeal the DSH/Medicaid Eligible Labor Room Days. The Provider contends that the Medicaid Proxy, according to HCFAR 97-2, should include all Medicaid Eligible Days in the DSH calculation. The Provider contends that Total Days includes all inpatient days, even days for labor room patients that are admitted as inpatients. The Provider states the Intermediary failed to include Medicaid Eligible Labor Room Days in the Medicaid proxy, as required by HCFAR 97-2. The Provider states the Intermediary include the SSI percentage and adjusted by Medicaid Eligible Days and Total Days in the Revised NPR, therefore, the Board does have jurisdictional over this appeal.

The Provider also notes that the DSH/Medicaid Eligible Labor Room Days was previously transferred to PRRB Case Number 10-1306GC and contends the transfer was proper.

**Board Determination:**

A provider has a right to a hearing before the Board, with respect to costs claimed on a timely filed cost report, if it is dissatisfied with the final determination of the intermediary, the amount in controversy is \$10,000 or more (\$50,000 for a group), and the request for a hearing is filed within 180 days of the date of the Notice of Program Reimbursement (NPR).<sup>1</sup>

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

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

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

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

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

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

**1. DSH/SSI (Provider Specific)**

In its description of the SSI Percentage (Provider Specific) issue, the Provider states:

---

<sup>1</sup> 42 U.S.C. §1395oo(a) and 42 C.F.R. §§405.1835-1841.

The Provider seeks to reconcile its records with CMS data and identify records that CMS may have failed to include in their determination of the SSI percentage. The Provider may exercise its' rights to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. See 42 U.S.C. §1395(d)(5)(F)(i). (Emphasis added.)

In recent cases, the Board majority has denied jurisdiction over this issue because the Provider has not yet requested that CMS recalculate their SSI percentage; therefore, the issue is premature. In addition, since this appeal was filed from a Revised NPR and this issue was not adjusted on the RNPR, the appeal of the DSH/SSI (Provider Specific) issue is invalid and premature. The Board majority hereby denies jurisdiction over the SSI Realignment (Provider Specific) issue because the Provider has not yet requested that CMS recalculate their SSI percentage; therefore, the issue is premature and the Board dismisses it from this appeal.

**2. DSH/SSI (Systemic Errors)**

Since this appeal was filed from a Revised NPR and this issue was not adjusted on the RNPR, the appeal of the DSH/SSI (Systemic Errors) issue is invalid. The Board finds it does not have jurisdiction over this issue and denies the Provider's request to transfer this issue to the QRS BIC 2000-2006 DSH/SSI Proxy CIRP Group, PRRB Case No. 09-0782GC.

**3. DSH/Medicaid Eligible Labor Room Days**

Since this appeal was filed from a Revised NPR and this issue was not adjusted on the RNPR, the appeal of the DSH/Medicaid Eligible Labor Room Days issue is invalid. The Board finds that it does not have jurisdiction over this issue and denies the Provider's request to transfer this issue to the QRS BIC 2003 DSH/Medicaid Eligible Labor Room Days Group, PRRB Case No. 10-1306GC.

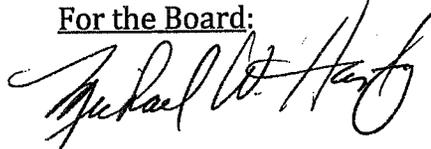
The only issue adjusted by the Intermediary on the RNPR was to Medicaid Eligible Days, (592 Medicaid Eligible Days adjusted and those specific additional total patient days (992) adjusted), which was not appealed by the Provider. None of the issues mentioned in the original appeal request were adjusted on the RNPR; therefore, they are invalid. The Board finds that it lacks jurisdiction over these issues and denies the transfers to Group Case Nos. 09-0782GC and 10-1306GC. Since there are no remaining issues in this appeal, the Board hereby closes PRRB Case No. 10-0365 and removes it from the docket.

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

**Board Members Participating**

Michael W. Harty  
Clayton J. Nix, Esq.  
L. Sue Andersen

**For the Board:**

  
Michael W. Harty  
Chairman

**Provider Reimbursement Review Board  
Page 5 – PRRB Case No. 10-0365**

**cc: Wisconsin Physicians Service  
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PROVIDER REIMBURSEMENT REVIEW BOARD**

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Refer to: 12-0226GC

CERTIFIED MAIL

**AUG 26 2013**

Ms. Corinna Goron  
President  
Healthcare Reimbursement Services  
17101 Preston RD, Suite 220  
Dallas, TX 75248-1372

Re: HRS WKHS 1998-2011 RFBNA Equitable Tolling CIRP Group, Provider Nos.: Various, FYEs: 1999-2011, Case No. 12-0226GC

Dear Ms. Goron:

The Provider Reimbursement Review Board (Board) has reviewed the hearing request submitted in the group appealed filed from Federal Register notices for the relevant fiscal periods. The Providers have asked the Board to consider equitable tolling to extend the time for filing an appeal with the Board.

The Providers appealed the Final PPS rules for their respective FFYs 1999-2011. There are no FFY 2012 appeals identified for any of the Providers listed on the Schedule of Providers, although the Providers stated they were appealing the final inpatient prospective payment rules published in the August 18, 2011 Federal Register. The latest cost report period under appeal ends 9/30/11 (FFY 2011) which was appealed from the August 16, 2010 Federal Register.<sup>1</sup> Consequently, none of the appeals were timely filed from the Federal Register notice giving rise to the dispute. (Note: Through correspondence dated 4/11/12 two of the Providers, Willis-Knighton Medical Center & Willis-Knighton Bossier Health Center appeals for Federal Fiscal Year 2010, were withdrawn from this case upon appeal of their respective NPRs. This new case, 12-0316GC is an appeal of FFY 2010).

**Pertinent Facts:**

By letter filed February 14, 2012 the Providers in the above case have requested equitable tolling because they contend they had no "reasonable means" to identify errors in the Secretary's computation of the rural floor budget neutrality adjustment. They proffer that when CMS' 2008 rulemaking established the prospective payment system (PPS) no information was provided regarding the purpose of the change. CMS did not indicate that errors had been made in its prior implementation of the budget neutrality provision and they are not published. Consequently they were unable to discern any error(s) and could not duplicate the Secretary's calculations. They seek a correction of all annual budget neutrality adjustments from 1999-2012 to allow full and complete relief.

<sup>1</sup> See Providers' February 14, 2012 hearing request Tab 1 (Schedule of Providers) and Tab 3 Statement of the Issue.

**Board Determination:**

**Equitable Tolling**

The Supreme Court recently addressed the question of whether the Board can consider equitable tolling and found that equitable tolling does not apply to appeals pending before the Board. *See Sebelius v. Auburn Regional Medical Center*, 133 S.Ct. 817 (2013). This appeal was not timely and the Board cannot consider equitable tolling to extend the time for filing.

**Good Cause**

In this case, the Providers filed their appeal based on the publication of the final inpatient prospective payment rules in the Federal Register for the Federal fiscal years (FFYs) under dispute. Pursuant to 42 C.F.R. § 405.1836, a provider may request good cause for late filing if it can demonstrate that there are extraordinary circumstances beyond its control that prevented timely filing of an appeal and the request for hearing was made within three years of date of receipt of the final determination.<sup>2</sup> The Board notes that the Providers did not request or demonstrate good cause for late filing for those appeals that were filed within three years of the publication of the Federal Register notices. In this regard, the Board notes that the public was on notice of the issues surrounding the RFBNA well before the Providers filed this appeal in 2012. *See, e.g., Cape Cod Hospital v. Sebelius*, 677 F. Supp. 2d 18 (D.D.C. 2009).

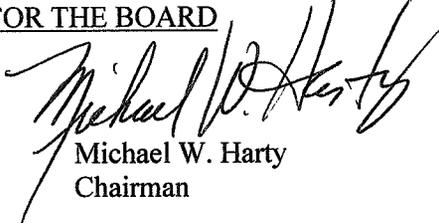
The Board hereby dismisses the appeals on the attached Schedule of Providers because they were not timely filed and hereby closes the case.

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**

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

**FOR THE BOARD**



Michael W. Harty  
Chairman

Enclosures: Schedule of Providers

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

cc: Kevin D. Shanklin, Executive Director, BCBSA (w/Schedule of Providers)  
Donna Silvio, Novitas Solutions, Inc. (w/Schedule of Providers)

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<sup>2</sup> In *District of Columbia Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993) Medicare and Medicaid Guide (CCH) ¶ 41,025 the Administrator determined that publication of notices in the Federal Register constitutes a final determination that can be appealed to the Board. The five day period for mailing to enable receipt of a final determination by a provider is not applicable to Federal Register notices because 42 U.S.C. § 1395oo(a)(3) states that a provider must file an appeal 180 days after it receives notice of the Secretary's final determination. In this case, the date that a notice is published in the Federal Register is the date of notice. 44 U.S.C. §1507 states that "[publication in the Federal Register] is sufficient to give notice of the contents of the document to a person subject to or affect by it." Consequently, with publication of the Federal Register there is no five-day delay in notice to allow for the mailing period.



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CERTIFIED MAIL

**AUG 26 2013**

12-0165GC

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

Re: QRS DCH FFYS 1999-2011 RFBNA Equitable Tolling Group  
FYE: 1999-2011  
Provider Nos.: Various  
PRRB Case No.: 12-0165GC

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (Board) has reviewed the hearing request submitted in the above appeal that was filed from the final publication inpatient prospective payment system rule for each FFY in the Federal Register. The Providers have asked the Board to consider equitable tolling to extend the time for filing an appeal with the Board. Some Providers furnished dates for the Notices of Program Reimbursement (NPRs) which were not timely appealed in this group appeal. NPRs for other years have not been issued most likely because of the hold on NPRs as a result of the *Baystate Medical Center v. Leavitt*, 545 F. Supp.2d 20 (2008), litigation.

**Pertinent Facts:**

The Providers in the above case have requested equitable tolling because they contend they had no "reasonable means" to identify errors in the Secretary's computation of the rural floor budget neutrality adjustment. They proffer that when CMS established the PPS rules no information was provided regarding the purpose of the change to the RFBNA. CMS did not indicate that errors had been made in its prior implementation of the budget neutrality provision when they were originally published. Consequently the Providers were unable to discern any error(s) and could not duplicate the Secretary's calculations. They seek a correction of all annual budget neutrality adjustments from 1999-2012 to allow full and complete relief.

The MAC has filed a jurisdictional challenge noting that that MAC made no determination to the cost reports on each participating provider on the Schedule of Providers. Consequently the MAC argues that the Board does not have jurisdiction over these cases.<sup>1</sup>

<sup>1</sup> MAC Jurisdictional Review of Group Appeal, p. 1.

**Board Determination:**

**Equitable Tolling**

The Supreme Court recently addressed the question of whether the Board can consider equitable tolling and found that equitable tolling does not apply to appeals pending before the Board. *See Sebelius v. Auburn Regional Medical Center*, 133 S.Ct. 817 (2013). This appeal was not timely and the Board cannot consider equitable tolling to extend the time for filing.

**Good Cause**

In this case, the Providers filed their appeal based on the publication of the final inpatient prospective payment rules in the Federal Register for the Federal fiscal years (FFYs) under dispute. Pursuant to 42 C.F.R. § 405.1836, a provider may request good cause for late filing if it can demonstrate that there are extraordinary circumstances beyond its control that prevented timely filing of an appeal and the request for hearing was made within three years of date of receipt of the final determination.<sup>2</sup> The Board notes that the Providers did not request or demonstrate good cause for late filing for those appeals that were filed within three years of the publication of the Federal Register notices. In this regard, the Board notes that the public was on notice of the issues surrounding the RFBNA well before the Providers filed this appeal in 2012. *See, e.g., Cape Cod Hospital v. Sebelius*, 677 F. Supp. 2d 18 (D.D.C. 2009).

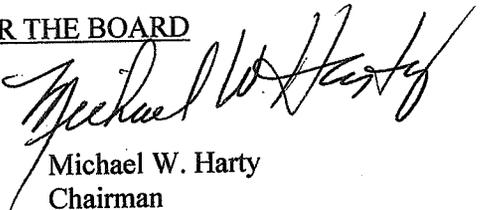
The Board hereby dismisses the appeals on the attached Schedule of Providers because they were not timely filed and hereby closes the case.

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**

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

**FOR THE BOARD**



Michael W. Harty  
Chairman

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

cc: Kevin Shanklin, Executive Director, BCBSA (w/Schedule of Providers)  
Renee Rhone, Cahaba Government Benefit Administrators (w/Schedule of Providers)

<sup>2</sup> In *District of Columbia Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993) Medicare and Medicaid Guide (CCH) ¶ 41,025 the Administrator determined that publication of notices in the Federal Register constitutes a final determination that can be appealed to the Board. The five day period for mailing to enable receipt of a final determination by a provider is not applicable to Federal Register notices because 42 U.S.C. § 1395oo(a)(3) states that a provider must file an appeal 180 days after it receives notice of the Secretary's final determination. In this case, the date that a notice is published in the Federal Register is the date of notice. 44 U.S.C. §1507 states that "[publication in the Federal Register] is sufficient to give notice of the contents of the document to a person subject to or affect by it." Consequently, with publication of the Federal Register there is no five-day delay in notice to allow for the mailing period.



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Refer to: 12-0254GC

CERTIFIED MAIL

**AUG 26 2013**

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

Re: QRS SGHS Health 1999-2012 RFBNA Equitable Tolling CIRP Group  
FYEs: 1999-2012  
Provider Nos.: Various  
PRRB Case No.: 12-0254GC

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (Board) has reviewed the hearing request submitted in the above appeal that was filed from the final publication inpatient prospective payment system rule for each FFY in the Federal Register. The Providers have asked the Board to consider equitable tolling to extend the time for filing an appeal with the Board. Some Providers furnished dates for the Notices of Program Reimbursement (NPRs) which were not timely appealed in this group appeal. NPRs for other years have not been issued most likely because of the hold on NPRs as a result of the *Baystate Medical Center v. Leavitt*, 545 F. Supp.2d 20 (2008), litigation.

**Pertinent Facts:**

The Providers in the above case have requested equitable tolling because they contend they had no "reasonable means" to identify errors in the Secretary's computation of the rural floor budget neutrality adjustment. They proffer that when CMS' 2008 rulemaking established the prospective payment system (PPS) no information was provided regarding the purpose of the change. CMS did not indicate that errors had been made in its prior implementation of the budget neutrality provision and they are not published. Consequently they were unable to discern any error(s) and could not duplicate the Secretary's calculations. They seek a correction of all annual budget neutrality adjustments from 1999-2012 to allow full and complete relief.

**Board Determination:**

**Equitable Tolling**

The Supreme Court recently addressed the question of whether the Board can consider equitable tolling and found that equitable tolling does not apply to appeals pending before the Board. *See Sebelius v. Auburn Regional Medical Center*, 133 S.Ct. 817 (2013). This appeal was not timely and the Board cannot consider equitable tolling to extend the time for filing.

**Good Cause**

In this case, the Providers filed their appeal based on the publication of the final inpatient prospective payment rules in the Federal Register for the Federal fiscal years (FFYs) under dispute. Pursuant to 42 C.F.R. § 405.1836, a provider may request good cause for late filing if it can demonstrate that there are extraordinary circumstances beyond its control that prevented timely filing of an appeal and the request for hearing was made within three years of date of receipt of the final determination.<sup>1</sup> The Board notes that the Providers did not request or demonstrate good cause for late filing for those appeals that were filed within three years of the publication of the Federal Register notices. In this regard, the Board notes that the public was on notice of the issues surrounding the RFBNA well before the Providers filed this appeal in 2012. *See, e.g., Cape Cod Hospital v. Sebelius*, 677 F. Supp. 2d 18 (D.D.C. 2009).

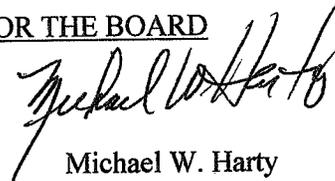
The Board hereby dismisses the appeals on the attached Schedule of Providers because they were not timely filed and hereby closes the case.

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**

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

**FOR THE BOARD**



Michael W. Harty  
Chairman

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

cc: Kevin D. Shanklin, Executive Director, BCBSA (w/Schedule of Providers)  
Renee Rhone, Cahaba Government Benefit Administrators (w/Schedule of Providers)

<sup>1</sup> In *District of Columbia Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993) Medicare and Medicaid Guide (CCH) ¶ 41,025 the Administrator determined that publication of notices in the Federal Register constitutes a final determination that can be appealed to the Board. The five day period for mailing to enable receipt of a final determination by a provider is not applicable to Federal Register notices because 42 U.S.C. § 1395oo(a)(3) states that a provider must file an appeal 180 days after it receives notice of the Secretary's final determination. In this case, the date that a notice is published in the Federal Register is the date of notice. 44 U.S.C. §1507 states that "[publication in the Federal Register] is sufficient to give notice of the contents of the document to a person subject to or affect by it." Consequently, with publication of the Federal Register there is no five-day delay in notice to allow for the mailing period.



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CERTIFIED MAIL

**AUG 26 2013**

12-0275GC

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

Re: QRS PHC 1999-2009, 2011-2012 RFBNA Equitable Tolling Group  
FYEs: 1999-2009; 2011-2012  
Provider Nos.: Various  
PRRB Case No.: 12-0275GC

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (Board) has reviewed the hearing request submitted in the above appeal that was filed from the final publication inpatient prospective payment system rule for each FFY in the Federal Register. The Providers have asked the Board to consider equitable tolling to extend the time for filing an appeal with the Board. Some Providers furnished dates for the Notices of Program Reimbursement (NPRs) which were not timely appealed in this group appeal. NPRs for other years have not been issued most likely because of the hold on NPRs as a result of the *Baystate Medical Center v. Leavitt*, 545 F. Supp.2d 20 (2008), litigation.

For the appeals filed within three years of the Final Determination no good cause extension was requested.

**Pertinent Facts:**

The remaining Providers in the above case have requested equitable tolling because they contend they had no "reasonable means" to identify errors in the Secretary's computation of the rural floor budget neutrality adjustment. They proffer that when CMS established the PPS rules no information was provided regarding the purpose of the change to the RFBNA. CMS did not indicate that errors had been made in its prior implementation of the budget neutrality provision when they were originally published. Consequently the Providers were unable to discern any error(s) and could not duplicate the Secretary's calculations. They seek a correction of all annual budget neutrality adjustments from 1999-2012 to allow full and complete relief.

The MAC has filed a jurisdictional challenge noting that that MAC made no determination to the cost reports on each participating provider on the Schedule of Providers. Consequently he argues that the Board does not have jurisdiction over these cases.<sup>1</sup>

**Board Determination:**

**Equitable Tolling**

The Supreme Court recently addressed the question of whether the Board can consider equitable tolling and found that equitable tolling does not apply to appeals pending before the Board. *See Sebelius v. Auburn Regional*

<sup>1</sup> MAC Jurisdictional Review of Group Appeal, p. 1.

*Medical Center*, 133 S.Ct. 817 (2013). This appeal was not timely and the Board cannot consider equitable tolling to extend the time for filing.

Good Cause

In this case, the Providers filed their appeal based on the publication of the final inpatient prospective payment rules in the Federal Register for the Federal fiscal years (FFYs) under dispute. Pursuant to 42 C.F.R. § 405.1836, a provider may request good cause for late filing if it can demonstrate that there are extraordinary circumstances beyond its control that prevented timely filing of an appeal and the request for hearing was made within three years of date of receipt of the final determination.<sup>2</sup> The Board notes that the Providers did not request or demonstrate good cause for late filing for those appeals that were filed within three years of the publication of the Federal Register notices. In this regard, the Board notes that the public was on notice of the issues surrounding the RFBNA well before the Providers filed this appeal in 2012. *See, e.g., Cape Cod Hospital v. Sebelius*, 677 F. Supp. 2d 18 (D.D.C. 2009).

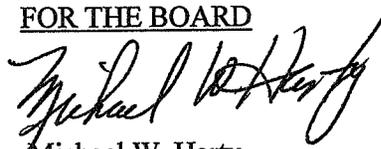
The Board hereby dismisses the appeals on the attached Schedule of Providers because they were not timely filed and hereby closes the case.

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

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

FOR THE BOARD



Michael W. Harty  
Chairman

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

cc: Kevin D. Shanklin, Executive Director, BCBSA (w/Schedule of Providers)  
Darwin San Luis, First Coast Service Options, Inc. - CA (w/Schedule of Providers)

<sup>2</sup> In *District of Columbia Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993) Medicare and Medicaid Guide (CCH) ¶ 41,025 the Administrator determined that publication of notices in the Federal Register constitutes a final determination that can be appealed to the Board. The five day period for mailing to enable receipt of a final determination by a provider is not applicable to Federal Register notices because 42 U.S.C. § 1395oo(a)(3) states that a provider must file an appeal 180 days after it receives notice of the Secretary's final determination. In this case, the date that a notice is published in the Federal Register is the date of notice. 44 U.S.C. §1507 states that "[publication in the Federal Register] is sufficient to give notice of the contents of the document to a person subject to or affect by it." Consequently, with publication of the Federal Register there is no five-day delay in notice to allow for the mailing period.



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Refer to: 12-0169GC, 13-2788GC

CERTIFIED MAIL

**AUG 26 2013**

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

Re: QRS Novant FFYs 1998-2011 RFBNA Equitable Tolling Group  
FYE: 1998-2011  
Provider Nos.: Various  
PRRB Case No.: 12-0169GC

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (Board) has reviewed the hearing request submitted in the above appeal that was filed from the final publication inpatient prospective payment system rule for each FFY in the Federal Register. The Providers have asked the Board to consider equitable tolling to extend the time for filing an appeal with the Board. Some Providers furnished dates for the Notices of Program Reimbursement (NPRs) which were not timely appealed in this group appeal. NPRs for other years have not been issued most likely because of the hold on NPRs as a result of the *Baystate Medical Center v. Leavitt*, 545 F. Supp.2d 20 (2008), litigation.

**Pertinent Facts:**

By letter filed January 30, 2012 the Providers in the above case have requested equitable tolling because they contend they had no "reasonable means" to identify errors in the Secretary's computation of the rural floor budget neutrality adjustment. They proffer that when CMS' 2008 rulemaking established the prospective payment system (PPS) no information was provided regarding the purpose of the change. CMS did not indicate that errors had been made in its prior implementation of the budget neutrality provision and they are not published. Consequently they were unable to discern any error(s) and could not duplicate the Secretary's calculations. They seek a correction of all annual budget neutrality adjustments from 1999-2012 to allow full and complete relief.

Jurisdiction Over Appeals filed for Federal Fiscal Year 2012:

Eight Providers included claims for FYE 12/31/11 and thus have timely filed an appeal for the period October 1, 2011 thru September 30, 2012 FFY (2012). The period January 1, 2011 through September 30, 2011 (FFY 2011) is late.

The following Providers filed appeals for cost reporting periods involving a portion of FFYs 2011 and 2012. The chart below sets forth the FYE under dispute and shows the entire length of the cost reporting period.

No.	Provider	FYE	Cost Reporting Period
23	Rowan Regional Medical Center (34-0015)	12/31/2011	1/1/2011-12/31/2011
59	Thomasville Medical Center (34-0085)	12/31/2011	1/1/2011-12/31/2011
73	Medical Park Hospital(34-0148)	12/31/2011	1/1/2011-12/31/2011
87	Presbyterian Orthopaedic Hospital (34-0153)	12/31/2011	1/1/2011-12/31/2011
102	Brunswick Novant (34-0158)	12/31/2011	1/1/2011-12/31/2011
116	Presbyterian Hospital Matthews (34-0171)	12/31/2011	1/1/2011-12/31/2011
124	Presbyterian Hospital Huntersville (34-0183)	12/31/2011	1/1/2011-12/31/2011
151	Prince William Hospital (49-0045)	12/31/2011	1/1/2011-12/31/2011

The following portions of the Providers cost reporting periods are part of FFY 2011 and are not timely filed from the publication of the final inpatient prospective payment rules in the August 16, 2010 Federal Register and are subject of the Board's jurisdictional determination set forth below:

No.	Provider	FYE	Untimely Period
23	Rowan Regional Medical Center (34-0015)	12/31/2011	1/1/2011-9/30/2011
59	Thomasville Medical Center (34-0085)	12/31/2011	1/1/2011-9/30/2011
73	Medical Park Hospital(34-0148)	12/31/2011	1/1/2011-9/30/2011
87	Presbyterian Orthopaedic Hospital (34-0153)	12/31/2011	1/1/2011-9/30/2011
102	Brunswick Novant (34-0158)	12/31/2011	1/1/2011-9/30/2011
116	Presbyterian Hospital Matthews (34-0171)	12/31/2011	1/1/2011-9/30/2011
124	Presbyterian Hospital Huntersville (34-0183)	12/31/2011	1/1/2011-9/30/2011
151	Prince William Hospital (49-0045)	12/31/2011	1/1/2011-9/30/2011

The following Providers have a portion of their cost reporting period which was timely filed from the August 18, 2011 publication date of the final inpatient prospective payment rules in the Federal Register notice for FFY 2012:

No.	Provider	FYE	Timely Period
23	Rowan Regional Medical Center (34-0015)	12/31/2011	10/1/2011-12/31/2011
59	Thomasville Medical Center (34-0085)	12/31/2011	10/1/2011-12/31/2011
73	Medical Park Hospital(34-0148)	12/31/2011	10/1/2011-12/31/2011
87	Presbyterian Orthopaedic Hospital (34-0153)	12/31/2011	10/1/2011-12/31/2011
102	Brunswick Novant (34-0158)	12/31/2011	10/1/2011-12/31/2011
116	Presbyterian Hospital Matthews (34-0171)	12/31/2011	10/1/2011-12/31/2011
124	Presbyterian Hospital Huntersville (34-0183)	12/31/2011	10/1/2011-12/31/2011
151	Prince William Hospital (49-0045)	12/31/2011	10/1/2011-12/31/2011

**Board Determination:**

**Creation of New Group**

The Board has placed the appeals of the partial cost reporting period that were timely filed from the issuance of the August 18, 2011 Federal Register in a new group appeal case, number 13-2788GC. The Providers and partial fiscal years to which this transfer applies are identified in the chart directly above.

**Equitable Tolling**

The Supreme Court recently addressed the question of whether the Board can consider equitable tolling and found that equitable tolling does not apply to appeals pending before the Board. *See Sebelius v. Auburn Regional Medical Center*, 133 S.Ct. 817 (2013). For the FFYs where the appeal was not timely, the Board cannot consider equitable tolling to extend the time for filing.

**Good Cause**

In this case, the Providers filed their appeal based on the publication of the final inpatient prospective payment rules in the Federal Register for the Federal fiscal years (FFYs) under dispute. Pursuant to 42 C.F.R. § 405.1836, a provider may request good cause for late filing if it can demonstrate that there are extraordinary circumstances beyond its control that prevented timely filing of an appeal and the request

for hearing was made within three years of date of receipt of the final determination.<sup>1</sup> The Board notes that the Providers did not request or demonstrate good cause for late filing for those appeals that were filed within three years of the publication of the Federal Register notices. In this regard, the Board notes that the public was on notice of the issues surrounding the RFBNA well before the Providers filed this appeal in 2012. *See, e.g., Cape Cod Hospital v. Sebelius*, 677 F. Supp. 2d 18 (D.D.C. 2009)

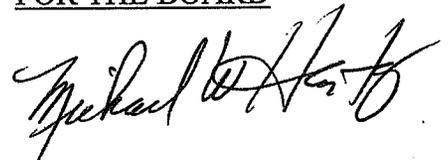
The Board hereby dismisses the appeals on the attached Schedule of Providers because they were not timely filed and hereby closes the case.

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

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

FOR THE BOARD



Michael W. Harty  
Chairman

Enclosures: Schedule of Providers  
Critical Due Dates Letter for case no. 13-2788GC  
42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin D. Shanklin, Executive Director, BCBSA (w/Schedule of Providers)  
Cecile Huggins, Palmetto GBA (w/Schedule of Providers)

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<sup>1</sup> In *District of Columbia Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993) Medicare and Medicaid Guide (CCH) ¶ 41,025 the Administrator determined that publication of notices in the Federal Register constitutes a final determination that can be appealed to the Board. The five day period for mailing to enable receipt of a final determination by a provider is not applicable to Federal Register notices because 42 U.S.C. § 1395oo(a)(3) states that a provider must file an appeal 180 days after it receives *notice* of the Secretary's final determination. In this case, the date that a notice is published in the Federal Register is the date of notice. 44 U.S.C. §1507 states that "[publication in the Federal Register] is sufficient to give notice of the contents of the document to a person subject to or affect by it." Consequently, with publication of the Federal Register there is no five-day delay in notice to allow for the mailing period.



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Refer to: 12-0226GC

CERTIFIED MAIL

**AUG 26 2013**

Ms. Corinna Goron  
President  
Healthcare Reimbursement Services  
17101 Preston RD, Suite 220  
Dallas, TX 75248-1372

Re: HRS WKHS 1998-2011 RFBNA Equitable Tolling CIRP Group, Provider Nos.: Various, FYEs: 1999-2011, Case No. 12-0226GC

Dear Ms. Goron:

The Provider Reimbursement Review Board (Board) has reviewed the hearing request submitted in the group appealed filed from Federal Register notices for the relevant fiscal periods. The Providers have asked the Board to consider equitable tolling to extend the time for filing an appeal with the Board.

The Providers appealed the Final PPS rules for their respective FFYs 1999-2011. There are no FFY 2012 appeals identified for any of the Providers listed on the Schedule of Providers, although the Providers stated they were appealing the final inpatient prospective payment rules published in the August 18, 2011 Federal Register. The latest cost report period under appeal ends 9/30/11 (FFY 2011) which was appealed from the August 16, 2010 Federal Register.<sup>1</sup> Consequently, none of the appeals were timely filed from the Federal Register notice giving rise to the dispute. (Note: Through correspondence dated 4/11/12 two of the Providers, Willis-Knighton Medical Center & Willis-Knighton Bossier Health Center appeals for Federal Fiscal Year 2010, were withdrawn from this case upon appeal of their respective NPRs. This new case, 12-0316GC is an appeal of FFY 2010).

**Pertinent Facts:**

By letter filed February 14, 2012 the Providers in the above case have requested equitable tolling because they contend they had no "reasonable means" to identify errors in the Secretary's computation of the rural floor budget neutrality adjustment. They proffer that when CMS' 2008 rulemaking established the prospective payment system (PPS) no information was provided regarding the purpose of the change. CMS did not indicate that errors had been made in its prior implementation of the budget neutrality provision and they are not published. Consequently they were unable to discern any error(s) and could not duplicate the Secretary's calculations. They seek a correction of all annual budget neutrality adjustments from 1999-2012 to allow full and complete relief.

<sup>1</sup> See Providers' February 14, 2012 hearing request Tab 1 (Schedule of Providers) and Tab 3 Statement of the Issue.

**Board Determination:**

**Equitable Tolling**

The Supreme Court recently addressed the question of whether the Board can consider equitable tolling and found that equitable tolling does not apply to appeals pending before the Board. *See Sebelius v. Auburn Regional Medical Center*, 133 S.Ct. 817 (2013). This appeal was not timely and the Board cannot consider equitable tolling to extend the time for filing.

**Good Cause**

In this case, the Providers filed their appeal based on the publication of the final inpatient prospective payment rules in the Federal Register for the Federal fiscal years (FFYs) under dispute. Pursuant to 42 C.F.R. § 405.1836, a provider may request good cause for late filing if it can demonstrate that there are extraordinary circumstances beyond its control that prevented timely filing of an appeal and the request for hearing was made within three years of date of receipt of the final determination.<sup>2</sup> The Board notes that the Providers did not request or demonstrate good cause for late filing for those appeals that were filed within three years of the publication of the Federal Register notices. In this regard, the Board notes that the public was on notice of the issues surrounding the RFBNA well before the Providers filed this appeal in 2012. *See, e.g., Cape Cod Hospital v. Sebelius*, 677 F. Supp. 2d 18 (D.D.C. 2009).

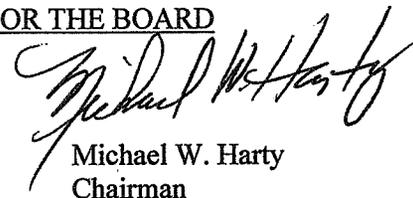
The Board hereby dismisses the appeals on the attached Schedule of Providers because they were not timely filed and hereby closes the case.

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**

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

**FOR THE BOARD**



Michael W. Harty  
Chairman

Enclosures: Schedule of Providers

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

cc: Kevin D. Shanklin, Executive Director, BCBSA (w/Schedule of Providers)  
Donna Silvio, Novitas Solutions, Inc. (w/Schedule of Providers)

<sup>2</sup>In *District of Columbia Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993) Medicare and Medicaid Guide (CCH) ¶ 41,025 the Administrator determined that publication of notices in the Federal Register constitutes a final determination that can be appealed to the Board. The five day period for mailing to enable receipt of a final determination by a provider is not applicable to Federal Register notices because 42 U.S.C. § 1395oo(a)(3) states that a provider must file an appeal 180 days after it receives notice of the Secretary's final determination. In this case, the date that a notice is published in the Federal Register is the date of notice. 44 U.S.C. §1507 states that "[publication in the Federal Register] is sufficient to give notice of the contents of the document to a person subject to or affect by it." Consequently, with publication of the Federal Register there is no five-day delay in notice to allow for the mailing period.



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Refer to: 12-0414GC

CERTIFIED MAIL

**AUG 26 2013**

Ms. Corinna Goron  
President  
Healthcare Reimbursement Services  
17101 Preston RD, Suite 220  
Dallas, TX 75248-1372

Re: HRS Promedica 1998-2009 & 2011 RFBNA Equitable Tolling CIRP Group, Provider Nos.:  
Various, FYEs: 1998-2009 & 2011, Case No. 12-0414GC

Dear Ms. Goron:

The Provider Reimbursement Review Board (Board) has reviewed the hearing request submitted in the above appeal that was filed from the final publication inpatient PPS rule for each FFY in the Federal Register. The Providers have asked the Board to consider equitable tolling to extend the time for filing an appeal with the Board. The Providers furnished dates for the Notice of Program Reimbursement (NPR) which were not timely appealed in this group appeal.

**Pertinent Facts:**

By letter filed June 21, 2012, the Providers in the above case have requested equitable tolling because they contend they had no "reasonable means" to identify errors in the Secretary's computation of the rural floor budget neutrality adjustment. They proffer that when CMS' 2008 rulemaking established the prospective payment system (PPS) no information was provided regarding the purpose of the change. CMS did not indicate that errors had been made in its prior implementation of the budget neutrality provision and they are not published. Consequently they were unable to discern any error(s) and could not duplicate the Secretary's calculations. They seek a correction of all annual budget neutrality adjustments from 1999-2012 to allow full and complete relief.

**Board Determination:**

**Equitable Tolling**

The Supreme Court recently addressed the question of whether the Board can consider equitable tolling and found that equitable tolling does not apply to appeals pending before the Board. *See Sebelius v. Auburn Regional Medical Center*, 133 S.Ct. 817 (2013). This appeal was not timely and the Board cannot consider equitable tolling to extend the time for filing.

Good Cause

In this case, the Providers filed their appeal based on the publication of the final inpatient prospective payment rules in the Federal Register for the Federal fiscal years (FFYs) under dispute. Pursuant to 42 C.F.R. § 405.1836, a provider may request good cause for late filing if it can demonstrate that there are extraordinary circumstances beyond its control that prevented timely filing of an appeal and the request for hearing was made within three years of date of receipt of the final determination.<sup>1</sup> The Board notes that the Providers did not request or demonstrate good cause for late filing for those appeals that were filed within three years of the publication of the Federal Register notices. In this regard, the Board notes that the public was on notice of the issues surrounding the RFBNA well before the Providers filed this appeal in 2012. *See, e.g., Cape Cod Hospital v. Sebelius*, 677 F. Supp. 2d 18 (D.D.C. 2009).

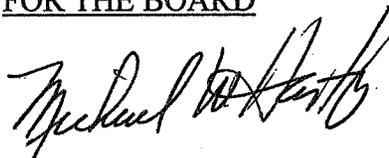
The Board hereby dismisses the appeals on the attached Schedule of Providers because they were not timely filed and hereby closes the case.

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

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

FOR THE BOARD

  
Michael W. Harty  
Chairman

Enclosures: Schedule of Providers

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

cc: Kevin D. Shanklin, Executive Director, BCBSA (w/Enclosures)  
Judith Cummings, CGS Administrators LLC (w/Enclosures)

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<sup>1</sup> In *District of Columbia Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993) Medicare and Medicaid Guide (CCH) ¶ 41,025 the Administrator determined that publication of notices in the Federal Register constitutes a final determination that can be appealed to the Board. The five day period for mailing to enable receipt of a final determination by a provider is not applicable to Federal Register notices because 42 U.S.C. § 1395oo(a)(3) states that a provider must file an appeal 180 days after it receives notice of the Secretary's final determination. In this case, the date that a notice is published in the Federal Register is the date of notice. 44 U.S.C. §1507 states that "[publication in the Federal Register] is sufficient to give notice of the contents of the document to a person subject to or affect by it." Consequently, with publication of the Federal Register there is no five-day delay in notice to allow for the mailing period.



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CERTIFIED MAIL

**AUG 26 2013**

12-0164GC & 12-0168GC

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

Re: QRS HMA FFYS 1998-2006 RFBNA Equitable Tolling Group, Case No. 12-0164GC, FYEs:  
1998-2006, Provider Nos.: Various  
QRS Providence FFYS 1999-2006 Equitable Tolling Group, Case No. 12-0168GC, FYEs: 1999-  
2006, Provider Nos.: Various

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (Board) has reviewed the hearing requests submitted in the attached appeals which were not timely filed from Federal Register notices for the relevant fiscal periods. The Providers have asked the Board to consider equitable tolling to extend the time for filing an appeal with the Board. The Providers appeal from Federal Register notices have untimely filed. Some Providers furnished dates for the Notice of Program Reimbursement (NPR) which were not timely appealed in this group appeal. NPRs for other years have not been issued most likely because of the hold on NPRs as a result of the *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (2008), litigation.

**Pertinent Facts:**

The Providers in the above cases have requested equitable tolling because they contend they had no "reasonable means" to identify errors in the Secretary's computation of the rural floor budget neutrality adjustment. They proffer that when CMS' 2008 rulemaking established the prospective payment system (PPS) no information was provided regarding the purpose of the change. CMS did not indicate that errors had been made in its prior implementation of the budget neutrality provision and they are not published. Consequently they were unable to discern any error(s) and could not duplicate the Secretary's calculations. They seek a correction of all annual budget neutrality adjustments from 1999-2012 to allow full and complete relief.

**Board Determination:**

**Equitable Tolling**

The Supreme Court recently addressed the question of whether the Board can consider equitable tolling and found that equitable tolling does not apply to appeals pending before the Board. *See Sebelius v. Auburn Regional Medical Center*, 133 S.Ct. 817 (2013). This appeal was not timely and the Board cannot consider equitable tolling to extend the time for filing.

Good Cause

In this case, the Providers filed their appeal based on the publication of the final inpatient prospective payment rules in the Federal Register for the Federal fiscal years (FFYs) under dispute. Pursuant to 42 C.F.R. § 405.1836, a provider may request good cause for late filing if it can demonstrate that there are extraordinary circumstances beyond its control that prevented timely filing of an appeal and the request for hearing was made within three years of date of receipt of the final determination.<sup>1</sup> The Board notes that the Providers did not request or demonstrate good cause for late filing for those appeals that were filed within three years of the publication of the Federal Register notices. In this regard, the Board notes that the public was on notice of the issues surrounding the RFBNA well before the Providers filed this appeal in 2012. *See, e.g., Cape Cod Hospital v. Sebelius*, 677 F. Supp. 2d 18 (D.D.C. 2009).

The Board hereby dismisses the appeals on the attached Schedule of Providers because they were not timely filed and hereby 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

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

FOR THE BOARD



Michael W. Harty  
Chairman

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

cc: Kevin D. Shanklin, Executive Director, BCBSA (w/Enclosures)  
Renee Rhone, Cahaba Government Benefit Administrators (w/Enclosures)  
Donna Silvio, Novitas Solutions, Inc. (w/Enclosures)  
Bryon Lamprecht, Wisconsin Physicians Services (w/Enclosures)  
Geoff Pike, First Coast Service Options, Inc.- FL (w/Enclosures)  
Danene Hartley, National Government Services, Inc. (w/Enclosures)  
Cecile Huggins, Palmetto GBA (w/Enclosures)

<sup>1</sup> In *District of Columbia Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993) Medicare and Medicaid Guide (CCH) ¶ 41,025 the Administrator determined that publication of notices in the Federal Register constitutes a final determination that can be appealed to the Board. The five day period for mailing to enable receipt of a final determination by a provider is not applicable to Federal Register notices because 42 U.S.C. § 1395oo(a)(3) states that a provider must file an appeal 180 days after it receives notice of the Secretary's final determination. In this case, the date that a notice is published in the Federal Register is the date of notice. 44 U.S.C. §1507 states that "[publication in the Federal Register] is sufficient to give notice of the contents of the document to a person subject to or affect by it." Consequently, with publication of the Federal Register there is no five-day delay in notice to allow for the mailing period.



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Refer to: 12-0228GC, 13-2791GC

CERTIFIED MAIL

**AUG 27 2013**

Ms. Corinna Goron  
President  
Healthcare Reimbursement Services  
17101 Preston RD, Suite 220  
Dallas, TX 75248-1372

Re: HRS Baptist Health 1998-2011 RFBNA Equitable Tolling CIRP Group, Provider Nos.: Various,  
FYE: 1998- 2011, Case No. 12-0228GC

Dear Ms. Goron:

The Provider Reimbursement Review Board (Board) has reviewed the hearing requests submitted in the above appeal that was filed from the final publication inpatient prospective payment system (PPS) rule for each Federal Fiscal Year (FFY) in the Federal Register. The Providers have asked the Board to consider equitable tolling to extend the time for filing an appeal with the Board. Some Providers furnished dates for the Notice of Program Reimbursement (NPR) which were not timely appealed in this group appeal. NPRs for other years have not been issued most likely because of the hold on NPRs as a result of the *Baystate Medical Center v. Leavitt*, 545 F. Supp.2d 20 (2008), litigation.

**Pertinent Facts:**

By letter filed February 14, 2012 the Providers in the above case have requested equitable tolling because they contend they had no "reasonable means" to identify errors in the Secretary's computation of the rural floor budget neutrality adjustment. They proffer that when CMS' 2008 rulemaking established the PPS no information was provided regarding the purpose of the change. CMS did not indicate that errors had been made in its prior implementation of the budget neutrality provision and they are not published. Consequently, they were unable to discern any error(s) and could not duplicate the Secretary's calculations. They seek a correction of all annual budget neutrality adjustments from 1999-2012 to allow full and complete relief.

Jurisdiction Over Appeals filed for Federal Fiscal Year 2012:

Two Providers included claims for FYE 12/31/11 and thus have timely filed an appeal for the period October 1, 2011 thru September 30, 2012 FFY (2012). The period January 1, 2011 through September 30, 2011 (FFY 2011) is late.

The following Providers filed appeals for cost reporting periods involving a portion of FFYs 2011 and 2012. The chart below sets forth the FYE under dispute and shows the entire length of the cost reporting period.

No.	Provider	FYE	Cost Reporting Period
14	Baptist Health Medical Center North Little Rock (05-0531)	12/31/2011	1/1/2011-12/31/2011
28	Baptist Health Medical Center Little Rock (04-0114)	12/31/2011	1/1/2011-12/31/2011

The following portions of the Providers cost reporting periods are part of FFY 2011 and are not timely filed from the publication of the final inpatient prospective payment rules in the August 16, 2010 Federal Register and are subject of the Board's jurisdictional determination set forth below:

No.	Provider	FYE	Untimely Period
14	Baptist Health Medical Center North Little Rock (05-0531)	12/31/2011	1/1/2011-9/31/2011
28	Baptist Health Medical Center Little Rock (04-0114)	12/31/2011	1/1/2011-9/31/2011

The following Providers have a portion of their cost reporting period which was timely filed from the August 18, 2011 publication date of the final inpatient prospective payment rules in the Federal Register notice for FFY 2012:

No.	Provider	FYE	Timely Period
14	Baptist Health Medical Center North Little Rock (05-0531)	12/31/2011	10/1/2011-12/31/2011
28	Baptist Health Medical Center Little Rock (04-0114)	12/31/2011	10/1/2011-12/31/2011

**Board Determination:**

Creation of New Group

The Board has placed the appeals of the partial cost reporting period that were timely filed from the issuance of the August 18, 2011 Federal Register in a new group appeal case, number 13-2791GC. The Providers and partial fiscal years to which this transfer applies are identified in the chart directly above.

Equitable Tolling

The Supreme Court recently addressed the question of whether the Board can consider equitable tolling and found that equitable tolling does not apply to appeals pending before the Board. *See Sebelius v. Auburn Regional Medical Center*, 133 S.Ct. 817 (2013). For the FFYs where the appeal was not timely, the Board cannot consider equitable tolling to extend the time for filing.

Good Cause

In this case, the Providers filed their appeal based on the publication of the final inpatient prospective payment rules in the Federal Register for the Federal fiscal years (FFYs) under dispute. Pursuant to 42 C.F.R. § 405.1836, a provider may request good cause for late filing if it can demonstrate that there are extraordinary circumstances beyond its control that prevented timely filing of an appeal and the request for hearing was made within three years of date of receipt of the final determination.<sup>1</sup> The Board notes that the Providers did not request or demonstrate good cause for late filing for those appeals that were filed within three years of the publication of the Federal Register notices. In this regard, the Board notes that the public was on notice of the issues surrounding the RFBNA well before the Providers filed this appeal in 2012. *See, e.g., Cape Cod Hospital v. Sebelius*, 677 F. Supp. 2d 18 (D.D.C. 2009)

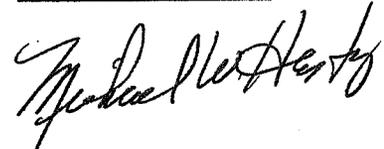
The Board hereby dismisses the appeals on the attached Schedule of Providers because they were not timely filed and hereby closes the case.

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

Michael W. Hartly  
John Gary Bowers, CPA  
Clayton J. Nix, Esq.  
L. Sue Andersen, Esq.

FOR THE BOARD

  
Michael W. Hartly  
Chairman

Enclosures: Schedule of Providers  
Critical Due Dates Letter for case no. 13-2791GC  
42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin D. Shanklin, Executive Director, BCBSA (w/Schedule of Providers)  
Donna Silvio, Novitas Solutions, Inc. (w/Schedule of Providers)

<sup>1</sup> In *District of Columbia Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993) Medicare and Medicaid Guide (CCH) ¶ 41,025 the Administrator determined that publication of notices in the Federal Register constitutes a final determination that can be appealed to the Board. The five day period for mailing to enable receipt of a final determination by a provider is not applicable to Federal Register notices because 42 U.S.C. § 1395oo(a)(3) states that a provider must file an appeal 180 days after it receives notice of the Secretary's final determination. In this case, the date that a notice is published in the Federal Register is the date of notice. 44 U.S.C. §1507 states that "[publication in the Federal Register] is sufficient to give notice of the contents of the document to a person subject to or affect by it." Consequently, with publication of the Federal Register there is no five-day delay in notice to allow for the mailing period.



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CERTIFIED MAIL

**AUG 27 2013**

Ms. Corinna Goron  
President  
Healthcare Reimbursement Services  
17101 Preston RD, Suite 220  
Dallas, TX 75248-1372

Re: HRS FFYs 1998-2012 RFBNA Equitable Tolling Group  
FYE: 1998-2012  
Provider Nos.: Various  
PRRB Case No.: 12-0160G

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (Board) has reviewed the hearing requests submitted in the above appeal that were filed from the final publication inpatient PPS rule for each FFY in the Federal Register. The Providers have asked the Board to consider equitable tolling to extend the time for filing an appeal with the Board.

**Pertinent Facts:**

By letter filed January 30, 2012 the Providers in the above case have requested equitable tolling because they contend they had no "reasonable means" to identify errors in the Secretary's computation of the rural floor budget neutrality adjustment. They proffer that when CMS' 2008 rulemaking established the prospective payment system (PPS) no information was provided regarding the purpose of the change. CMS did not indicate that errors had been made in its prior implementation of the budget neutrality provision and they are not published. Consequently they were unable to discern any error(s) and could not duplicate the Secretary's calculations. They seek a correction of all annual budget neutrality adjustments from 1999-2012 to allow full and complete relief.

**Jurisdiction Over Appeals filed for Federal Fiscal Year 2012:**

Eight Providers included claims for 12/31/11 while two Providers included claims for 6/30/2012 and thus have timely filed an appeal for the period October 1, 2011 thru September 30, 2012 FFY (2012). The period January 1, 2011 through September 30, 2011 (FFY 2011) is late.

The following Providers filed appeals for cost reporting periods involving a portion of FFYs 2011 and 2012. The chart below sets forth the FYE under dispute and shows the entire length of the cost reporting period.

No.	Provider	FYE	Cost Reporting Period
26	Lafayette General Surgical Hospital (19-0268)	12/31/2011	1/1/2011-12/31/2011
60	Verdugo Hills Hospital (05-124)	12/31/2011	1/1/2011-12/31/2011
83	Lodi Memorial Hospital (05-0036)	12/31/2011	1/1/2011-12/31/2011
93	North Hawaii Hospital (12-0028)	12/31/2011	1/1/2011-12/31/2011
142	Lima Memorial Health System (36-0009)	12/31/2011	1/1/2011-12/31/2011
153	Akron General Medical Center (36-0027)	12/31/2011	1/1/2011-12/31/2011
165	Robinson Memorial Hospital (36-0078)	12/31/2011	1/1/2011-12/31/2011
175	Lake Health System (36-0098)	12/31/2011	1/1/2011-12/31/2011
11	Queen's Medical Center (12-0001)	6/30/2012	7/1/2011-10/1/2011
38	Central Maine Center (20-0024)	6/30/2012	7/1/2011-10/1/2011

The following portions of the Providers cost reporting periods are part of FFY 2011 and are not timely filed from the publication of the final inpatient prospective payment rules in the August 16, 2010 Federal Register and are subject of the Board's jurisdictional determination set forth below:

No.	Provider	FYE	Untimely Period
26	Lafayette General Surgical Hospital (19-0268)	12/31/2011	1/1/2011-9/30/2011
60	Verdugo Hills Hospital (05-124)	12/31/2011	1/1/2011-9/30/2011
83	Lodi Memorial Hospital (05-0036)	12/31/2011	1/1/2011-9/30/2011
93	North Hawaii Hospital (12-0028)	12/31/2011	1/1/2011-9/30/2011
142	Lima Memorial Health System (36-0009)	12/31/2011	1/1/2011-9/30/2011
153	Akron General Medical Center (36-0027)	12/31/2011	1/1/2011-9/30/2011
165	Robinson Memorial Hospital (36-0078)	12/31/2011	1/1/2011-9/30/2011
175	Lake Health System (36-0098)	12/31/2011	1/1/2011-9/30/2011
11	Queen's Medical Center (12-0001)	6/30/2012	7/1/2011-9/30/2011
38	Central Maine Center (20-0024)	6/30/2012	7/1/2011-9/30/2011

The following Providers have a portion of their cost reporting period which was timely filed from the August 18, 2011 publication date of the final inpatient prospective payment rules in the Federal Register notice for FFY 2012:

No.	Provider	FYE	Timely Period
26	Lafayette General Surgical Hospital (19-0268)	12/31/2011	10/1/2011-12/31/2011
60	Verdugo Hills Hospital (05-124)	12/31/2011	10/1/2011-12/31/2011
83	Lodi Memorial Hospital (05-0036)	12/31/2011	10/1/2011-12/31/2011
93	North Hawaii Hospital (12-0028)	12/31/2011	10/1/2011-12/31/2011
142	Lima Memorial Health System (36-0009)	12/31/2011	10/1/2011-12/31/2011
153	Akron General Medical Center (36-0027)	12/31/2011	10/1/2011-12/31/2011
165	Robinson Memorial Hospital (36-0078)	12/31/2011	10/1/2011-12/31/2011
175	Lake Health System (36-0098)	12/31/2011	10/1/2011-12/31/2011
11	Queen's Medical Center (12-0001)	6/30/2012	10/1/2011-6/30/2012
38	Central Maine Center (20-0024)	6/30/2012	10/1/2011-6/30/2012

**Board Determination:**

**Creation of New Group**

The Board has placed the appeals of the partial cost reporting period that were timely filed from the issuance of the August 18, 2011 Federal Register in a new group appeal case, number 13-2910GC. The Providers and partial fiscal years to which this transfer applies are identified in the chart directly above.

**Equitable Tolling**

The Supreme Court recently addressed the question of whether the Board can consider equitable tolling and found that equitable tolling does not apply to appeals pending before the Board. *See Sebelius v. Auburn Regional Medical Center*, 133 S.Ct. 817 (2013). For the FFYs where the appeal was not timely, the Board cannot consider equitable tolling to extend the time for filing.

**Good Cause**

In this case, the Providers filed their appeal based on the publication of the final inpatient prospective payment rules in the Federal Register for the Federal fiscal years (FFYs) under dispute. Pursuant to 42 C.F.R. § 405.1836, a provider may request good cause for late filing if it can demonstrate that there are extraordinary circumstances beyond its control that prevented timely filing of an appeal and the request

for hearing was made within three years of date of receipt of the final determination.<sup>1</sup> The Board notes that the Providers did not request or demonstrate good cause for late filing for those appeals that were filed within three years of the publication of the Federal Register notices. In this regard, the Board notes that the public was on notice of the issues surrounding the RFBNA well before the Providers filed this appeal in 2012. *See, e.g., Cape Cod Hospital v. Sebelius*, 677 F. Supp. 2d 18 (D.D.C. 2009)

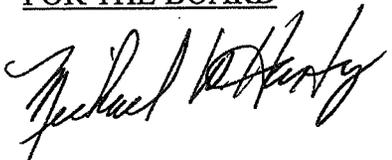
The Board hereby dismisses the appeals on the attached Schedule of Providers because they were not timely filed and hereby closes the case.

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

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

FOR THE BOARD



Michael W. Harty  
Chairman

Enclosures: Schedule of Providers  
Critical Due Dates Letter for case no. 13-2910GC  
42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin D. Shanklin, Executive Director, BCBSA (w/Schedule of Providers)  
Darwin San Luis, Palmetto, GBA (w/Schedule of Providers)

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<sup>1</sup> In *District of Columbia Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993) Medicare and Medicaid Guide (CCH) ¶ 41,025 the Administrator determined that publication of notices in the Federal Register constitutes a final determination that can be appealed to the Board. The five day period for mailing to enable receipt of a final determination by a provider is not applicable to Federal Register notices because 42 U.S.C. § 1395oo(a)(3) states that a provider must file an appeal 180 days after it receives notice of the Secretary's final determination. In this case, the date that a notice is published in the Federal Register is the date of notice. 44 U.S.C. §1507 states that "[publication in the Federal Register] is sufficient to give notice of the contents of the document to a person subject to or affect by it." Consequently, with publication of the Federal Register there is no five-day delay in notice to allow for the mailing period.



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Refer to: 12-0227GC, 13-2793GC

CERTIFIED MAIL

**AUG 27 2013**

Ms. Corinna Goron  
President  
Healthcare Reimbursement Services  
17101 Preston RD, Suite 220  
Dallas, TX 75248-1372

Re: HRS Prime Healthcare 2001-2011 RFBNA Equitable Tolling CIRP Group, Provider Nos.:  
Various, FYEs: 2001- 2011, Case No. 12-0227GC

Dear Ms. Goron:

The Provider Reimbursement Review Board (Board) has reviewed the hearing requests submitted in the attached appeals filed from Federal Register notices for the relevant fiscal periods. The Providers have asked the Board to consider equitable tolling to extend the time for filing an appeal with the Board.

**Pertinent Facts:**

By letter filed February 14, 2012 the Providers in the above case have requested equitable tolling because they contend they had no "reasonable means" to identify errors in the Secretary's computation of the rural floor budget neutrality adjustment. They proffer that when CMS' 2008 rulemaking established the prospective payment system (PPS) no information was provided regarding the purpose of the change. CMS did not indicate that errors had been made in its prior implementation of the budget neutrality provision and they are not published. Consequently they were unable to discern any error(s) and could not duplicate the Secretary's calculations. They seek a correction of all annual budget neutrality adjustments from 1999-2012 to allow full and complete relief.

**Jurisdiction Over Appeals filed for Federal Fiscal Year 2012:**

Fourteen Participants included a claim for 12/31/11 and thus have timely filed an appeal for the period October 1, 2011 thru December 31, 2011 (FFY 2012). The period January 1, 2011 through September 30, 2011 (FFY 2011) is late.

The following Providers filed appeals for cost reporting periods involving a portion of FFYs 2011 and 2012. The chart below sets forth the FYE under dispute and shows the entire length of the cost reporting period.

No.	Provider	FYE	Cost Reporting Period
7	Paradise Valley Hospital (05-0024)	12/31/2011	1/1/2011-12/31/2011
12	Encino Hospital Medical Center (05-0158)	12/31/2011	1/1/2011-12/31/2011
17	Garden Grove Hospital & Medical Center (05-0230)	12/31/2011	1/1/2011-12/31/2011
24	W. Anaheim Medical Center (05-0426)	12/31/2011	1/1/2011-12/31/2011
32	Huntington Beach Hospital (05-0526)	12/31/2011	1/1/2011-12/31/2011
39	La Palma Intercommunity (05-0580)	12/31/2011	1/1/2011-12/31/2011
46	Chino Valley Medical Center (05-0586)	12/31/2011	1/1/2011-12/31/2011
51	San Dimas Community Hospital (05-0588)	12/31/2011	1/1/2011-12/31/2011
62	Desert Valley Hospital (05-0709)	12/31/2011	1/1/2011-12/31/2011
67	Centinela Hospital Medical Center (05-0739)	12/31/2011	1/1/2011-12/31/2011
73	Sherman Oaks (05-0755)	12/31/2011	1/1/2011-12/31/2011
78	Alvarado Hospital Medical Center (05-0757)	12/31/2011	1/1/2011-12/31/2011
84	Montclair Hospital (05-0758)	12/31/2011	1/1/2011-12/31/2011
87	Shasta Regional Medical Center (05-0764)	12/31/2011	1/1/2011-12/31/2011

The following portions of the Providers cost reporting periods are part of FFY 2011 and are not timely filed from the publication of the final inpatient prospective payment rules in the August 16, 2010 Federal Register and are subject of the Board's jurisdictional determination set forth below:

No.	Provider	FYE	Untimely Period
7	Paradise Valley Hospital (05-0024)	12/31/2011	1/1/2011-9/30/2011
12	Encino Hospital Medical Center (05-0158)	12/31/2011	1/1/2011-9/30/2011
17	Garden Grove Hospital & Medical Center (05-0230)	12/31/2011	1/1/2011-9/30/2011
24	W. Anaheim Medical Center (05-0426)	12/31/2011	1/1/2011-9/30/2011
32	Huntington Beach Hospital (05-0526)	12/31/2011	1/1/2011-9/30/2011
39	La Palma Intercommunity (05-0580)	12/31/2011	1/1/2011-9/30/2011
46	Chino Valley Medical Center (05-0586)	12/31/2011	1/1/2011-9/30/2011
51	San Dimas Community Hospital (05-0588)	12/31/2011	1/1/2011-9/30/2011
62	Desert Valley Hospital (05-0709)	12/31/2011	1/1/2011-9/30/2011
67	Centinela Hospital Medical Center (05-0739)	12/31/2011	1/1/2011-9/30/2011
73	Sherman Oaks (05-0755)	12/31/2011	1/1/2011-9/30/2011
78	Alvarado Hospital Medical Center (05-0757)	12/31/2011	1/1/2011-9/30/2011
84	Montclair Hospital (05-0758)	12/31/2011	1/1/2011-9/30/2011
87	Shasta Regional Medical Center (05-0764)	12/31/2011	1/1/2011-9/30/2011

The following Providers have a portion of their cost reporting period which was timely filed from the August 18, 2011 publication date of the final inpatient prospective payment rules in the Federal Register notice for FFY 2012:

No.	Provider	FYE	Timely Period
7	Paradise Valley Hospital (05-0024)	12/31/2011	10/1/2011- 12/31/2011
12	Encino Hospital Medical Center (05-0158)	12/31/2011	10/1/2011- 12/31/2011
17	Garden Grove Hospital & Medical Center (05-0230)	12/31/2011	10/1/2011- 12/31/2011
24	W. Anaheim Medical Center (05-0426)	12/31/2011	10/1/2011- 12/31/2011
32	Huntington Beach Hospital (05-0526)	12/31/2011	10/1/2011- 12/31/2011
39	La Palma Intercommunity (05-0580)	12/31/2011	10/1/2011- 12/31/2011
46	Chino Valley Medical Center (05-0586)	12/31/2011	10/1/2011- 12/31/2011
51	San Dimas Community Hospital (05-0588)	12/31/2011	10/1/2011- 12/31/2011
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67	Centinela Hospital Medical Center (05-0739)	12/31/2011	10/1/2011- 12/31/2011
73	Sherman Oaks (05-0755)	12/31/2011	10/1/2011- 12/31/2011
78	Alvarado Hospital Medical Center (05-0757)	12/31/2011	10/1/2011- 12/31/2011
84	Montclair Hospital (05-0758)	12/31/2011	10/1/2011- 12/31/2011
87	Shasta Regional Medical Center (05-0764)	12/31/2011	10/1/2011- 12/31/2011

**Board Determination:**

**Creation of New Group**

The Board has placed the appeals of the partial cost reporting period that were timely filed from the issuance of the August 18, 2011 Federal Register in a new group appeal case, number 13-2793GC. The Providers and partial fiscal years to which this transfer applies are identified in the chart directly above.

Equitable Tolling

The Supreme Court recently addressed the question of whether the Board can consider equitable tolling and found that equitable tolling does not apply to appeals pending before the Board. *See Sebelius v. Auburn Regional Medical Center*, 133 S.Ct. 817 (2013). For the FFYs where the appeal was not timely, the Board cannot consider equitable tolling to extend the time for filing.

Good Cause

In this case, the Providers filed their appeal based on the publication of the final inpatient prospective payment rules in the Federal Register for the Federal fiscal years (FFYs) under dispute. Pursuant to 42 C.F.R. § 405.1836, a provider may request good cause for late filing if it can demonstrate that there are extraordinary circumstances beyond its control that prevented timely filing of an appeal and the request for hearing was made within three years of date of receipt of the final determination.<sup>1</sup> The Board notes that the Providers did not request or demonstrate good cause for late filing for those appeals that were filed within three years of the publication of the Federal Register notices. In this regard, the Board notes that the public was on notice of the issues surrounding the RFBNA well before the Providers filed this appeal in 2012. *See, e.g., Cape Cod Hospital v. Sebelius*, 677 F. Supp. 2d 18 (D.D.C. 2009)

The Board hereby dismisses the appeals on the attached Schedule of Providers because they were not timely filed and hereby 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

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

FOR THE BOARD

  
Michael W. Harty  
Chairman

Enclosures: Schedule of Providers  
Critical Due Dates Letter for case no. 13-2793GC  
42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin D. Shanklin, Executive Director, BCBSA (w/ Schedule of Providers)  
Darwin San Luis, Palmetto GBA (w/ Schedule of Providers)

<sup>1</sup> In *District of Columbia Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993) Medicare and Medicaid Guide (CCH) ¶ 41,025 the Administrator determined that publication of notices in the Federal Register constitutes a final determination that can be appealed to the Board. The five day period for mailing to enable receipt of a final determination by a provider is not applicable to Federal Register notices because 42 U.S.C. § 1395oo(a)(3) states that a provider must file an appeal 180 days after it receives notice of the Secretary's final determination. In this case, the date that a notice is published in the Federal Register is the date of notice. 44 U.S.C. §1507 states that "[publication in the Federal Register] is sufficient to give notice of the contents of the document to a person subject to or affect by it." Consequently, with publication of the Federal Register there is no five-day delay in notice to allow for the mailing period.



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Refer to:

06-1643G

CERTIFIED MAIL

**AUG 27 2013**

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

Noridian Administrative Services  
Lee Crooks  
Appeals Coordinator  
WA/AK Part A Audit Appeals  
P.O. Box 6720  
Fargo, ND 58108-6720

RE: Jurisdiction Determination for St. Cloud Hospital, Provider No. 24-0036  
As a participant in QRS 2000 DSH/SSI Proxy Group (2)  
PRRB Case No.: 06-1643G  
FYE(s): 06/30/2000

Dear Ms. Crooks and Mr. Ravindran,

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

**Background**

Participant #4, St. Cloud Hospital (24-0036), filed directly into a group appeal (case no. 00-0850G<sup>1</sup>) from receipt of its Notice of Program Reimbursement on September 4, 2002.

On September 18, 2003, the Representative sent the Board a letter clarifying the description of the group issue in case. no. 00-0850G. The issue was characterized as CMS' failure to properly calculate the Providers' DSH calculation so as to include all appropriate patient days as defined below:

- Charity Care
- State General Assistance
- State Medical Assistance
- County General Assistance
- County Medical Assistance
- County Medical Assistance
- State Only or County Only Health Program
- Low Income Care

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<sup>1</sup> Case No. 00-0850G is identified as National DSH Group I.

- Indigent Care
- Uncompensated Care
- Bad Debt
- Medicaid DSH
- Section 1115 Waiver Demonstration Project
- Population Days
- SSI Days
- Dual Eligible Days
- Eligible Paid Days

Subsequently, on July 1, 2005, the Provider requested to have its "Patient Days issue" transferred from the group, case no. 00-0850G, to an individual appeal. The Board granted the Provider's request and established a new individual appeal for FYE 2000 to which it assigned case no. 05-1881.<sup>2</sup> In the Board's letter it advised that the individual appeal was being created for the sole purpose of processing the Patient Days issue.

The Board previously determined that it had jurisdiction over the SSI issue. The Board found that the Intermediary was "confined to using the SSI eligibility information furnished by CMS and does not have authority to use other data when auditing the cost report."<sup>3</sup> The Board held where the appealed cost report did not include an audit adjustment for the Supplemental Security Income (SSI) percentage issue, the issue may be properly appealed in accordance with *Bethesda Hospital Association v. Bowen*, 485 U.S. 399 (1988).

While the issue is a proper one pursuant to *Bethesda*, a Provider must satisfy all jurisdictional requirements in order for the Board to assert jurisdiction. Here the Provider has failed to properly transfer the SSI issue into case no. 06-1643G. The Provider requested the SSI issue be transferred from its individual appeal, case no. 05-1881 to case 06-1643G. The individual appeal did not include the SSI issue. Case no. 05-1881 was created by the Board for the sole purpose of processing Patient Days issue. As such there was no SSI issue to transfer. The SSI issue was included in the aforementioned group case 00-0850G, however, there is no documentation showing the transfer of the SSI issue from case no. 00-0850G to this group appeal.

#### **Board Determination for St. Cloud Hospital:**

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

A group appeal consists of a single issue only, which involves a question of fact or an interpretation of law, regulation or CMS Ruling. (Emphasis added)

<sup>2</sup>The individual appeal was created more than 180 days after the issuance of the Provider's NPR.

<sup>3</sup>Jurisdictional Determination, June 17, 2010.

The Board finds that St. Cloud Hospital did not properly transfer the SSI issue to this group. The SSI issue was not included in the individual appeal, case no. 05-1881. There is no documentation showing the transfer of the SSI issue from case no. 00-0850G to this group appeal. Consequently St. Cloud Hospital is hereby dismissed from participation in group case number 06-1643G.

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

The remaining participants in the group appeal, QRS 2000 DSH/SSI Proxy Group (2), are subject to remand pursuant to CMS Ruling 1498-R. Enclosed, please find the Board's remand under the standard procedure.

Board Members Participating:

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

For the Board



Michael W. Harty  
Chairman

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

cc: Kevin D. Shanklin, Executive Director, BCBSA



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Refer to: 13-0052  
Certified Mail

**AUG 27 2013**

Radhika Vemula, Esq.  
Kennedy Attorneys and Counselors at Law  
12222 Merit Drive, Suite 1750  
Dallas, TX 75251

RE: Carter Healthcare, Inc.  
Provider No. 37-1580  
Cap Period November 1, 2009 through October 31, 2010  
PRRB Case No. 13-0052

Dear Ms. Vemula:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's July 29, 2013 request for expedited judicial review (EJR) and appeal (received July 30, 2013) based on the issuance of a revised Notice of Cap Amount, the July 3, 2013 Proposed Joint Scheduling Order and the original request for hearing based on the original Notice of Effect of Inpatient Day Limitation and Hospice Cap Amount. The Provider contends that the regulation establishing the calculation of the hospice cap, 42 C.F.R. § 418.309(b)(1), fails to comply with the statutory authority, 42 U.S.C. § 1395f(i)(2), for establishing the hospice cap. The decision of the Board is set forth below.

### **Statutory and Regulatory Background**

#### **Hospice Reimbursement under Medicare**

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

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

In 1983, the Secretary adopted a rule that allocates hospice care on an aggregate basis by allocating each beneficiary entirely to the cap year in which he or she would be likely to receive the preponderance of his or her care. 48 Fed. Reg. 56,008, 56,022 (December 16, 1983). Once

a beneficiary is counted for a given hospice, the beneficiary is not counted in the cap in subsequent years if services continue into more than one cap year.<sup>1</sup>

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

In 2006, Providers began filing appeals objecting to the current counting methodology used in calculating hospice reimbursement, seeking to have the overpayment determination calculated under the methodology described above invalidated. The Federal district courts and courts of appeals that ruled on the question have issued decisions concluding that the methodology is in consistent with the plain language of the Medicare statute and set aside the overpayment determinations.<sup>2</sup>

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

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

Under the Ruling intermediaries and Medicare Administrative Contractors (MACs) were to identify properly pending appeals and recalculate the aggregate cap using the patient-by-patient methodology using the best available data. For hospices which had not filed appeals challenging the cap, the intermediaries and MACs were to use the reimbursement methodology that appeared in the regulation at 42 C.F.R. § 418.309(b)(1) for any cap year ending on or before October 31, 2011, unless CMS adopted a rule providing otherwise.<sup>3</sup>

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<sup>1</sup> Ruling 1355-R at 3-5.

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

<sup>3</sup> Ruling at 9-11.

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

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

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

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

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

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

76 Fed. Reg. 47302, 47310 (August 3, 2011).

Hospice Geographical Location and Payment

When Congress first authorized Medicare payment for hospice care under the Tax Equity and Fiscal Responsibility Act of 1982 (Pub. Law 97-248) (TEFRA) the benefit period was two 90-day benefit periods and a 30 day extension of benefits. 42 U.S.C. § 1395(dd)(3)(A) (1984). In 1997, Congress amended the statute to extend the benefit period providing beneficiaries with unlimited 60-day extensions for care. 42 U.S.C. § 1395d(d)(1).

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<sup>4</sup> 76 Fed. Reg. 47302, 47308 (August 4, 2011).

TEFRA directed the Secretary to make payments to hospices for the reasonable cost of providing services under 42 U.S.C. § 1395(d)(i)(1) (1982). Pursuant to this statutory authority, the Health Care Financing Administration (HCFA, now CMS) instituted a prospective payment system for paying rates based on the level of care. 48 Fed. Reg. 56008 (December 16, 1983). Rather than apply an adjustment based on regional Medicare expenditures as provided for under 42 U.S.C. § 1395f(i)(2)(B), HCFA based its adjustment based on 1981 data furnished by the Bureau of Labor Statistics (BLS) that was also used in the initial Metropolitan Statistical Area (MSA) index for inpatient hospital prospective payment. *See* 48 Fed. Reg. at 56021-22.

The prospectively determined hospice rates were also subject to a cap on payments that hospices can receive for treatment of Medicare beneficiaries. *See*, 42 U.S.C. § 1395f(i)(2)(B). The Provider asserts that TEFRA instructed the Secretary to devise the cap so that it would represent 40 percent of the average cost of providing hospice care to a patient during the last six months of the beneficiary's life. The Secretary was then to "compute a regional average Medicare per capita expenditure amount for each region, by adjusting the national average Medicare per capita expenditure" to reflect the relative difference between that regions average cost of delivering health care and the national average cost . . ." 42 U.S.C. § 1395(i)(2)(B)(iii) (1982).

Less than a year after the TEFRA law was enacted and before the proposed regulations implementing the hospice benefit were issued, Congress passed a "technical amendment" to the hospice cap requirement in Pub. Law 98-90. Congress replaced the 40 percent target with a flat cap of \$6,500 to be adjusted annually for inflation according to the Consumer Price Index's health care expenditure figure. *See* H.R. Rep. 98-333, 98<sup>th</sup> Cong. (1983) (reprinted in 1983 U.S.C.C.A.N. 1043).

In 1997, HCFA altered the way it calculates the hospice wage index used to adjust the prospective payment rates for hospice care. Initially, the hospice wage index was tied to the 1981 BLS data used for the inpatient hospital prospective payment system. In 1997, after undertaking negotiated rulemaking on the issue, HCFA adopted a new wage index methodology for hospice rates based on 1993 hospital cost data. *See* 62 Fed. Reg. 42860 (August 8, 1997). In response to comments made in the August 8, 1997 Federal Register regard concerns as to why wage rates were based on the location of the hospice rather than where the service is furnished, the Secretary stated:

Hospices provide services in various locations. These may include the patient's home, an inpatient facility and the hospice facility itself. Currently, the wage index for hospice services is based on the location of the hospice rather than the location of the service delivery. Although this was not an issue addressed by this rule a proposal linking payments for hospice services to the geographical location of the site where the service was furnished was included in the Administrator's Medicare and

Medicaid Fraud, Abuse and Waste Prevention Amendments of  
1997.

62 Fed. Reg. at 42861

CMS has never adjusted the hospice cap for regional differences in the cost of furnishing hospice care. Congress amended the hospice cap provision of the Medicare statute in 1997 to require that hospices “shall submit claims for payment for hospice care furnished in an individual’s home under this title only on the basis of geographic location at which the service is furnished, as determined by the Secretary.” 42 U.S.C. § 1395f(i)(2)(D) (1997). This provision is located in the part of the statute establishing the hospice cap. In 2005, CMS began setting the per diem rate paid to hospices based on the location where the service is furnished. 42 C.F.R. § 418.306(c)(2007). However, the wage indices applied to these hospice payment rates are published in the Federal Register. *See e.g.* 71 Fed. Reg. 52080 (September 1, 2006). However, the published wage indices for hospice payments do not apply to the hospice cap. As a result, a hospice in a higher per diem payment area will receive higher payment than those in a lower per diem payment area, but not based on the location of the patient.

### Procedural History

#### Original Hearing Request

The Provider’s original hearing request was filed through correspondence dated October 25, 2012, and was received in the Board’s offices on October 31, 2012. The Provider appealed its September 12, 2012 Notice of Effective of Inpatient Day Limitation and Hospice Cap Amount which had been calculated using the streamline methodology described in 42 C.F.R. § 418.309(b).<sup>5</sup> The Provider contended that the regulation used to determine the Provider’s cap liability based on the streamline methodology failed to comply with the statute, 42 U.S.C. § 1395f(l)(2).

The hearing request also contained a request for EJR alleging that the cap regulation, 42 C.F.R. § 418.309, was invalid. The Board denied the Provider’s request for EJR because the regulation, 42 C.F.R. § 418.309(d)(2)(B) permits the Board to find that a provider can be reimbursed under the patient-by-patient proportional methodology described in 42 C.F.R. § 418.309(c). As part of its determination denying EJR, the Board reminded the Provider that it must comply with the due dates set forth in the Acknowledgement and Critical Due Dates letter.

#### Proposed Joint Scheduling Order

To comply with those due dates the Provider submitted a Proposed Joint Scheduling Order (PJSO) on July 3, 2013, indicating that it did not believe that its overpayments exceeded the cap limit by the amount identified in its cap notice and that the “ruling pursuant to which Medicare performed the calculation of the CAP is invalid.” In its legal position the Provider argues that:

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<sup>5</sup> Providers October 25, 2012 hearing request at 3.

[It] is challenging the validity of the hospice cap ruling 1355-R that Medicare uses to calculate cap repayment demands. Respondent fails to properly allocate cap allowances across years of service and *based on geographical location* which materially overstated overpayments. (emphasis added)

July 29, 2013 EJR Request

The Provider received a revised Notice of Cap Amount dated February 1, 2013. This revised cap amount was calculated based on the patient-by-patient proportional methodology as described in 42 C.F.R. § 418.309(c). The Provider filed an appeal of the revised cap determination and a simultaneous request for EJR through correspondence dated July 29, 2013 (received July 30, 2013). The Provider is challenging the validity of Ruling 1355-R, which it asserts established the methodology for calculating the cap liability.<sup>6</sup> The Provider contends that the validity of the overpayment is subject to review.<sup>7</sup>

As a result of litigation involving the validity of 42 U.S.C. § 418.309(b), the streamlined methodology, the District Court in *Lion Health Services, Inc. v. Sebelius*<sup>8</sup> invalidated the regulation and enjoined the Secretary from enforcing and collecting overpayments calculated under 42 C.F.R. § 418.309(b).<sup>9</sup> As a result of this case and others challenging the validity of the regulation CMS issued Ruling 1355-R, the Secretary<sup>10</sup> issued a new regulation, 42 C.F.R. § 418.309(c), establishing the proportional methodology. The Provider alleges that the Ruling and the regulations continue to incorporate the use of the streamlined methodology which the courts have invalidated. The Provider argues that this procedure authorizes the collection of hospice cap overpayment liability through unlawful demands. Since CMS is allegedly using the Ruling and streamline methodology the Provider maintains that the overpayment is invalid. The Provider asks that the Board grant EJR since it is not authorized to determine the lawfulness of a CMS Ruling or regulation.

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<sup>6</sup> Provider's July 29, 2013 Hearing Request and Request for EJR at 1.

<sup>7</sup> *Id.* at 2.

<sup>8</sup> 689 F. Supp.2d 849, 858 (2010)

<sup>9</sup> *But see Lion Health Service, Inc. v. Sebelius* 635 F.3d 693, 695 (5<sup>th</sup> Cir. 2011). The Fifth Circuit affirmed the lower court's holding that the methodology was invalid, but determined that that the district court was incorrect in ordering the Secretary to refund all payment obligations and should have remanded to the agency to recalculate the amounts owed.

<sup>10</sup> of the Department of Health and Human Services.

## Decision of the Board

### Addition of the Geographic Location Issue

The Board finds that of the issue of the proper allocation of cap payments based on the geographic location of the hospice contained in the PJSO is a new issue and was not timely filed from the issuance of the original Notice of Inpatient Limitation and Hospice Cap Amount on September 12, 2012. Consequently, the Board dismisses the geographic location issue from the appeal. The regulation, 42 C.F.R. § 405.1835(c) (2008) permits providers to add issue to an existing appeal if the Board receives the request to add issues no later than 60 days after the expiration of the applicable 180-day appeal period described in section 405.1835. In this case, the Provider's original cap determination was issued on September 12, 2012 and the geographical location issue was not received<sup>11</sup> in the Board's offices until July 5, 2013, 291 days after the Provider was deemed to have received its final determination.<sup>12</sup>

### Appeal of Original Notice of Inpatient Limitation and Hospice Cap Amount

The Board notes that the original cap amount was calculated under the provisions of 42 C.F.R. § 418.309(b), the streamlined methodology, the method of calculation to which the Provider objected. Subsequently, the MAC issued a revised cap calculation using the patient-by-patient proportional method described in 42 C.F.R. § 318.309(c). The Board finds that the Provider's appeal of the original cap determination issue September 12, 2012 is moot because the MAC has granted the relief sought by the Provider. As the court pointed out in *Goldstar Home Health System v. Sebelius*<sup>13</sup> "when a challenged regulation has been superseded by a new regulation, 'the issue of the validity of the old regulation is moot' . . . . agency action is rendered moot when the agency takes action that grants the relief requested."<sup>14</sup> The Board hereby dismisses the Provider's appeal of its original cap determination.

### Appeal of the Revised Cap Determination and the Request for EJR

The Board concludes that the Provider's appeal is moot because the Provider received payment under the regulation 42 C.F.R. § 418.309(c) which created a methodology consistent with the requirements of 42 U.S.C. § 1395f(i)(2). This was the remedy is sought when it filed its appeal of the original Notice of Effective of Inpatient Day Limitation and Hospice Cap Amount which had been calculated using the streamline methodology described in 42 C.F.R. § 418.309(b). The Provider received the relief sought in its original hearing request. As the court noted in *Goldstar*

<sup>11</sup> Pursuant to 42 C.F.R. § 405.1801(a)(2)(i) (2008) the determination of the date of receipt by the Board is the date delivered by a nationally recognized overnight carrier, in this case FedEx. Pursuant to 405.1835(a)(3)(i) (2008) the date of receipt by the Board is the date of filing.

<sup>12</sup> See 42 C.F.R. §405.1801(a)(1)(iii) (2008), a provider is presumed to have received documents involved in the proceedings 5 days after the date of the intermediary notice. The issue was added to the appeal 296 days after the issuance of the cap notice, 5 days were subtracted to allow for the delivery of the determination through the mail, as required.

<sup>13</sup> 2013 WL 3096190 (N.D. Tex).

<sup>14</sup> *Id.* at 6-7, internal citations omitted.

*Home Health System v. Sebelius*<sup>15</sup> agency action is rendered moot when the agency takes action to grant the relief requested. Because the Providers appeal has been rendered moot by the action of the MAC in recalculating the cap liability, the Board does not have jurisdiction over the appeal of the revised cap determination. Since jurisdiction is a prerequisite to granting a request for EJR, the Provider's request for EJR is hereby denied. See 42 C.F.R. § 405.1842(a).

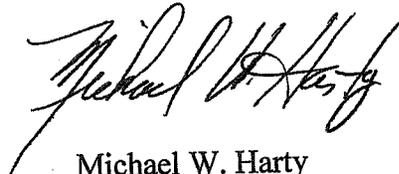
Since the Board has denied the request to add an issue to the appeal and dismissed the appeals of both the original and revised cap determinations the Board hereby closes the case.

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

Board Members Participating

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

FOR THE BOARD:



Michael W. Harty  
Chairman

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

cc: Cecile Huggins, Palmetto GBA  
Kevin Shanklin, BCBSA

---

<sup>15</sup> 2013 WL 3096190 (N.D. Tex).



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Refer to: 05-1610

**AUG 27 2013**

CERTIFIED MAIL

Hooper, Lundy & Bookman, P.C.  
Robert L. Roth  
975 F Street, NW  
Suite 1050  
Washington, DC 20004

First Coast Service Options, Inc. - FL  
Geoff Pike  
Provider Audit and Reimbursement Dept.  
532 Riverside Avenue  
Jacksonville, FL 32231-0014

RE: Doctor's Center, Inc.  
PN: 40-0118  
FYE: 12/31/1999  
PRRB Case No.: 05-1610

Dear Ms. Webster and Ms. Silvio,

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

**Background**

The Provider was issued a revised Notice of Program Reimbursement (NPR) for fiscal year 12/31/1999 on November 18, 2004. On May 11, 2005, the Provider filed a hearing request with the Board appealing the SSI% issue. Subsequently, the Provider added the Medicare + Choice Days issue to its individual appeal on December 21, 2007. In order to establish the Board's jurisdiction, the Provider submitted "Documents Confirming Board Jurisdiction Over RNPR Appeal" on May 20, 2008.

This individual appeal is one of a number of appeals by hospitals in Puerto Rico that are currently before the Board on two common issues: the SSI% issue and the Medicare + Choice days issue. On August 13, 2007, the Board sent a letter to the various Providers requesting additional documentation related to the revised NPR appeals in order to determine whether it has jurisdiction over the issues. In the same letter, the Board explained that it was considering, on its own motion, an EJR because it was unsure whether it had the authority to decide the question before it (referring to the SSI% issue). The Board stated that the replacement of cash assistance under Titles I, X, and XIV of the Social Security Act by Title XVI (SSI) in 1974 does not apply to Puerto Rico. The Provider, on the other hand, argued that anyone eligible for cash assistance under Titles I, X, and XIV would qualify for benefits under Title XVI. The Board requested that both parties submit comments regarding a potential EJR, in addition to the requested jurisdictional documents.

On February 7, 2008, the Board issued a decision finding that it had jurisdiction to determine

whether eligibility under Title I, X, and XIV also satisfies eligibility under Title XVI, therefore an EJR was not granted. On that same date, the Board sent another letter to the Provider requesting additional documentation related to the appeal from a revised NPR. The Board specified what information it was requesting, including workpapers related to both the SSI% as well as Medicare + Choice Days. On May 20, 2008, the Provider submitted "Documents Confirming Board Jurisdiction Over RNPR Appeal." These documents, however, did not include any workpapers that the Board could use to determine whether there was an adjustment to the M+C days.

### **Provider's Position**

The Provider argues in its May 20, 2008 jurisdictional submission that the Board has jurisdiction over the revised NPR appeal. The Provider argues that the Board has jurisdiction because the revised NPR adjusted DSH and because the SSI percentage used to calculate the Provider's DSH adjustment is specifically addressed in the provided documents. The Provider also states that it specifically protested the Intermediary's refusal to revise the Hospital's SSI percentage. Finally, the Provider references the jurisdictional decision in Saint Rose Hospital, PRRB case number 98-0443, arguing that it stands for the proposition that the Board has jurisdiction when "the DSH calculation was reopened and changed."

### **Board's Decision**

The Board finds that it does not have jurisdiction over either the SSI% issue or the Medicare + Choice issue, because neither was specifically adjusted in the revised NPR that forms the basis for this appeal.

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

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

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

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

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

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

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

The Board finds that it does not have jurisdiction over the SSI% issue because it was not adjusted when the cost report was reopened. The audit adjustment report shows only an adjustment to DSH generally, not to the SSI% specifically. Furthermore, on Worksheet E Part A supplied by the Provider, it indicates that the SSI% remained at .33.

In addition, the Board also finds that it does not have jurisdiction over the Medicare + Choice issue that was added to the appeal. The Provider did not submit any documentation showing that Medicare + Choice days were adjusted in the reopening of the cost report, therefore the Board finds that it does not have jurisdiction over this issue.

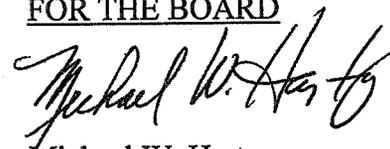
The Board finds that it does not have jurisdiction over the two issues in this individual appeal because they were not specifically adjusted in the revised NPR. Therefore, the Board hereby dismisses the two issues and closes case number 05-1610.

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

Board Members Participating:

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

FOR THE BOARD

  
Michael W. Harty  
Chairman

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

cc: Kevin D. Shanklin, BCBSA



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Refer to: 12-0229GC

CERTIFIED MAIL

**AUG 27 2013**

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

Re: QRS Asante Health 1998-2011 RFBNA Equitable Tolling CIRP Group  
FYEs: 1998-2011  
Provider Nos.: Various  
PRRB Case No.: 12-0229GC

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (Board) has reviewed the hearing request submitted in the above appeal that were untimely filed from the final publication inpatient PPS rule for each FFY in the Federal Register. The Providers have asked the Board to consider equitable tolling to extend the time for filing an appeal with the Board. Some Providers furnished dates for the Notice of Program Reimbursement (NPR) which were not timely appealed in this group appeal. NPRs for other years may have not been issued because of the hold on NPRs as a result of the *Baystate Medical Center v. Leavitt*, 545 F. Supp.2d 20 (2008), litigation.

**Pertinent Facts:**

By letter dated February 21, 2012 the Providers in the above case have requested equitable tolling because they contend they had no "reasonable means" to identify errors in the Secretary's computation of the rural floor budget neutrality adjustment. They proffer that when CMS' 2008 rulemaking established the prospective payment system (PPS) no information was provided regarding the purpose of the change. CMS did not indicate that errors had been made in its prior implementation of the budget neutrality provision and they are not published. Consequently they were unable to discern any error(s) and could not duplicate the Secretary's calculations. They seek a correction of all annual budget neutrality adjustments from 1999-2011 to allow full and complete relief.

**Board Determination:**

**Equitable Tolling**

The Supreme Court recently addressed the question of whether the Board can consider equitable tolling and found that equitable tolling does not apply to appeals pending before the Board. *See Sebelius v. Auburn Regional Medical Center*, 133 S.Ct. 817 (2013). This appeal was not timely and the Board cannot consider equitable tolling to extend the time for filing.

Good Cause

In this case, the Providers filed their appeal based on the publication of the final inpatient prospective payment rules in the Federal Register for the Federal fiscal years (FFYs) under dispute. Pursuant to 42 C.F.R. § 405.1836, a provider may request good cause for late filing if it can demonstrate that there are extraordinary circumstances beyond its control that prevented timely filing of an appeal and the request for hearing was made within three years of date of receipt of the final determination.<sup>1</sup> The Board notes that the Providers did not request or demonstrate good cause for late filing for those appeals that were filed within three years of the publication of the Federal Register notices. In this regard, the Board notes that the public was on notice of the issues surrounding the RFBNA well before the Providers filed this appeal in 2012. *See, e.g., Cape Cod Hospital v. Sebelius*, 677 F. Supp. 2d 18 (D.D.C. 2009).

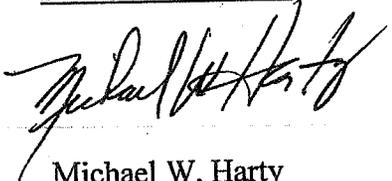
The Board hereby dismisses the appeals on the attached Schedule of Providers because they were not timely filed and hereby closes the case.

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

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

FOR THE BOARD



Michael W. Harty  
Chairman

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

cc: Kevin D. Shanklin, Executive Director, BCBSA (w/Schedule of Providers)  
John Bloom, Noridian Administrative Services (w/Schedule of Providers)

<sup>1</sup> In *District of Columbia Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993) Medicare and Medicaid Guide (CCH) ¶ 41,025 the Administrator determined that publication of notices in the Federal Register constitutes a final determination that can be appealed to the Board. The five day period for mailing to enable receipt of a final determination by a provider is not applicable to Federal Register notices because 42 U.S.C. § 1395oo(a)(3) states that a provider must file an appeal 180 days after it receives notice of the Secretary's final determination. In this case, the date that a notice is published in the Federal Register is the date of notice. 44 U.S.C. §1507 states that "[publication in the Federal Register] is sufficient to give notice of the contents of the document to a person subject to or affect by it." Consequently, with publication of the Federal Register there is no five-day delay in notice to allow for the mailing period.



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Refer to:

AUG 29 2013

CERTIFIED MAIL

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

Palmetto GBA c/o First Coast Service Options  
Darwin San Luis  
Appeals Coordinator  
4880 Santa Rosa Road, Suite 170  
Camarillo, CA 93012-0951

Re: Mercy San Juan Hospital, Provider No. 05-0516 (Participant #13), FYE 3/31/2004  
St. Bernardine Medical Center, Provider No. 05-0129 (Participant #19), FYE 6/30/2004  
As Participants in CHW 2004 DSH SSI Ratio CIRP Group  
PRRB Case No.: 07-1668GC

Dear Mr. Knight and Mr. San Luis:

The Provider Reimbursement Review Board (Board) has reviewed your appeal for standard remand in accordance with CMS-1498-R. Upon review the Board noted a jurisdictional impediment with regard to two of the participants in the group appeal. The pertinent facts with regard to these participants and the Board's determination are set forth below.

**Pertinent Facts:**

Mercy San Juan Hospital (Participant 13), appealed from a revised Notice of Program Reimbursement (RNPR) that notes its purpose is to "[a]mend the DSH Medicaid Eligible Days as required in your letter dated July 20, 2007." The Provider did not include copies of the original NPR, the Request to Reopen, the Reopening Notice, or worksheets associated with the original NPR. The documents submitted do not support an adjustment of the SSI Ratio.

St. Bernadine Medical Center (Participant 19), appealed from a Notice of Correction of Program Reimbursement (Notice) dated February 6, 2008. The Notice does not state a reason for the correction. Additionally the Provider did not include copies of the Request for Reopening or the Notice of Reopening that may have precipitated a correction. The worksheets submitted do not support an adjustment to the SSI Ratio.

**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 of the NPR.

The Board finds that it lacks jurisdiction over Mercy San Juan Hospital (05-0516) and St. Bernadine Medical Center (05-0129) as the Providers appealed from revised NPRs that did not specifically adjust the SSI Percentage issue.

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

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

42 C.F.R. § 405.1889(b)(1) explains the effect of a cost report revision: "Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision."

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

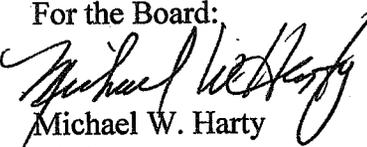
Therefore, Mercy San Juan Hospital and St. Bernadine Medical Center are hereby dismissed from the group appeal. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Enclosed is correspondence regarding the applicability of CMS 1498-R for the remaining participants in the subject group appeal.

Board Members Participating:

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

For the Board:

  
Michael W. Harty  
Chairman

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

cc: Kevin Shanklin, Executive Director, BCBSA (w/remand enclosures)



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**AUG 29 2013**

Refer to:

CERTIFIED MAIL

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

Noridian Administrative Services  
Lee Crooks, Appeals Coordinator  
WA/AK Part A Audit Appeals  
P.O. Box 6720  
Fargo, ND 58108-6720

RE: Jurisdiction Determination for Tulsa Regional Medical Center, Provider No. 37-0078  
As a participant in QRS 1999 DSH/SSI Proxy Group (2), PRRB Case No.: 06-1644G

Dear Mr. Ravindran and Ms. Crooks:

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced appeal, and notes a jurisdictional impediment with regard to one of the participants. The pertinent facts and the Board's jurisdictional determination are set forth below.

Pertinent Facts:

Tulsa Regional Medical Center (Participant #6) filed an appeal dated August 29, 2005 from a revised Notice of Program Reimbursement (RNPR) dated March 4, 2005. The Board assigned case number 05-2073. The Provider purports that the SSI Percentage issue was self-disallowed.

The RNPR states that adjustments were made:

- To add in Airevac costs
- To include additional Title XIX days for DSH
- To properly state the IME cap at the 1996 amount
- To properly state the IME & GME prior year Intern & Resident counts and the IME prior year resident-to-bed ratio at the prior year amount.

On August 8, 2006, the Provider submitted a request to add the SSI Proxy issue (which had already been included in the initial appeal request) and subsequently transfer the issue to the subject group appeal.

Board Determination:

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

The Board finds that it lacks jurisdiction over Tulsa Regional Medical Center for FYE 12/31/1999, as it appealed from a RNPR and has not demonstrated an adjustment to the SSI Percentage.

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

- (a) General. (1) A Secretary determination, an intermediary determination, or a decision by a

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

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

Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in §405.1885, such revision shall be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. §§ 405.1811, 405.1835, 405.1875 and 405.1877 are applicable.

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

In the Schedule of Providers at tab 6D, the Provider included a statement indicating that it validly self-disallowed the SSI Percentage. Self-disallowance, however, is not applicable to appeals from RNPRs. Appeals from RNPRs are limited to the specific matters revised in the revised determination. Therefore, the Board dismisses Tulsa Regional Medical Center from the group appeal as there was no evidence that the SSI Percentage was actually adjusted.

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

Enclosed please find a standard remand pursuant to CMS Ruling 1498-R for the remaining participants in the group appeal.

Board Members

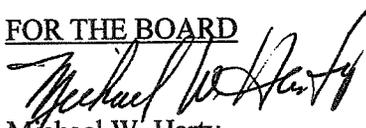
Michael W. Hartly

John Gary Bowers, CPA

Clayton J. Nix, Esq.

L. Sue Andersen, Esq.

FOR THE BOARD

  
Michael W. Hartly  
Chairman

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

cc: Kevin D. Shanklin, Executive Director, BCBSA



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**AUG 29 2013**

Refer to: 13-2675

Certified Mail

Mark S. Kennedy, Esq.  
Kennedy Attorneys and Counselors at Law  
12222 Merit Drive, Suite 1750  
Dallas, TX 75251

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

RE: Bluebonnet Hospice Care, Inc.  
Provider No. 67-1534  
Cap Period November 1, 2010 through October 31, 2011  
PRRB Case No. 13-2675

Dear Mr. Kennedy and Ms. Huggins:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's July 15, 2013 hearing request and request for expedited judicial review (EJR) (received August 9, 2013) in the above-referenced appeal. The decision of the Board is set forth below.

**Statutory and Regulatory Background**

**Hospice Reimbursement under Medicare**

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

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

In 1983, the Secretary adopted a rule that allocates hospice care on an aggregate basis by allocating each beneficiary entirely to the cap year in which he or she would be likely to receive the preponderance of his or her care. 48 Fed. Reg. 56,000, 56,022 (December 16, 1983). Once a beneficiary is counted for a given hospice, the beneficiary is not counted in the cap in subsequent years if services continue into more than one cap year.<sup>1</sup>

<sup>1</sup>Ruling 1355-R at 3-5.

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

In 2006, Providers began filing appeals objecting to the current counting methodology used in calculating hospice reimbursement, seeking to have the overpayment determination calculated under the methodology described above invalidated. The Federal district courts and courts of appeals that ruled on the question have issued decisions concluding that the methodology is in consistent with the plain language of the Medicare statute and set aside the overpayment determinations.<sup>2</sup>

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

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

Under the Ruling intermediaries and Medicare Administrative Contractors (MACs) were to identify properly pending appeals and recalculate the aggregate cap using the patient-by-patient methodology using the best available data. For hospices which had not filed appeals challenging the cap, the intermediaries and MACs were to use the reimbursement methodology that appeared in the regulation at 42 C.F.R. § 418.309(b)(1) for any cap year ending on or before October 31, 2011, unless CMS adopted a rule providing otherwise.<sup>3</sup>

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

In the August 4, 2011 Federal Register<sup>4</sup> the Secretary announced changes to calculations of hospice cap calculation for cap years before October 31, 2011 and on or after October 31, 2012. This notice included a change in the hospice payment regulation, 42 C.F.R. § 418.309, allowing

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

<sup>3</sup> Ruling at 9-11.

<sup>4</sup> 76 Fed. Reg. 47302, 47308 (August 4, 2011).

providers reimbursement to be calculated under either the new patient-by-patient proportional methodology or the streamlined methodology (the existing methodology). These changes were made as a result of the litigation resulting in Ruling 1355-R, described above, and the Secretary's requests for comments on potential modernization of the hospice cap calculation.<sup>5</sup>

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

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

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

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

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

### **Provider's Request for EJR**

The Provider's request for hearing and EJR was received (filed) on August 9, 2013, and appealed Notice of the Effect of Inpatient Day Limitation and Hospice Cap Amount issued on April 15, 2013. The Provider was notified of an overpayment of \$2,848,406 which was calculated under the streamlined methodology, 42 C.F.R. § 318.309(b)(1). The hearing request also contained a request for EJR challenging the validity of the hospice cap regulation, 42 C.F.R. § 318.309(b)(1) which has been invalidated by numerous Federal courts.<sup>6</sup>

The Provider acknowledges that subsequent to the court decisions, CMS issued Ruling 1355-R and a published a new regulation regarding the calculation hospice cap reimbursement in August 3, 2011 Federal Register.<sup>7</sup> It asserts that the new regulation, 42 C.F.R. § 318.309(c), "is not

<sup>5</sup> See note 5.

<sup>6</sup> See Footnote 2.

<sup>7</sup> 76 Fed. Reg. 47302, 47310 (August 3, 2011).

faithful to 42 U.S.C. § 1395f(i)(2).” The regulatory provisions of 42 C.F.R. § 418.309, the Provider argues, permit CMS to use a procedure to allegedly collect “cap liability through unlawful demands under the regulation and methodology that the courts have found to be inconsistent with the Medicare Act.”<sup>8</sup> Since the overpayment determination was based upon a calculation using the “unlawful ‘cap’ regulation, the overpayment is void and should be set aside”<sup>9</sup> The Provider believes that EJR is appropriate because the Board cannot determine the validity or lawfulness of an agency ruling or regulation after an appeal after an appeal is filed to contest the calculation of an overpayment made under such a ruling or regulation.<sup>10</sup>

### **Decision of the Board**

The Board hereby denies the Provider’s request for EJR. The Provider in this case filed an appeal regarding payment that was made under 42 C.F.R. §418.309(b), the streamline methodology, for cap period ending October 31, 2010. The appeal challenged the reimbursement calculation made under that payment methodology, noting that that reimbursement methodology had been invalidated by numerous Federal courts. The Board concludes that it is required to order the MAC to calculate reimbursement under 42 C.F.R. § 418.309(c), the patient-by-patient, proportional methodology because the regulation, 42 C.F.R. § 418.309(d)(1) (2011), mandates that:

For cap years ending October 31, 2011 and for prior cap years, a hospice’s aggregated cap is calculated using the streamlined methodology described in paragraph (b) of this section subject to the following:

(i) A hospice that has not received a cap determination for a cap year ending on or before October 31, 2011 as of October 1, 2011, may elect to have its final cap determination for such cap years calculated using the patient-by-patient methodology described in paragraph (c) of this section; or

(ii) *A hospice that has filed a timely appeal regarding the methodology used for determining the number of Medicare beneficiaries in its cap calculation for any cap year is deemed to have elected that its cap determination for the challenged year, and all subsequent cap years be calculated using the patient-by-patient proportional methodology described in paragraph (c) of this section. (emphasis added)*

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<sup>8</sup> Provider’s July 15, 2013 EJR Request at 2.

<sup>9</sup> *Id.* at 3.

<sup>10</sup> *Id.*

Remand<sup>11</sup> as the Result of the Requirements of 42 C.F.R. § 418.309(d)(1)

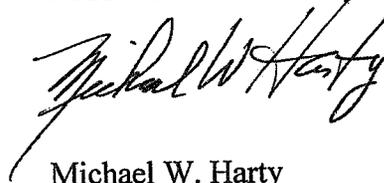
The Board is bound by the regulations issued under Title XVII of the Social Security Act and the hospice cap regulations found in Subpart G of Part 418 of Title 42 of the Code of Federal Regulations were issued under that authority. See 42 C.F.R. § 405.1867. Pursuant to the regulation, 42 C.F.R. § 418.309(d)(ii), a timely appeal of the methodology used for determining the number of Medicare beneficiaries a cap calculation, is deemed to be an election requiring the provider's cap determination be calculated using the patient-by-patient proportional methodology described in 42 C.F.R. § 418.309(c). Since the Board is bound by this regulation, it finds that it must remand the appeal to the MAC for determination of reimbursement under the patient-by-patient proportional methodology described in 42 C.F.R. § 418.309(c). Since there is no other action for the Board to take in this case, the Board hereby 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

Michael W. Harty  
John Gary Blowers, CPA  
Clayton J. Nix, Esq.  
L. Sue Andersen, Esq.

FOR THE BOARD:



Michael W. Harty  
Chairman

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

cc: Kevin Shanklin, BCBSA

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<sup>11</sup> The Board's remand authority is found in 42 C.F.R. § 405.1845(h).



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**AUG 29 2013**

Refer to:

CERTIFIED MAIL

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

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

Re: Uniontown Hospital, Provider No. 39-0041 (Participant #17), FYE: 6/30/2001  
As a Participant in Blumberg-Ribner 2001 SSI Percentage Group  
PRRB Case No.: 08-1710G

Dear Mr. Blumberg and Mr. Browning:

The Provider Reimbursement Review Board (Board) has reviewed the above-captioned appeal for standard remand in accordance with CMS-1498-R. Upon review the Board noted a jurisdictional impediment with regard to one of the participants in your group appeal. The pertinent facts with regard to this participant and the Board's determination are set forth below.

**Pertinent Facts:**

Uniontown Hospital (Provider No. 39-0041) filed an appeal from a Correction of Notice of Amount of Program Reimbursement (revised NPR) dated February 16, 2007. The Provider contends that the SSI percentage used to calculate the Medicare Disproportionate Share Payments (DSH) is inaccurate. The Audit Worksheets submitted by the Provider do not demonstrate an adjustment to the SSI percentage.

**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 of the NPR.

The Board finds that it lacks jurisdiction over Uniontown Hospital (39-0041) as the Provider appeals from a revised NPR which does not demonstrate an adjustment to the SSI percentage.

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

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

42 C.F.R. § 405.1889(b)(1) explains the effect of a cost report revision: "Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision."

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

Consequently, the Board dismisses Uniontown Hospital (participant #17) from the group appeal. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Enclosed please find correspondence regarding the applicability of CMS 1498-R for the remaining participants in the subject group appeal.

Board Members Participating:

Michael W. Harty  
Clayton J. Nix, Esq.  
L. Sue Andersen, Esq.

For the Board:

  
Michael W. Harty  
Chairman

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

cc: Kevin Shanklin, Executive Director, BCBSA (w/remand enclosures)



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CERTIFIED MAIL

**AUG 29 2013**

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

Re: Oregon Health & Science University  
Provider No. 38-0009  
FYE 06/30/08  
PRRB Case No. 13-0513

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's request for expedited judicial review (EJR) dated July 29, 2013 (received July 31, 2013). This request is unopposed. The issue under dispute involves whether the Centers for Medicare & Medicaid Services (CMS) erred in calculating a budget neutrality adjustment to the PPS standardized amount to account for the effects of the rural floor on the wage index. The Board's jurisdictional determination over the rural floor budget neutrality issue and determination with respect to the request for EJR is set forth below.<sup>1</sup>

**Medicare Statutory and Regulatory Background**

This is a dispute over the amount of Medicare reimbursement due to a provider of medical services.

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

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the PPS. The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors. *See* 42 U.S.C. § 1395ww(d)(5). This case involves the annual changes

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<sup>1</sup> The federal fiscal years (FFYs) under appeal in these cases comprise two FFYs. The period from 07/01/07-09/30/07, comprises FFY 2007, and the period from 10/1/07-06/30/08, comprises FFY 2008. This letter will address both of these FFYs.

to the PPS rates for hospital inpatient operating costs (IPPS) and the methodology for determining those rates.

### Standardized Amount

The statute, 42 U.S.C. § 1395ww(d)(2)(A), required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The base-year cost data were used in the initial development of the standardized amounts for PPS which were then used to compute the Federal rates. The standardized amounts are based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Section 1395ww(d)(2)(C) requires that updated base-year per discharge costs be standardized in order to adjust data which might cause variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments (for Alaska and Hawaii), indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994).

Section 1395ww(d)(3)(E) requires the Secretary from time to time to adjust the proportion of the hospitals' costs that are attributable to wages and wage-related costs of the DRG prospective payment rates for area differences in hospital wage levels. The adjustment factors (wage index) should reflect the relative hospital wage level in the geographic area of the hospital being compared to the national average hospital wage level. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor related amount is adjusted by the wage index. Section 1395ww(d)(3)(E)(ii) requires that 62% of the standardized amount be adjusted by the wage index unless doing so would result in lower payments to a hospital than would otherwise be made. 71 Fed. Reg. 47870, 48146 (August 18, 2006).

### Budget Neutrality

Budget neutrality is determined by comparing aggregate IPPS payments before and after making changes that are required to be budget neutral (e.g., reclassifying and recalibrating the diagnostic related groups (DRGs)). Outlier payments are also included in the simulations. *Id.* at 48147. In FFYs 2007 and prior, CMS stated that: [the] budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the [prior years'] budget neutrality adjustments. *Id.* at 48147.

In establishing the PPS rate for FFY 2008 CMS applied the budget neutrality adjustment to the wage index rather than to the standardized amount as it had done in previous years. CMS believes that an adjustment to the wage index would result in substantially similar payments as an adjustment to the standardized amount, as both involve multipliers to the standardized amount and both would be based upon the same modeling parameters. 72 Fed. Reg. 47130 (August 22, 2007).

### Rural Floor

Section 4410 of the Balanced Budget Act of 1997 (BBA of 1997) established the rural floor by requiring that the wage index of a hospital in any urban area cannot be less than

the wage index determined for the state's rural area. Since Federal fiscal year (FFY) 1998, CMS has implemented the budget neutrality requirement of this provision by adjusting the standardized amounts. 72 Fed. Reg. 24680, 24787 (May 3, 2007). In establishing the PPS standardized amount for FFY 2007 and for prior Federal fiscal years, CMS adjusted the standardized amount downward to account for the effects of the rural floor. *See e.g.* 71 Fed. Reg. at 48145-48148 (August 18, 2006). In FFY 2008 CMS applied the budget neutrality adjustment to the wage index, rather than the standardized amount.<sup>2</sup>

In responding to providers concerns regarding the change to the calculation set forth above and the cumulative effect of the budget neutrality adjustment in the final IPPS rule, CMS stated that:

[T]he rural floor budget neutrality adjustment previously was a cumulative adjustment, similar to the adjustments we currently make for updates to the wage index and DRG [diagnostic related groups] reclassification and recalibration. Beginning in 2008, the rural floor budget neutrality adjustment will be noncumulative.

\*\*\*\*

With regard to alleged errors in FY 1999 through 2007, our calculation of the budget neutrality in past fiscal years is not within the scope of this rulemaking. Even if errors were made in prior fiscal years, we would not make an adjustment to make up for those errors when setting rates for FY 2008. It is our longstanding policy that finality is critical to a prospective payment system. Although such errors in rate setting are inevitable, we believe the need to establish final prospective rates outweighs the greater accuracy we might gain if we retroactively recomputed rates whenever an error is discovered.

72 Fed. Reg. 47130, 47330 (August 22, 2007).

#### Wage Index

The statute, 42 U.S.C. § 1395ww(d)(3)(E) and (d)(9)(C)(iv), requires that CMS make an adjustment to the labor-related portion of the national and Puerto Rico PPS rates to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. *Id.* at 48153. The wage index must be updated annually. *Id.* at 48005.

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<sup>2</sup> 72 Fed. Reg. 47130, 47329 (August 22, 2007).

### **Procedural History**

This appeal was timely filed on January 14, 2013, from an original NPR. The Provider contends that the rural floor budget neutrality adjustments as implemented by CMS violate the law's requirement of budget neutrality. The Provider challenges CMS' calculation and application of the budget neutrality adjustment to the PPS standardized amount to account for annual adjustments to the PPS wage index. The Provider asserts that CMS implemented the "rural floor" provisions on a budget "negative" basis as opposed to a budget "neutral" basis as required. The budget neutrality adjustments made by CMS have been compounding over the years rather than having been applied and removed on a yearly basis. The Provider maintains there have been errors in the application of these factors over the years that have resulted in understated PPS payments.

The Provider contends that CMS has erred in the computation of the annual budget neutrality adjustment factors, including the adjustment factor applied to the standardized amounts to account for changes in the wage index and rural floor. CMS has been applying non-reversing rural floor budget neutrality adjustments to the national standardized amounts (which impacts PPS payments) each year since 1998 to reduce payments to hospitals; wherein CMS should have used a reversing type of adjustment. The alleged error results in a systematic understatement of the PPS standardized amount because it overstates the budget neutrality factor for annual updates to the wage index. The Provider believes the error is annual and recurring.

### **Basis for EJRs**

To establish the PPS rate for FFYs 2007 and 2008 and for prior years, CMS used a payment simulation model to determine each year's budget neutrality adjustment to the standardized amount to account for the effect of the rural floor. In the FFY 2007 rule, CMS described the simulation model and its calculation of the resulting budget neutrality adjustment as follows:

[W]e used FY 2005 discharge data to simulate payments and compared aggregate payments using the FY 2006 relative weights and wage indexes to aggregate payments using the FY 2007 relative weights and wage indexes. The same methodology was used for the FY 2006 budget neutrality adjustment.

... These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2006 budget neutrality adjustments.

71 Fed. Reg. 47870, 48147 (August 18, 2006).

In establishing the PPS rate for FFY 2008 CMS applied the budget neutrality adjustment to the wage index rather than to the standardized amount as it had done in previous years. 72 Fed. Reg. 47130, 47330 (August 22, 2007). CMS did not rectify the cumulative impact of its methodology errors from FFY 1999 through 2007, as described above. *Id.* at 47421. Thus, for FFY 2008, the Provider is appealing the understated FFY 2008 standardized amount used in other FFYs.

The Provider is challenging an aspect of CMS' calculation of the final PPS rates published in the Federal Register for FFYs 2007<sup>3</sup> and 2008. The Provider contends that CMS erred in calculating a budget neutrality adjustment to the PPS standardized amount to account for the effects of the rural floor on the wage index. This alleged error results in a systematic understatement of the PPS rates, and this error has been an annual and recurring one. Each year's error is permanently incorporated into the standardized amount paid under PPS for each successive year.

### **Jurisdiction over the Issue**

The Provider contends that the Board has jurisdiction over these appeals because the appeals were timely filed from NPRs and the amount in controversy threshold has been met. The Provider points out that review of the PPS payment determination is subject only to the exceptions set forth at 42 U.S.C. § 1395oo(g)(2). This section provides, in relevant part, that determinations described in 42 U.S.C. § 1395ww(d)(7) shall not be reviewed by the Board or any court. Among the matters not subject to review is the determination of the requirement, or the proportional amount, of any budget neutrality adjustment. The Provider contends that this preclusion of review provision is limited to certain budget neutrality adjustments for fiscal years 1984 and 1985 to ensure that the total amounts paid under PPS, then a new system, were the same as the total amounts that would have been spent under the Medicare law (as modified by the Tax Equity & Fiscal Responsibility Act of 1982 (TEFRA)). 42 U.S.C. § 1395ww(e)(1)(A)-(B).

The Intermediary did not provide comment to the Board in this matter.

### **Decision of the Board**

The Board concludes that it lacks jurisdiction over the appeal because review of budget neutrality adjustments is expressly prohibited by the statute and regulations. See 42 U.S.C. § 1395ww(d)(7); 42 U.S.C. § 1395oo(g)(2); 42 C.F.R. §§ 405.1804 and 405.1840(b)(2). Because jurisdiction over an issue is a prerequisite to granting a request for EJR, the Board finds that EJR is not appropriate.

Payment under the prospective payment system is governed by the statutory provisions of 42 U.S.C. § 1395ww. Subsection (d)(7) states that:

There shall be no administrative or judicial review under [42 U.S.C. § 1395oo] or otherwise of—

(A) the determination of the requirement, or the proportional amount of any adjustment effected pursuant to subsection (e)(1) [budget

---

<sup>3</sup> The final PPS rates for FFY 2007 were published in the Federal Register on October 11, 2006. 71 Fed. Reg. 59886, 59889 (October 11, 2006). The August 18, 2006 Federal Register cited above noted that the standardized amount was tentative because factors such as the outlier offset and budget neutrality adjustment for the wage index and reclassification that are applied to the standardized amount had not been determined pending the calculation of the occupational mix adjustment. 71 Fed. Reg. 47870, 48146.

neutrality] or the determination of the applicable percentage increase under paragraph (12)(A)(ii) . . .

The Board's governing statute, 42 U.S.C. § 1395oo(g)(2), states that:

The determinations and other decisions described in section 1395ww(d)(7) shall not be reviewed by the Board or by any court pursuant to action brought under subsection (f) or otherwise.

CMS' implementing regulation, 42 C.F.R. § 405.1804, entitled "Matters not subject to administrative and judicial review under prospective payment" provides:

Neither administrative or judicial review is available for controversies about the following matters:

- (a) The determination of the requirement, or the proportional amount, of any budget neutrality adjustment in the prospective payment rates. . . . (emphasis added)

CMS stated at the time the rule was adopted that the purpose of the rule is:

to state that the determinations and decisions described in section 1886(d)(7) of the Act may not receive Board or judicial review. Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:

A determination of the requirement, or the proportional amounts of, any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act . . .

48 Fed. Reg. 39752, 39785 (September 1, 1983).

In addition, section 701(a) of the Administrative Procedure Act (APA) states that the appeal provisions of the APA apply to the administrative actions except where statutes preclude judicial review. *See* 5 U.S.C. § 701(a). The statutes and the regulations both preclude administrative and judicial review of the budget neutrality adjustment.

In *Amgen, Inc. v. Smith*,<sup>4</sup> the D.C. Circuit Court considered whether there is jurisdiction over outpatient PPS (OPPS) payments where the statute precludes administrative or judicial review of the "other adjustments" to OPPS (the classification system, establishment of groups and relative payment weights for covered services, of wage adjustment factors). The Court explained that there is a strong presumption that Congress intends judicial review of administrative action which can only be overcome with "clear and convincing evidence" that Congress intended to preclude appeal. The Court concluded that where the statute stipulated that "there should be no

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<sup>4</sup> 357 F.3d 103 (D.C. Cir. 2004).

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In an earlier decision, *Universal Health Services of McAllen, Inc. v. Sullivan*,<sup>5</sup> (UHS) the D. C. District Court distinguished between an appeal of a Medicare Geographic Classification Review Board (MGCRB) decision (over which judicial review is precluded) and a challenge to the validity of the guidelines utilized by the MGCRB and the Secretary to make reclassification decisions. The Court noted that § 701(a) of the APA precludes judicial review where a statute or regulation denies review. In UHS, the Court found that it had jurisdiction over the challenge to the guidelines but would not have had jurisdiction over an appeal of an MGCRB decision which was precluded by law.

#### Allegation that Review of Budget Neutrality is Limited to FY 1984 and 1985

The Board is not persuaded by the Provider's argument that preclusion of review of budget neutrality provisions is limited to the fiscal years 1984 and 1985. When Congress enacted the PPS payment rates for 1984 and 1985, it instructed the Secretary to determine the allowable operating cost from the most recently available cost reporting period for which data are available, updated to 1983 and further updated to 1984 by the market basket plus one percent. The resulting amounts were standardized by excluding specified costs and then an average standardized amount was computed for urban and rural hospitals under TEFRA. The average standardized amounts were reduced to be budget neutral. Congress noted that the method of calculating the PPS rates for 1986 and later were the same, but there was no step in the process for budget neutrality. Instead an independent panel would advise the Secretary regarding the updating factor to be used. The Secretary was required to publish the methodology and the data used to create the PPS rates, including any adjustment to produce budget neutrality, in the Federal Register on or before September 1 of each fiscal year. House Report No. 98-25(I) 1983 U.S.C.C.A.N. 219, 354-355 (1983).

In addressing the appeals process, Congress provided for the same administrative and judicial review of payments made under PPS as was available for cost-based reimbursement. Review was permitted with the exception of determinations necessary to maintain budget neutrality and the establishment of diagnosis related groups (DRGs), the methods for classifying DRGs and the DRG weighting factors. Congress stated that such preclusion of judicial review was necessary to maintain a workable payment system. House Report No. 98-25(I) 1983 U.S.C.C.A.N. 219, 361-362 (1983) and Senate Report No. 98-23 1983 U.S.C.C.A.N. 143, 197-198 (1983). This preclusion of administrative and judicial review was codified in 42 U.S.C. § 1395ww(d)(7).

Subsection (d)(7) states that there shall be no administrative or judicial review under 42 U.S.C. § 1395oo of the determination of the requirement or the proportional amount of any adjustment

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<sup>5</sup> 770 F. Supp. 704 (D.C. Dist. 1991.)

effected pursuant to subsection (e)(1). 42 U.S.C. §1395ww(e)(1) provides that for cost reporting periods of hospitals beginning in fiscal years 1984 or 1985 the Secretary shall provide for a proportional adjustment in the applicable percentage increase (otherwise applicable to the periods under subsection (b)(3)(B)) as may be necessary to assure budget neutrality. Section 1395ww(b)(3)(B) references all cost reporting periods from 1986 through the present as being affected by the budget neutrality adjustment.

In response to the enactment of the above statutes, the Board's governing regulations were modified. In the September 1, 1983 preamble to new regulations, the Secretary explained that 42 U.S.C. § 1395oo(g)(2) was added by Pub. L. 98-21 to state that the determinations and decisions described in § 1395ww(d)(7) precludes administrative and judicial review of, among other things, a determination of the requirement, or proportional amount of any "budget neutrality" adjustment effected under §1395ww(e)(1). The Secretary stated that it was the clear intent of Congress that a hospital would not be permitted to argue that the level of payment that it receives under the prospective payment system is inadequate to cover its costs. The Secretary amended 42 C.F.R. Part 405, Subpart R to implement the changes to 42 U.S.C. § 1395(g)(2) contained in Pub. L. 98-21. The changes to the regulation included the addition of 42 C.F.R. § 405.1804 to describe matters not reviewable by the Board or the courts as provided in § 1395ww(d)(7).<sup>6</sup> Section 405.1804 states specifically that there is neither administrative nor judicial review of the determination of the requirement or the proportional amount of any budget neutrality adjustment in the prospective payment rate. Therefore, the Secretary clearly interpreted the statutory prohibition on review as not being confined to 1984 and 1985.

When the Secretary "updated, clarified and revised"<sup>7</sup> the Board's governing regulations in 2008, he separately and specifically addressed the limitations on the Board's jurisdiction. The original regulation at 42 C.F.R. § 405.1804, stating that budget neutrality issues are not reviewable, was reissued without change or comment. In addition, the Secretary added 42 C.F.R. § 405.1840 to the regulations specifically dealing with the Board's jurisdiction. Section 405.1840(b) states that certain matters at issue were removed from the jurisdiction of the Board and included "[c]ertain matters affecting payments to hospitals under the prospective payment system, as provided in [42 U.S.C. § 1395ww(d)(7)] and § 405.1804 of this subpart." If the budget neutrality provisions of § 405.1804 were limited to appeals of FY 1984 and 1985, there would be no reason to leave the regulation unchanged during a comprehensive revision of the Board's regulations and certainly no need to add § 405.1840(b)(2) reiterating and emphasizing the Board's lack of jurisdiction over the budget neutrality issue. The Secretary's action demonstrates a twenty five year consistent position that all budget neutrality determinations are off limits to the Board; not just those relating to fiscal years 1984 and 1985. Whether the Secretary's view is consistent with Congress' intent is not for the Board to decide for it is bound by the regulation.

#### EJR Determination

42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permit providers to bypass the Board's hearing procedure and obtain judicial review of a specific matter at issue involving a question of

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<sup>6</sup> 48 Fed. Reg. 39740, 39785 (September 1, 1983).

<sup>7</sup> 73 Fed. Reg. 30190 (May 23, 2008).

law or regulation where the Board determines that it is without authority to decide the legal question. Prior to rendering a decision that it lacks the authority to decide the legal question before it, the Board must determine that it has jurisdiction over the matter at issue in the appeal under 42 U.S.C. § 1395oo. 42 C.F.R. § 405.1842(a)(2008). We conclude that both the statute and regulation preclude administrative review of the budget neutrality adjustment; therefore, the Board lacks jurisdiction over the issue.

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

#### Application of *Cape Cod* case on the Request for EJR

Ordinarily our EJR analysis would end with a determination of no jurisdiction. However, in *Cape Cod HC 2007 Wage Index/Rural Floor Group*, PRRB case number 07-0705G et al, (*Cape Cod*), the Secretary has taken a contrary position. In *Cape Cod*, the Board concluded that it lacked jurisdiction over the budget neutrality adjustment based on the authorities set forth above. The Board's decision was not reversed by the CMS Administrator. On appeal to the Federal district court, however, the Secretary moved for remand on the basis that the Board had jurisdiction over the issue. The provider plaintiffs responded that the remand was unnecessary because the case was properly before the court on EJR. It argued that implicit in the Board's finding it lacked jurisdiction was a determination that it also lacked authority to decide the question, thus, EJR was appropriate. In its remand order, the District Court explained that the two findings are distinct. "Jurisdiction to take any legal action" asks whether the Providers may obtain a hearing at all; "authority to decide the question" asks whether the Board has authority to reach the merits of Providers' claims. The Court concluded that the Secretary's position was correct: the Court lacked subject matter jurisdiction without the Board's first being afforded an opportunity to consider the merits of the Providers' claims, including whether it has authority to decide the question. Neither the D.C. District court remand<sup>8</sup> nor the remand from the Deputy Administrator addresses the Secretary's rationale for his position regarding jurisdiction. Assuming, however, that the Secretary will take the same position in this case with respect to the Board's having jurisdiction over the budget neutrality issue, and in the interest of judicial economy, the Board will also address the question of whether EJR is appropriate.<sup>9</sup>

The Provider in this appeal seeks to have its final wage index rate modified by applying a different calculation methodology relating to the budget neutrality and rural floor factors. Pursuant to 42 C.F.R. § 412.64, the Secretary calculates the standardized amount on an annual basis. This calculation is published annually in the Federal Register following a complex and lengthy process of data collection and analysis. The methodology for the calculation is described in general terms.

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<sup>8</sup> *Cape Cod Hospital v. Leavitt*, (D.D.C. July 21, 2008) (2008 WL 2791683).

<sup>9</sup> After the above remand based on the Secretary's position regarding jurisdiction, the Board found the Provider was entitled to expedited judicial review. In December of 2009, the District Court for the District of Columbia granted the defendant's (government's) motion for summary judgment for the budget neutrality adjustment. *Cape Cod Hospital et al. v. Sebelius*, 2009 WL 4981330 (D.D.C. December 22, 2009) at pp. 9-16.

The Board is bound by the Secretary's final rules and has no authority to review the data underlying the rate published unless specifically authorized. Notably the Final Rule only provides for Board review of denials of requests by hospitals for correction of certain wage data that eventually goes into one hospital-specific component of the final rate.<sup>10</sup> If the provider appealing the denial is successful, the remedy is limited to the hospital bringing the successful appeal. There is no provision for the Board to adjust the rate itself (as applied to all hospitals) to account for the effect of the error. The Board concludes that the specific grant of authority and establishment of a detailed process for correcting the rate of only the hospital bringing the appeal, coupled with the failure to include the effect of that correction on other hospitals or to establish a similar correction process for other components of the wage index, are strong indications that the Board does not have authority to change the rate itself.

Even more compelling, however, is the language of the statute and the regulation quoted above that prohibits review of budget neutrality determinations which are at the heart of the question before the Board in this case. Even if the Board interpreted the statutory and regulatory prohibitions on review of budget neutrality determinations too broadly to bar jurisdiction, those prohibitions cannot be ignored altogether. We conclude that the statute and regulation evidence Congress' and the Secretary's intent that budget neutrality determinations are insulated from the Board's authority to affirm, reverse or modify a reimbursement determination. Otherwise, the specific prohibitions articulated there would be rendered meaningless.

Assuming, arguendo, that the Secretary takes the same position in these cases that the Board has jurisdiction, then the Board finds that:

- 1) based upon the Provider's unopposed assertions regarding the challenges to the rural floor/budget neutrality methodology, there are no findings of fact for resolution by the Board;
- 2) it is bound by the Final Rule in the Federal Register and the regulation; and
- 3) it is without authority to decide the legal question of whether the calculation methodology for the budget neutrality/rural floor adjustment is valid.

Accordingly, the Board finds that the budget neutrality/rural floor issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and expedited judicial review is appropriate. Because this is the only issue under appeal in this case, the Board hereby closes the case.

BOARD MEMBERS PARTICIPATING:

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

For the Board:



Michael W. Harty  
Chairman

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<sup>10</sup> 64 Fed. Reg. 41490, 41513 (July 30, 1999). This authority has never been codified in the code of Federal Regulations.

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

cc: Kevin D. Shanklin, Blue Cross Blue Shield Association  
John Bloom, Noridian Administrative Services



**DEPARTMENT OF HEALTH AND HUMAN SERVICES  
PROVIDER REIMBURSEMENT REVIEW BOARD**

2520 Lord Baltimore Drive, Suite L  
Baltimore MD 21244-2670

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FAX: 410-786-5298

Internet: [www.cms.gov/PRRBReview](http://www.cms.gov/PRRBReview)

CERTIFIED MAIL

**AUG 29 2013**

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

Re: Princeton Community Hospital  
Provider No. 51-0046  
FYE 06/30/08  
PRRB Case No. 13-1381

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's request for expedited judicial review (EJR) dated July 31, 2013 (received August 2, 2013). This request is unopposed. The issue under dispute involves whether the Centers for Medicare & Medicaid Services (CMS) erred in calculating a budget neutrality adjustment to the PPS standardized amount to account for the effects of the rural floor on the wage index. The Board's jurisdictional determination over the rural floor budget neutrality issue and determination with respect to the request for EJR is set forth below.<sup>1</sup>

**Medicare Statutory and Regulatory Background**

This is a dispute over the amount of Medicare reimbursement due to a provider of medical services.

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

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the PPS. The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors. *See* 42 U.S.C. § 1395ww(d)(5). This case involves the annual changes

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<sup>1</sup> The federal fiscal years (FFYs) under appeal in these cases comprise two FFYs. The period from 07/01/07-09/30/07, comprises FFY 2007, and the period from 10/1/07-06/30/08, comprises FFY 2008. This letter will address both of these FFYs.

to the PPS rates for hospital inpatient operating costs (IPPS) and the methodology for determining those rates.

### Standardized Amount

The statute, 42 U.S.C. § 1395ww(d)(2)(A), required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The base-year cost data were used in the initial development of the standardized amounts for PPS which were then used to compute the Federal rates. The standardized amounts are based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. § 1395ww(d). Section 1395ww(d)(2)(C) requires that updated base-year per discharge costs be standardized in order to adjust data which might cause variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments (for Alaska and Hawaii), indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994).

Section 1395ww(d)(3)(E) requires the Secretary from time to time to adjust the proportion of the hospitals' costs that are attributable to wages and wage-related costs of the DRG prospective payment rates for area differences in hospital wage levels. The adjustment factors (wage index) should reflect the relative hospital wage level in the geographic area of the hospital being compared to the national average hospital wage level. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor related amount is adjusted by the wage index. Section 1395ww(d)(3)(E)(ii) requires that 62% of the standardized amount be adjusted by the wage index unless doing so would result in lower payments to a hospital than would otherwise be made. 71 Fed. Reg. 47870, 48146 (August 18, 2006).

### Budget Neutrality

Budget neutrality is determined by comparing aggregate IPPS payments before and after making changes that are required to be budget neutral (e.g., reclassifying and recalibrating the diagnostic related groups (DRGs)). Outlier payments are also included in the simulations. *Id.* at 48147. In FFYs 2007 and prior, CMS stated that: [the] budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the [prior years'] budget neutrality adjustments. *Id.* at 48147.

In establishing the PPS rate for FFY 2008 CMS applied the budget neutrality adjustment to the wage index rather than to the standardized amount as it had done in previous years. CMS believes that an adjustment to the wage index would result in substantially similar payments as an adjustment to the standardized amount, as both involve multipliers to the standardized amount and both would be based upon the same modeling parameters. 72 Fed. Reg. 47130 (August 22, 2007).

### Rural Floor

Section 4410 of the Balanced Budget Act of 1997 (BBA of 1997) established the rural floor by requiring that the wage index of a hospital in any urban area cannot be less than

the wage index determined for the state's rural area. Since Federal fiscal year (FFY) 1998, CMS has implemented the budget neutrality requirement of this provision by adjusting the standardized amounts. 72 Fed. Reg. 24680, 24787 (May 3, 2007). In establishing the PPS standardized amount for FFY 2007 and for prior Federal fiscal years, CMS adjusted the standardized amount downward to account for the effects of the rural floor. *See e.g.* 71 Fed. Reg. at 48145-48148 (August 18, 2006). In FFY 2008 CMS applied the budget neutrality adjustment to the wage index, rather than the standardized amount.<sup>2</sup>

In responding to providers concerns regarding the change to the calculation set forth above and the cumulative effect of the budget neutrality adjustment in the final IPPS rule, CMS stated that:

[T]he rural floor budget neutrality adjustment previously was a cumulative adjustment, similar to the adjustments we currently make for updates to the wage index and DRG [diagnostic related groups] reclassification and recalibration. Beginning in 2008, the rural floor budget neutrality adjustment will be noncumulative.

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With regard to alleged errors in FY 1999 through 2007, our calculation of the budget neutrality in past fiscal years is not within the scope of this rulemaking. Even if errors were made in prior fiscal years, we would not make an adjustment to make up for those errors when setting rates for FY 2008. It is our longstanding policy that finality is critical to a prospective payment system. Although such errors in rate setting are inevitable, we believe the need to establish final prospective rates outweighs the greater accuracy we might gain if we retroactively recomputed rates whenever an error is discovered.

72 Fed. Reg. 47130, 47330 (August 22, 2007).

### Wage Index

The statute, 42 U.S.C. § 1395ww(d)(3)(E) and (d)(9)(C)(iv), requires that CMS make an adjustment to the labor-related portion of the national and Puerto Rico PPS rates to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. *Id.* at 48153. The wage index must be updated annually. *Id.* at 48005.

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<sup>2</sup> 72 Fed. Reg. 47130, 47329 (August 22, 2007).

### **Procedural History**

This appeal was timely filed on April 5, 2013, from an original NPR. The Provider contends that the rural floor budget neutrality adjustments as implemented by CMS violate the law's requirement of budget neutrality. The Provider challenges CMS' calculation and application of the budget neutrality adjustment to the PPS standardized amount to account for annual adjustments to the PPS wage index. The Provider asserts that CMS implemented the "rural floor" provisions on a budget "negative" basis as opposed to a budget "neutral" basis as required. The budget neutrality adjustments made by CMS have been compounding over the years rather than having been applied and removed on a yearly basis. The Provider maintains there have been errors in the application of these factors over the years that have resulted in understated PPS payments.

The Provider contends that CMS has erred in the computation of the annual budget neutrality adjustment factors, including the adjustment factor applied to the standardized amounts to account for changes in the wage index and rural floor. CMS has been applying non-reversing rural floor budget neutrality adjustments to the national standardized amounts (which impacts PPS payments) each year since 1998 to reduce payments to hospitals; wherein CMS should have used a reversing type of adjustment. The alleged error results in a systematic understatement of the PPS standardized amount because it overstates the budget neutrality factor for annual updates to the wage index. The Provider believes the error is annual and recurring.

### **Basis for EJR**

To establish the PPS rate for FFYs 2007 and 2008 and for prior years, CMS used a payment simulation model to determine each year's budget neutrality adjustment to the standardized amount to account for the effect of the rural floor. In the FFY 2007 rule, CMS described the simulation model and its calculation of the resulting budget neutrality adjustment as follows:

[W]e used FY 2005 discharge data to simulate payments and compared aggregate payments using the FY 2006 relative weights and wage indexes to aggregate payments using the FY 2007 relative weights and wage indexes. The same methodology was used for the FY 2006 budget neutrality adjustment.

. . . These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2006 budget neutrality adjustments.

71 Fed. Reg. 47870, 48147 (August 18, 2006).

In establishing the PPS rate for FFY 2008 CMS applied the budget neutrality adjustment to the wage index rather than to the standardized amount as it had done in previous years. 72 Fed. Reg. 47130, 47330 (August 22, 2007). CMS did not rectify the cumulative impact of its methodology errors from FFY 1999 through 2007, as described above. *Id.* at 47421. Thus, for FFY 2008, the Provider is appealing the understated FFY 2008 standardized amount used in other FFYs.

The Provider is challenging an aspect of CMS' calculation of the final PPS rates published in the Federal Register for FFYs 2007<sup>3</sup> and 2008. The Provider contends that CMS erred in calculating a budget neutrality adjustment to the PPS standardized amount to account for the effects of the rural floor on the wage index. This alleged error results in a systematic understatement of the PPS rates, and this error has been an annual and recurring one. Each year's error is permanently incorporated into the standardized amount paid under PPS for each successive year.

### **Jurisdiction over the Issue**

The Provider contends that the Board has jurisdiction over these appeals because the appeals were timely filed from NPRs and the amount in controversy threshold has been met. The Provider points out that review of the PPS payment determination is subject only to the exceptions set forth at 42 U.S.C. § 1395oo(g)(2). This section provides, in relevant part, that determinations described in 42 U.S.C. § 1395ww(d)(7) shall not be reviewed by the Board or any court. Among the matters not subject to review is the determination of the requirement, or the proportional amount, of any budget neutrality adjustment. The Provider contends that this preclusion of review provision is limited to certain budget neutrality adjustments for fiscal years 1984 and 1985 to ensure that the total amounts paid under PPS, then a new system, were the same as the total amounts that would have been spent under the Medicare law (as modified by the Tax Equity & Fiscal Responsibility Act of 1982 (TEFRA)). 42 U.S.C. § 1395ww(e)(1)(A)-(B).

The Intermediary did not provide comment to the Board in this matter.

### **Decision of the Board**

The Board concludes that it lacks jurisdiction over the appeal because review of budget neutrality adjustments is expressly prohibited by the statute and regulations. See 42 U.S.C. § 1395ww(d)(7); 42 U.S.C. § 1395oo(g)(2); 42 C.F.R. §§ 405.1804 and 405.1840(b)(2). Because jurisdiction over an issue is a prerequisite to granting a request for EJR, the Board finds that EJR is not appropriate.

Payment under the prospective payment system is governed by the statutory provisions of 42 U.S.C. § 1395ww. Subsection (d)(7) states that:

There shall be no administrative or judicial review under [42 U.S.C. §1395oo] or otherwise of—

(A) the determination of the requirement, or the proportional amount of any adjustment effected pursuant to subsection (e)(1) [budget

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<sup>3</sup> The final PPS rates for FFY 2007 were published in the Federal Register on October 11, 2006. 71 Fed. Reg. 59886, 59889 (October 11, 2006). The August 18, 2006 Federal Register cited above noted that the standardized amount was tentative because factors such as the outlier offset and budget neutrality adjustment for the wage index and reclassification that are applied to the standardized amount had not been determined pending the calculation of the occupational mix adjustment. 71 Fed. Reg. 47870, 48146.

neutrality] or the determination of the applicable percentage increase under paragraph (12)(A)(ii) . . .

The Board's governing statute, 42 U.S.C. § 1395oo(g)(2), states that:

The determinations and other decisions described in section 1395ww(d)(7) shall not be reviewed by the Board or by any court pursuant to action brought under subsection (f) or otherwise.

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(a) The determination of the requirement, or the proportional amount, of any budget neutrality adjustment in the prospective payment rates. . . .  
(emphasis added)

CMS stated at the time the rule was adopted that the purpose of the rule is:

to state that the determinations and decisions described in section 1886(d)(7) of the Act may not receive Board or judicial review. Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:

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#### Allegation that Review of Budget Neutrality is Limited to FY 1984 and 1985

The Board is not persuaded by the Provider's argument that preclusion of review of budget neutrality provisions is limited to the fiscal years 1984 and 1985. When Congress enacted the PPS payment rates for 1984 and 1985, it instructed the Secretary to determine the allowable operating cost from the most recently available cost reporting period for which data are available, updated to 1983 and further updated to 1984 by the market basket plus one percent. The resulting amounts were standardized by excluding specified costs and then an average standardized amount was computed for urban and rural hospitals under TEFRA. The average standardized amounts were reduced to be budget neutral. Congress noted that the method of calculating the PPS rates for 1986 and later were the same, but there was no step in the process for budget neutrality. Instead an independent panel would advise the Secretary regarding the updating factor to be used. The Secretary was required to publish the methodology and the data used to create the PPS rates, including any adjustment to produce budget neutrality, in the Federal Register on or before September 1 of each fiscal year. House Report No. 98-25(I) 1983 U.S.C.C.A.N. 219, 354-355 (1983).

In addressing the appeals process, Congress provided for the same administrative and judicial review of payments made under PPS as was available for cost-based reimbursement. Review was permitted with the exception of determinations necessary to maintain budget neutrality and the establishment of diagnosis related groups (DRGs), the methods for classifying DRGs and the DRG weighting factors. Congress stated that such preclusion of judicial review was necessary to maintain a workable payment system. House Report No. 98-25(I) 1983 U.S.C.C.A.N. 219, 361-362 (1983) and Senate Report No. 98-23 1983 U.S.C.C.A.N. 143, 197-198 (1983). This preclusion of administrative and judicial review was codified in 42 U.S.C. § 1395ww(d)(7).

Subsection (d)(7) states that there shall be no administrative or judicial review under 42 U.S.C. §1395oo of the determination of the requirement or the proportional amount of any adjustment

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<sup>5</sup> 770 F. Supp. 704 (D.C. Dist. 1991.)

effected pursuant to subsection (e)(1). 42 U.S.C. §1395ww(e)(1) provides that for cost reporting periods of hospitals beginning in fiscal years 1984 or 1985 the Secretary shall provide for a proportional adjustment in the applicable percentage increase (otherwise applicable to the periods under subsection (b)(3)(B)) as may be necessary to assure budget neutrality. Section 1395ww(b)(3)(B) references all cost reporting periods from 1986 through the present as being affected by the budget neutrality adjustment.

In response to the enactment of the above statutes, the Board's governing regulations were modified. In the September 1, 1983 preamble to new regulations, the Secretary explained that 42 U.S.C. § 1395oo(g)(2) was added by Pub. L. 98-21 to state that the determinations and decisions described in § 1395ww(d)(7) precludes administrative and judicial review of, among other things, a determination of the requirement, or proportional amount of any "budget neutrality" adjustment effected under §1395ww(e)(1). The Secretary stated that it was the clear intent of Congress that a hospital would not be permitted to argue that the level of payment that it receives under the prospective payment system is inadequate to cover its costs. The Secretary amended 42 C.F.R. Part 405, Subpart R to implement the changes to 42 U.S.C. § 1395(g)(2) contained in Pub. L. 98-21. The changes to the regulation included the addition of 42 C.F.R. § 405.1804 to describe matters not reviewable by the Board or the courts as provided in § 1395ww(d)(7).<sup>6</sup> Section 405.1804 states specifically that there is neither administrative nor judicial review of the determination of the requirement or the proportional amount of any budget neutrality adjustment in the prospective payment rate. Therefore, the Secretary clearly interpreted the statutory prohibition on review as not being confined to 1984 and 1985.

When the Secretary "updated, clarified and revised"<sup>7</sup> the Board's governing regulations in 2008, he separately and specifically addressed the limitations on the Board's jurisdiction. The original regulation at 42 C.F.R. § 405.1804, stating that budget neutrality issues are not reviewable, was reissued without change or comment. In addition, the Secretary added 42 C.F.R. § 405.1840 to the regulations specifically dealing with the Board's jurisdiction. Section 405.1840(b) states that certain matters at issue were removed from the jurisdiction of the Board and included "[c]ertain matters affecting payments to hospitals under the prospective payment system, as provided in [42 U.S.C. § 1395ww(d)(7)] and § 405.1804 of this subpart." If the budget neutrality provisions of § 405.1804 were limited to appeals of FY 1984 and 1985, there would be no reason to leave the regulation unchanged during a comprehensive revision of the Board's regulations and certainly no need to add § 405.1840(b)(2) reiterating and emphasizing the Board's lack of jurisdiction over the budget neutrality issue. The Secretary's action demonstrates a twenty five year consistent position that all budget neutrality determinations are off limits to the Board; not just those relating to fiscal years 1984 and 1985. Whether the Secretary's view is consistent with Congress' intent is not for the Board to decide for it is bound by the regulation.

#### EJR Determination

42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permit providers to bypass the Board's hearing procedure and obtain judicial review of a specific matter at issue involving a question of

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<sup>6</sup> 48 Fed. Reg. 39740, 39785 (September 1, 1983).

<sup>7</sup> 73 Fed. Reg. 30190 (May 23, 2008).

law or regulation where the Board determines that it is without authority to decide the legal question. Prior to rendering a decision that it lacks the authority to decide the legal question before it, the Board must determine that it has jurisdiction over the matter at issue in the appeal under 42 U.S.C. § 1395oo. 42 C.F.R. § 405.1842(a)(2008). We conclude that both the statute and regulation preclude administrative review of the budget neutrality adjustment; therefore, the Board lacks jurisdiction over the issue.

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

#### Application of *Cape Cod* case on the Request for EJR

Ordinarily our EJR analysis would end with a determination of no jurisdiction. However, in *Cape Cod HC 2007 Wage Index/Rural Floor Group*, PRRB case number 07-0705G et al, (*Cape Cod*), the Secretary has taken a contrary position. In *Cape Cod*, the Board concluded that it lacked jurisdiction over the budget neutrality adjustment based on the authorities set forth above. The Board's decision was not reversed by the CMS Administrator. On appeal to the Federal district court, however, the Secretary moved for remand on the basis that the Board had jurisdiction over the issue. The provider plaintiffs responded that the remand was unnecessary because the case was properly before the court on EJR. It argued that implicit in the Board's finding it lacked jurisdiction was a determination that it also lacked authority to decide the question, thus, EJR was appropriate. In its remand order, the District Court explained that the two findings are distinct. "Jurisdiction to take any legal action" asks whether the Providers may obtain a hearing at all; "authority to decide the question" asks whether the Board has authority to reach the merits of Providers' claims. The Court concluded that the Secretary's position was correct: the Court lacked subject matter jurisdiction without the Board's first being afforded an opportunity to consider the merits of the Providers' claims, including whether it has authority to decide the question. Neither the D.C. District court remand<sup>8</sup> nor the remand from the Deputy Administrator addresses the Secretary's rationale for his position regarding jurisdiction. Assuming, however, that the Secretary will take the same position in this case with respect to the Board's having jurisdiction over the budget neutrality issue, and in the interest of judicial economy, the Board will also address the question of whether EJR is appropriate.<sup>9</sup>

The Provider in this appeal seeks to have its final wage index rate modified by applying a different calculation methodology relating to the budget neutrality and rural floor factors. Pursuant to 42 C.F.R. § 412.64, the Secretary calculates the standardized amount on an annual basis. This calculation is published annually in the Federal Register following a complex and lengthy process of data collection and analysis. The methodology for the calculation is described in general terms.

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<sup>8</sup> *Cape Cod Hospital v. Leavitt*, (D.D.C. July 21, 2008) (2008 WL 2791683).

<sup>9</sup> After the above remand based on the Secretary's position regarding jurisdiction, the Board found the Provider was entitled to expedited judicial review. In December of 2009, the District Court for the District of Columbia granted the defendant's (government's) motion for summary judgment for the budget neutrality adjustment. *Cape Cod Hospital et al. v. Sebelius*, 2009 WL 4981330 (D.D.C. December 22, 2009) at pp. 9-16.

The Board is bound by the Secretary's final rules and has no authority to review the data underlying the rate published unless specifically authorized. Notably the Final Rule only provides for Board review of denials of requests by hospitals for correction of certain wage data that eventually goes into one hospital-specific component of the final rate.<sup>10</sup> If the provider appealing the denial is successful, the remedy is limited to the hospital bringing the successful appeal. There is no provision for the Board to adjust the rate itself (as applied to all hospitals) to account for the effect of the error. The Board concludes that the specific grant of authority and establishment of a detailed process for correcting the rate of only the hospital bringing the appeal, coupled with the failure to include the effect of that correction on other hospitals or to establish a similar correction process for other components of the wage index, are strong indications that the Board does not have authority to change the rate itself.

Even more compelling, however, is the language of the statute and the regulation quoted above that prohibits review of budget neutrality determinations which are at the heart of the question before the Board in this case. Even if the Board interpreted the statutory and regulatory prohibitions on review of budget neutrality determinations too broadly to bar jurisdiction, those prohibitions cannot be ignored altogether. We conclude that the statute and regulation evidence Congress' and the Secretary's intent that budget neutrality determinations are insulated from the Board's authority to affirm, reverse or modify a reimbursement determination. Otherwise, the specific prohibitions articulated there would be rendered meaningless.

Assuming, arguendo, that the Secretary takes the same position in these cases that the Board has jurisdiction, then the Board finds that:

- 1) based upon the Provider's unopposed assertions regarding the challenges to the rural floor/budget neutrality methodology, there are no findings of fact for resolution by the Board;
- 2) it is bound by the Final Rule in the Federal Register and the regulation; and
- 3) it is without authority to decide the legal question of whether the calculation methodology for the budget neutrality/rural floor adjustment is valid.

Accordingly, the Board finds that the budget neutrality/rural floor issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and expedited judicial review is appropriate. Because this is the only issue under appeal in this case, the Board hereby closes the case.

BOARD MEMBERS PARTICIPATING:

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

For the Board:

  
Michael W. Harty  
Chairman

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<sup>10</sup> 64 Fed. Reg. 41490, 41513 (July 30, 1999). This authority has never been codified in the code of Federal Regulations.

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

cc: Kevin D. Shanklin, Blue Cross Blue Shield Association  
Cecile Huggins, Palmetto GBA



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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CERTIFIED MAIL

**AUG 29 2013**

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

Re: Request for EJR for the FYE 12/31/07, FFYs 2007 and 2008 Wage Index/Rural Floor individual cases (see attached case list)

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' request for expedited judicial review (EJR) dated July 26, 2013 (received July 31, 2013) and dated July 31, 2013 (received August 02, 2013), for the individual cases on the attached list. These requests are unopposed. The issue under dispute involves whether the Centers for Medicare & Medicaid Services (CMS) erred in calculating a budget neutrality adjustment to the PPS standardized amount to account for the effects of the rural floor on the wage index. The Board's jurisdictional determination over the rural floor budget neutrality issue and determination with respect to the requests for EJR are set forth below.<sup>1</sup>

**Medicare Statutory and Regulatory Background**

This is a dispute over the amount of Medicare reimbursement due to a provider of medical services.

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

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the PPS. The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors. *See* 42 U.S.C. § 1395ww(d)(5). This case involves the annual changes to the PPS rates for hospital inpatient operating costs (IPPS) and the methodology for determining those rates.

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<sup>1</sup> The federal fiscal years (FFYs) under appeal in these cases comprise two FFYs. The period from 01/01/07-09/30/07, comprises FFY 2007, and the period from 10/1/07-12/31/07, comprises FFY 2008. This letter will address both of these FFYs.

### Standardized Amount

The statute, 42 U.S.C. § 1395ww(d)(2)(A), required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The base-year cost data were used in the initial development of the standardized amounts for PPS which were then used to compute the Federal rates. The standardized amounts are based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Section 1395ww(d)(2)(C) requires that updated base-year per discharge costs be standardized in order to adjust data which might cause variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments (for Alaska and Hawaii), indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994).

Section 1395ww(d)(3)(E) requires the Secretary from time to time to adjust the proportion of the hospitals' costs that are attributable to wages and wage-related costs of the DRG prospective payment rates for area differences in hospital wage levels. The adjustment factors (wage index) should reflect the relative hospital wage level in the geographic area of the hospital being compared to the national average hospital wage level. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor related amount is adjusted by the wage index. Section 1395ww(d)(3)(E)(ii) requires that 62% of the standardized amount be adjusted by the wage index unless doing so would result in lower payments to a hospital than would otherwise be made. 71 Fed. Reg. 47870, 48146 (August 18, 2006).

### Budget Neutrality

Budget neutrality is determined by comparing aggregate IPPS payments before and after making changes that are required to be budget neutral (e.g., reclassifying and recalibrating the diagnostic related groups (DRGs)). Outlier payments are also included in the simulations. *Id.* at 48147. In FFYs 2007 and prior, CMS stated that: [the] budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the [prior years'] budget neutrality adjustments. *Id.* at 48147.

In establishing the PPS rate for FFY 2008 CMS applied the budget neutrality adjustment to the wage index rather than to the standardized amount as it had done in previous years. CMS believes that an adjustment to the wage index would result in substantially similar payments as an adjustment to the standardized amount, as both involve multipliers to the standardized amount and both would be based upon the same modeling parameters. 72 Fed. Reg. 47130 (August 22, 2007).

### Rural Floor

Section 4410 of the Balanced Budget Act of 1997 (BBA of 1997) established the rural floor by requiring that the wage index of a hospital in any urban area cannot be less than the wage index determined for the state's rural area. Since Federal fiscal year (FFY) 1998, CMS has implemented the budget neutrality requirement of this provision by adjusting the standardized amounts. 72 Fed. Reg. 24680, 24787 (May 3, 2007). In

establishing the PPS standardized amount for FFY 2007 and for prior Federal fiscal years, CMS adjusted the standardized amount downward to account for the effects of the rural floor. *See e.g.* 71 Fed. Reg. at 48145-48148 (August 18, 2006). In FFY 2008 CMS applied the budget neutrality adjustment to the wage index, rather than the standardized amount.<sup>2</sup>

In responding to providers concerns regarding the change to the calculation set forth above and the cumulative effect of the budget neutrality adjustment in the final IPPS rule, CMS stated that:

[T]he rural floor budget neutrality adjustment previously was a cumulative adjustment, similar to the adjustments we currently make for updates to the wage index and DRG [diagnostic related groups] reclassification and recalibration. Beginning in 2008, the rural floor budget neutrality adjustment will be noncumulative.

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With regard to alleged errors in FY 1999 through 2007, our calculation of the budget neutrality in past fiscal years is not within the scope of this rulemaking. Even if errors were made in prior fiscal years, we would not make an adjustment to make up for those errors when setting rates for FY 2008. It is our longstanding policy that finality is critical to a prospective payment system. Although such errors in rate setting are inevitable, we believe the need to establish final prospective rates outweighs the greater accuracy we might gain if we retroactively recomputed rates whenever an error is discovered.

72 Fed. Reg. 47130, 47330 (August 22, 2007).

#### Wage Index

The statute, 42 U.S.C. § 1395ww(d)(3)(E) and (d)(9)(C)(iv), requires that CMS make an adjustment to the labor-related portion of the national and Puerto Rico PPS rates to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. *Id.* at 48153. The wage index must be updated annually. *Id.* at 48005.

#### Procedural History

These appeals were timely filed on April 12, 2013, from original NPRs. The Providers contend that the rural floor budget neutrality adjustments as implemented by CMS violate the law's requirement of budget neutrality. The Providers challenge CMS' calculation and application of

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<sup>2</sup> 72 Fed. Reg. 47130, 47329 (August 22, 2007).

the budget neutrality adjustment to the PPS standardized amount to account for annual adjustments to the PPS wage index. The Providers assert that CMS implemented the “rural floor” provisions on a budget “negative” basis as opposed to a budget “neutral” basis as required. The budget neutrality adjustments made by CMS have been compounding over the years rather than having been applied and removed on a yearly basis. The Providers maintain there have been errors in the application of these factors over the years that have resulted in understated PPS payments.

The Providers contend that CMS has erred in the computation of the annual budget neutrality adjustment factors, including the adjustment factor applied to the standardized amounts to account for changes in the wage index and rural floor. CMS has been applying non-reversing rural floor budget neutrality adjustments to the national standardized amounts (which impacts PPS payments) each year since 1998 to reduce payments to hospitals; wherein CMS should have used a reversing type of adjustment. The alleged error results in a systematic understatement of the PPS standardized amount because it overstates the budget neutrality factor for annual updates to the wage index. The Providers believe the error is annual and recurring.

### **Basis for EJR**

To establish the PPS rate for FFYs 2007 and 2008 and for prior years, CMS used a payment simulation model to determine each year’s budget neutrality adjustment to the standardized amount to account for the effect of the rural floor. In the FFY 2007 rule, CMS described the simulation model and its calculation of the resulting budget neutrality adjustment as follows:

[W]e used FY 2005 discharge data to simulate payments and compared aggregate payments using the FY 2006 relative weights and wage indexes to aggregate payments using the FY 2007 relative weights and wage indexes. The same methodology was used for the FY 2006 budget neutrality adjustment.

... These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2006 budget neutrality adjustments.

71 Fed. Reg. 47870, 48147 (August 18, 2006).

In establishing the PPS rate for FFY 2008 CMS applied the budget neutrality adjustment to the wage index rather than to the standardized amount as it had done in previous years. 72 Fed. Reg. 47130, 47330 (August 22, 2007). CMS did not rectify the cumulative impact of its methodology errors from FFY 1999 through 2007, as described above. *Id.* at 47421. Thus, for FFY 2008, the Providers are appealing the understated FFY 2008 standardized amount used in other FFYs. The Providers are challenging an aspect of CMS’ calculation of the final PPS rates published in the Federal Register for FFYs 2007<sup>3</sup> and 2008. The Providers contend that CMS erred in

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<sup>3</sup> The final PPS rates for FFY 2007 were published in the Federal Register on October 11, 2006. 71 Fed. Reg. 59886, 59889 (October 11, 2006). The August 18, 2006 Federal Register cited above noted that the

calculating a budget neutrality adjustment to the PPS standardized amount to account for the effects of the rural floor on the wage index. This alleged error results in a systematic understatement of the PPS rates, and this error has been an annual and recurring one. Each year's error is permanently incorporated into the standardized amount paid under PPS for each successive year.

### **Jurisdiction over the Issue**

The Providers contend that the Board has jurisdiction over these appeals because the appeals were timely filed from NPRs and the amount in controversy threshold has been met. The Providers point out that review of the PPS payment determination is subject only to the exceptions set forth at 42 U.S.C. § 1395oo(g)(2). This section provides, in relevant part, that determinations described in 42 U.S.C. § 1395ww(d)(7) shall not be reviewed by the Board or any court. Among the matters not subject to review is the determination of the requirement, or the proportional amount, of any budget neutrality adjustment. The Providers contend that this preclusion of review provision is limited to certain budget neutrality adjustments for fiscal years 1984 and 1985 to ensure that the total amounts paid under PPS, then a new system, were the same as the total amounts that would have been spent under the Medicare law (as modified by the Tax Equity & Fiscal Responsibility Act of 1982 (TEFRA)). 42 U.S.C. § 1395ww(e)(1)(A)-(B).

The Intermediary did not provide comment to the Board in this matter.

### **Decision of the Board**

The Board concludes that it lacks jurisdiction over the appeal because review of budget neutrality adjustments is expressly prohibited by the statute and regulations. *See* 42 U.S.C. § 1395ww(d)(7); 42 U.S.C. § 1395oo(g)(2); 42 C.F.R. §§ 405.1804 and 405.1840(b)(2). Because jurisdiction over an issue is a prerequisite to granting a request for EJR, the Board finds that EJR is not appropriate.

Payment under the prospective payment system is governed by the statutory provisions of 42 U.S.C. § 1395ww. Subsection (d)(7) states that:

There shall be no administrative or judicial review under [42 U.S.C. §1395oo] or otherwise of—

- (A) the determination of the requirement, or the proportional amount of any adjustment effected pursuant to subsection (e)(1) [budget neutrality] or the determination of the applicable percentage increase under paragraph (12)(A)(ii) . . .

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standardized amount was tentative because factors such as the outlier offset and budget neutrality adjustment for the wage index and reclassification that are applied to the standardized amount had not been determined pending the calculation of the occupational mix adjustment. 71 Fed. Reg. 47870, 48146.

The Board's governing statute, 42 U.S.C. § 1395oo(g)(2), states that:

The determinations and other decisions described in section 1395ww(d)(7) shall not be reviewed by the Board or by any court pursuant to action brought under subsection (f) or otherwise.

CMS' implementing regulation, 42 C.F.R. § 405.1804, entitled "Matters not subject to administrative and judicial review under prospective payment" provides:

Neither administrative or judicial review is available for controversies about the following matters:

(a) The determination of the requirement, or the proportional amount, of any budget neutrality adjustment in the prospective payment rates. . . .  
(emphasis added)

CMS stated at the time the rule was adopted that the purpose of the rule is:

to state that the determinations and decisions described in section 1886(d)(7) of the Act may not receive Board or judicial review. Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:

A determination of the requirement, or the proportional amounts of, any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act . . .

48 Fed. Reg. 39752, 39785 (September 1, 1983).

In addition, section 701(a) of the Administrative Procedure Act (APA) states that the appeal provisions of the APA apply to the administrative actions except where statutes preclude judicial review. See 5 U.S.C. § 701(a). The statutes and the regulations both preclude administrative and judicial review of the budget neutrality adjustment.

In *Amgen, Inc. v. Smith*,<sup>4</sup> the D.C. Circuit Court considered whether there is jurisdiction over outpatient PPS (OPPS) payments where the statute precludes administrative or judicial review of the "other adjustments" to OPPS (the classification system, establishment of groups and relative payment weights for covered services, of wage adjustment factors). The Court explained that there is a strong presumption that Congress intends judicial review of administrative action which can only be overcome with "clear and convincing evidence" that Congress intended to preclude appeal. The Court concluded that where the statute stipulated that "there should be no administrative or judicial review," that language constituted clear and convincing evidence that the appeal was precluded. The Court further noted that payments under PPS are made on a prospective basis and, given the length of time that review of individual appeals could take, the

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<sup>4</sup> 357 F.3d 103 (D.C. Cir. 2004).

result would be retroactive adjustments to payment rates with the potential of creating havoc with the payment system. The aggregate impact of appeal decisions would undermine the Secretary's ability to ensure budget neutrality.

In an earlier decision, *Universal Health Services of McAllen, Inc. v. Sullivan*,<sup>5</sup> (*UHS*) the D. C. District Court distinguished between an appeal of a Medicare Geographic Classification Review Board (MGCRB) decision (over which judicial review is precluded) and a challenge to the validity of the guidelines utilized by the MGCRB and the Secretary to make reclassification decisions. The Court noted that § 701(a) of the APA precludes judicial review where a statute or regulation denies review. In *UHS*, the Court found that it had jurisdiction over the challenge to the guidelines but would not have had jurisdiction over an appeal of an MGCRB decision which was precluded by law.

#### Allegation that Review of Budget Neutrality is Limited to FY 1984 and 1985

The Board is not persuaded by the Providers' argument that preclusion of review of budget neutrality provisions is limited to the fiscal years 1984 and 1985. When Congress enacted the PPS payment rates for 1984 and 1985, it instructed the Secretary to determine the allowable operating cost from the most recently available cost reporting period for which data are available, updated to 1983 and further updated to 1984 by the market basket plus one percent. The resulting amounts were standardized by excluding specified costs and then an average standardized amount was computed for urban and rural hospitals under TEFRA. The average standardized amounts were reduced to be budget neutral. Congress noted that the method of calculating the PPS rates for 1986 and later were the same, but there was no step in the process for budget neutrality. Instead an independent panel would advise the Secretary regarding the updating factor to be used. The Secretary was required to publish the methodology and the data used to create the PPS rates, including any adjustment to produce budget neutrality, in the Federal Register on or before September 1 of each fiscal year. House Report No. 98-25(I) 1983 U.S.C.C.A.N. 219, 354-355 (1983).

In addressing the appeals process, Congress provided for the same administrative and judicial review of payments made under PPS as was available for cost-based reimbursement. Review was permitted with the exception of determinations necessary to maintain budget neutrality and the establishment of diagnosis related groups (DRGs), the methods for classifying DRGs and the DRG weighting factors. Congress stated that such preclusion of judicial review was necessary to maintain a workable payment system. House Report No. 98-25(I) 1983 U.S.C.C.A.N. 219, 361-362 (1983) and Senate Report No. 98-23 1983 U.S.C.C.A.N. 143, 197-198 (1983). This preclusion of administrative and judicial review was codified in 42 U.S.C. § 1395ww(d)(7).

Subsection (d)(7) states that there shall be no administrative or judicial review under 42 U.S.C. § 1395oo of the determination of the requirement or the proportional amount of any adjustment effected pursuant to subsection (e)(1). 42 U.S.C. § 1395ww(e)(1) provides that for cost reporting periods of hospitals beginning in fiscal years 1984 or 1985 the Secretary shall provide for a proportional adjustment in the applicable percentage increase (otherwise applicable to the

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<sup>5</sup> 770 F. Supp. 704 (D.C. Dist. 1991.)

periods under subsection (b)(3)(B)) as may be necessary to assure budget neutrality. Section 1395ww(b)(3)(B) references all cost reporting periods from 1986 through the present as being affected by the budget neutrality adjustment.

In response to the enactment of the above statutes, the Board's governing regulations were modified. In the September 1, 1983 preamble to new regulations, the Secretary explained that 42 U.S.C. § 1395oo(g)(2) was added by Pub. L. 98-21 to state that the determinations and decisions described in § 1395ww(d)(7) precludes administrative and judicial review of, among other things, a determination of the requirement, or proportional amount of any "budget neutrality" adjustment effected under §1395ww(e)(1). The Secretary stated that it was the clear intent of Congress that a hospital would not be permitted to argue that the level of payment that it receives under the prospective payment system is inadequate to cover its costs. The Secretary amended 42 C.F.R. Part 405, Subpart R to implement the changes to 42 U.S.C. § 1395(g)(2) contained in Pub. L. 98-21. The changes to the regulation included the addition of 42 C.F.R. § 405.1804 to describe matters not reviewable by the Board or the courts as provided in § 1395ww(d)(7).<sup>6</sup> Section 405.1804 states specifically that there is neither administrative nor judicial review of the determination of the requirement or the proportional amount of any budget neutrality adjustment in the prospective payment rate. Therefore, the Secretary clearly interpreted the statutory prohibition on review as not being confined to 1984 and 1985.

When the Secretary "updated, clarified and revised"<sup>7</sup> the Board's governing regulations in 2008, he separately and specifically addressed the limitations on the Board's jurisdiction. The original regulation at 42 C.F.R. § 405.1804, stating that budget neutrality issues are not reviewable, was reissued without change or comment. In addition, the Secretary added 42 C.F.R. § 405.1840 to the regulations specifically dealing with the Board's jurisdiction. Section 405.1840(b) states that certain matters at issue were removed from the jurisdiction of the Board and included "[c]ertain matters affecting payments to hospitals under the prospective payment system, as provided in [42 U.S.C. § 1395ww(d)(7)] and § 405.1804 of this subpart." If the budget neutrality provisions of § 405.1804 were limited to appeals of FY 1984 and 1985, there would be no reason to leave the regulation unchanged during a comprehensive revision of the Board's regulations and certainly no need to add § 405.1840(b)(2) reiterating and emphasizing the Board's lack of jurisdiction over the budget neutrality issue. The Secretary's action demonstrates a twenty five year consistent position that all budget neutrality determinations are off limits to the Board; not just those relating to fiscal years 1984 and 1985. Whether the Secretary's view is consistent with Congress' intent is not for the Board to decide for it is bound by the regulation.

#### EJR Determination

42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permit providers to bypass the Board's hearing procedure and obtain judicial review of a specific matter at issue involving a question of law or regulation where the Board determines that it is without authority to decide the legal question. Prior to rendering a decision that it lacks the authority to decide the legal question before it, the Board must determine that it has jurisdiction over the matter at issue in the appeal

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<sup>6</sup> 48 Fed. Reg. 39740, 39785 (September 1, 1983).

<sup>7</sup> 73 Fed. Reg. 30190 (May 23, 2008).

under 42 U.S.C. § 1395oo. 42 C.F.R. § 405.1842(a)(2008). We conclude that both the statute and regulation preclude administrative review of the budget neutrality adjustment; therefore, the Board lacks jurisdiction over the issue.

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

#### Application of *Cape Cod* case on the Request for EJR

Ordinarily our EJR analysis would end with a determination of no jurisdiction. However, in *Cape Cod HC 2007 Wage Index/Rural Floor Group*, PRRB case number 07-0705G et al, (*Cape Cod*), the Secretary has taken a contrary position. In *Cape Cod*, the Board concluded that it lacked jurisdiction over the budget neutrality adjustment based on the authorities set forth above. The Board's decision was not reversed by the CMS Administrator. On appeal to the Federal district court, however, the Secretary moved for remand on the basis that the Board had jurisdiction over the issue. The provider plaintiffs responded that the remand was unnecessary because the case was properly before the court on EJR. It argued that implicit in the Board's finding it lacked jurisdiction was a determination that it also lacked authority to decide the question, thus, EJR was appropriate. In its remand order, the District Court explained that the two findings are distinct. "Jurisdiction to take any legal action" asks whether the Providers may obtain a hearing at all; "authority to decide the question" asks whether the Board has authority to reach the merits of Providers' claims. The Court concluded that the Secretary's position was correct: the Court lacked subject matter jurisdiction without the Board's first being afforded an opportunity to consider the merits of the Providers' claims, including whether it has authority to decide the question. Neither the D.C. District court remand<sup>8</sup> nor the remand from the Deputy Administrator addresses the Secretary's rationale for his position regarding jurisdiction. Assuming, however, that the Secretary will take the same position in this case with respect to the Board's having jurisdiction over the budget neutrality issue, and in the interest of judicial economy, the Board will also address the question of whether EJR is appropriate.<sup>9</sup>

The Providers in this appeal seek to have its final wage index rate modified by applying a different calculation methodology relating to the budget neutrality and rural floor factors. Pursuant to 42 C.F.R. § 412.64, the Secretary calculates the standardized amount on an annual basis. This calculation is published annually in the Federal Register following a complex and lengthy process of data collection and analysis. The methodology for the calculation is described in general terms.

The Board is bound by the Secretary's final rules and has no authority to review the data underlying the rate published unless specifically authorized. Notably the Final Rule only provides for Board review of denials of requests by hospitals for correction of certain wage data

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<sup>8</sup> *Cape Cod Hospital v. Leavitt*, (D.D.C. July 21, 2008) (2008 WL 2791683).

<sup>9</sup> After the above remand based on the Secretary's position regarding jurisdiction, the Board found the Provider was entitled to expedited judicial review. In December of 2009, the District Court for the District of Columbia granted the defendant's (government's) motion for summary judgment for the budget neutrality adjustment. *Cape Cod Hospital et al. v. Sebelius*, 2009 WL 4981330 (D.D.C. December 22, 2009) at pp. 9-16.

that eventually goes into one hospital-specific component of the final rate.<sup>10</sup> If the provider appealing the denial is successful, the remedy is limited to the hospital bringing the successful appeal. There is no provision for the Board to adjust the rate itself (as applied to all hospitals) to account for the effect of the error. The Board concludes that the specific grant of authority and establishment of a detailed process for correcting the rate of only the hospital bringing the appeal, coupled with the failure to include the effect of that correction on other hospitals or to establish a similar correction process for other components of the wage index, are strong indications that the Board does not have authority to change the rate itself.

Even more compelling, however, is the language of the statute and the regulation quoted above that prohibits review of budget neutrality determinations which are at the heart of the question before the Board in this case. Even if the Board interpreted the statutory and regulatory prohibitions on review of budget neutrality determinations too broadly to bar jurisdiction, those prohibitions cannot be ignored altogether. We conclude that the statute and regulation evidence Congress' and the Secretary's intent that budget neutrality determinations are insulated from the Board's authority to affirm, reverse or modify a reimbursement determination. Otherwise, the specific prohibitions articulated there would be rendered meaningless.

Assuming, arguendo, that the Secretary takes the same position in these cases that the Board has jurisdiction, then the Board finds that:

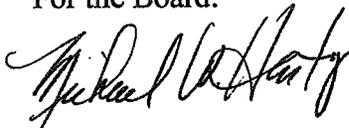
- 1) based upon the Providers' unopposed assertions regarding the challenges to the rural floor/budget neutrality methodology, there are no findings of fact for resolution by the Board;
- 2) it is bound by the Final Rule in the Federal Register and the regulation; and
- 3) it is without authority to decide the legal question of whether the calculation methodology for the budget neutrality/rural floor adjustment is valid.

Accordingly, the Board finds that the budget neutrality/rural floor issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and expedited judicial review is appropriate. Because this is the only issue under appeal in these cases, the Board hereby closes the cases.

BOARD MEMBERS PARTICIPATING:

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

For the Board:

  
Michael W. Harty  
Chairman

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<sup>10</sup> 64 Fed. Reg. 41490, 41513 (July 30, 1999). This authority has never been codified in the code of Federal Regulations.

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

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

**Case list for EJR for the (FYE 12/31/07) FFYs 2007 and 2008 Wage Index/Rural Floor**

- 1.) Hospital Cayetano Coll y Toste, Provider No. 40-0087, PRRB Case No. 13-1697
- 2.) Hospital De Damas, Provider No. 40-0022, PRRB Case No. 13-1704
- 3.) Dr. Dominguez Hospital, Provider No. 40-0011, PRRB Case No. 13-1577



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**AUG 30 2013**

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RE: Baptist Hospital of East Tennessee, Provider No. 44-0019, FYE 6/30/2003, and  
Baptist Hospital of East Tennessee, Provider No. 44-0019, FYE 6/30/2004  
*as participants in Catholic Health Partners 98, 00-05 Nursing Home CIRP Group*  
PRRB Case No. 11-0711G

Dear Mr. Prine:

On July 8, 2013, the Provider Reimbursement Review Board (the Board) received the "Provider Response to PRRB Letter Dated June 6, 2013" for the above captioned appeals. Based on this correspondence, the revised Schedules of Providers, and the additional jurisdictional support submitted, the Board has completed its jurisdictional review of the participating Providers. The Board's findings are addressed below.

**BACKGROUND**

On March 17, 2003, a number of providers filed an optional group appeal pertaining to the Supplemental Security Income (SSI) issue, for which the Board established Case No. 03-1254G. Upon initial review of the jurisdictional documentation provided for Case No. 03-1254G, the Board noted that the group contained hospitals that were independent as well as those that were commonly owned or controlled. On March 14, 2008, the Board established 26 Common Issue-Related Party (CIRP) group cases from the original case and left the independent hospitals in the optional group. One of the newly formed CIRP groups was Catholic Health Partners, for which the Board assigned Case No. 08-1175GC. A live hearing was held on March 17, 2008.

On May 5, 2011, the Board noted that the status of groups that were to be considered as part of the hearing had not yet been finalized by the parties. The Board further noted that in the interim, the Centers for Medicare & Medicaid Services (CMS) issued Ruling Number CMS-1498-R effectively ended the Board's deliberations as the cases heard included a primary issue of entitled days and a subsidiary issue of nursing home days. Since the entitled days were subject to the Ruling but the nursing home days were not, the Board further bifurcated Case No. 03-1254G and each of the restructured CIRP groups on July 20, 2011 to account for these two issues in separate groups. The Catholic Health Partners Nursing Home Days group was established as Case No. 11-0711GC.

On April 4, 2012, and June 6, 2013, the Board sent development letter addressing various jurisdictional concerns related to Case Nos. 08-1175GC and 11-0711GC, respectively. On July 5, 2013, the Representative submitted a response and a final Schedule of Providers with supporting documentation applicable to Case No 11-0711GC.

The Provider removed all Providers that had been previously identified by the Board as having a potential jurisdictional problem with the exception of Baptist Hospital of East Tennessee, Provider No. 44-0019, FYEs 6/30/2003 and 6/30/2004 (Participants 19 & 20). These two participants are addressed further below.

### **JURISDICTIONAL STATUS OF PARTICIPATING PROVIDERS**

*Participant 19 - Baptist Hospital of East Tennessee, Provider No. 44-0019, FYE 6/30/2003*

*Participant 20 - Baptist Hospital of East Tennessee, Provider No. 44-0019, FYE 6/30/2004*

Baptist Hospital of East Tennessee (Provider) timely filed its initial appeals for both fiscal years on March 21, 2006, challenging Notices of Program Reimbursement issued by the Intermediary on September 25, 2005. The Provider was represented by Michael McKibben of McKibben Consulting. The Board assigned Case Nos. 06-1310 and 06-1311, respectively. In the appeal requests the Provider stated:

The Provider appeals the Medicare SSI proxy and Title XIX proxy used in the calculation of the Medicare disproportionate share adjustment because it contends that these factors are inherently understated from errors in Medicare SSI days used by CMS to determine the SSI ratio, because of CMS policies regarding dual eligible Title XIX days for Medicare beneficiary stays when Part B coverage, only, is available or Medicare HMO dual eligible days and for other State and local indigent care programs funded via Title XIX.

The Provider addressed this issue within its final position paper dated July 23, 2007 (received July 30, 2007).

On July 27, 2007, Elizabeth Elias of Hall Render Killian Heath & Lyman submitted a letter requesting on behalf of the hospital to clarify the description of the SSI Days issue that was previously included in the pending individual appeals and to transfer the issue from Case Nos. 06-1310 and 06-1311 to the Virginia Medicare DSH-SSI Days Proxy (II) Group appeal, Case No. 07-2155G.

On August 17, 2011, Manie Campbell of CampbellWilson filed a request to transfer the DSH SSI issue again from Case Nos. 06-1310 and 06-1311 to the Catholic Health Partners 98, 00-05 SSI Group Appeal, Case No. 08-1175G. The Board acknowledged the transfers into Case No. 08-1175GC on September 29, 2011 and closed the individual appeals.

On February 16, 2012, the Board identified that a number of participants within Case No. 07-2155G, were commonly owned, therefore requiring a mandatory CIRP group appeal. The Board also specifically noted that Baptist Hospital of East Tennessee, FYEs 6/30/2003 and FYE 6/30/2004 were simultaneously participating in both Hall Render's optional group (Case No. 07-2155G) and CampbellWilson's CIRP group (Case No. 08-1175GC). In response, on March 16, 2012, Hall Render requested that a new CIRP group be formed for the Catholic Health Partners System for fiscal years 2003, 2004, and 2006, and stated that it was in the process of clarifying which of the two group appeals was appropriate. On April 4, 2012, the Board confirmed the inclusion of the Provider in the existing CIRP appeal (Case No. 08-1175GC) for fiscal years 2003-2004 and denied the transfer of this Provider for those years into the newly formed Catholic Health Partners 2006 SSI Percentage Group appeal (Case No. 12-0270GC).

### **BOARD'S DETERMINATION**

The Board finds that it does not have jurisdiction over Baptist Hospital of East Tennessee, FYEs 6/30/2003 and FYE 6/30/2004 (Participants 19 and 20), within Case No. 11-0711GC because the Provider never transferred to the current group appeal and did not timely raise the issue of Nursing Home Days within its appeal.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1841, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is \$10,000 or more (or \$50,000 for a group), and the request for a hearing is filed within 180 days of the date of the final determination. The 2008 revision to the regulations applicable to Subpart R of 42 C.F.R. Part 405 placed limitation on the timeframes to add issues to appeals pending before the Board. Specifically, 73 Fed. Reg. 30190, 30240 (May 23, 2008) stated:

For appeals pending before ... the Board prior to the effective date of this rule, a provider that wishes to add one or more issues to its appeal must do so by the expiration of the later of the following periods:

++ Sixty days after the expiration of the applicable 180-day period prescribed in ... Section 405.1835(a)(3) (for Board hearings); or (ii) 60 days after the effective date of this rule.<sup>1</sup>

Within its individual appeals for both 2003 and 2004, the Providers raised an SSI issue that addressed the accuracy of data. The SSI issue was transferred for both fiscal years to Case No. 07-2155G in 2007 and later transferred again to Case No. 08-1175GC in 2011, though the Board only recognized the latter transfers to the mandatory CIRP group. There is no evidence in the record of any transfers from the individual appeals, or from either group appeal, to Case No. 11-0711GC.

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<sup>1</sup> The Final Rule issued May 23, 2008 governing Provider Reimbursement Determinations and Appeals were effective August 21, 2008. 73 Fed. Reg. 30190. Therefore, added issues were to be submitted to the Board no later than October 20, 2008.

Although Case No. 11-0711GC had been formed based on the bifurcation of Case No. 08-1175GC in order to account for the distinct issues of entitled/omitted days and nursing home days within the SSI ratio, the Board notes that it identified the requirement to bifurcate the general SSI issue by a letter to the Group Representative dated May 5, 2011. The separation of the cases was completed on July 20, 2011, thereby leaving the existing group, Case No. 08-1175GC, for the entitled omitted days issue and creating the new group, Case No. 11-0711GC, specific to the nursing home days issue. Therefore, the current group case was established prior to the Provider's August 17, 2011 requests to transfer the SSI issue to Case No. 08-1175GC, and there were not corresponding transfer requests to Case No. 11-0711GC. However, assuming arguendo that there had been such a transfer, there is no evidence in the record that the Provider ever raised the specific issue of nursing home days in its appeal, and therefore, the Provider would be ineligible to transfer an issue that had not been timely raised.

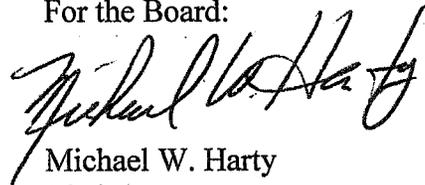
The Board hereby dismisses Baptist Hospital of East Tennessee, FYE 6/30/2003 (Participant 19) and Baptist Hospital of East Tennessee, FYE 6/30/2004 (Participant 20) from Case No. 11-0711GC.

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

Board Members:

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

For the Board:



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Chairman

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Refer to:

13-2297, 13-2294, 13-2295

Certified Mail

**AUG 30 2013**

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Cecile Huggins, Supervisor  
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RE: Southeast Arkansas Hospice  
Provider No. 04-1570  
PRRB Case Nos.

13-2297 Cap Period November 1, 2008-October 31, 2009

13-2294 Cap Period November 1, 2009-October 31, 2010

13-2295 Cap Period November 1, 2010-October 31, 2011

Dear Mr. Trimble and Ms. Huggins:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's May 31, 2013 request for expedited judicial review (EJR) (received June 6, 2013) and the Provider's August 6, 2013 response (received August 12, 2013) to the Board's June 28, 2013 request for additional information. The Board determination with respect to its jurisdiction over the appeals and EJR is set forth below.

**Procedural Background**

The Provider filed timely appeals<sup>1</sup> of its hospice cap determinations for each respective cap periods referenced above. In each hearing request, the Provider challenged the amount of the cap overpayment and requested that the cap determination be recalculated using the patient-by-patient proportional methodology<sup>2</sup> described in 42 C.F.R. § 419.309(c). In addition, the Provider asserted that:

- a. The Agreement between [the Provider] and Medicare results [in a] regulatory taking . . . (42 CFR 418.26);

<sup>1</sup> Case number 13-2297, cap period ending October 31, 2009, appealed a revised cap determination dated January 16, 2013, hearing request received June 6, 2013 (under the revised cap determination the Provider's reimbursement was calculated using the proportional methodology); case number 13-2294, cap period ending October 31, 2010, appeal of a cap determination dated January 16, 2013, hearing request received June 6, 2013; case number 13-2295, cap period ending October 31, 2011, appeal of a cap determination dated May 2, 2013, hearing request received June 6, 2013.

<sup>2</sup> This includes the Provider appeal in case number 13-2297 in which the revised Cap Amount was calculated using the patient-by-patient proportional methodology.

- b. The Agreement between [the Provider] and Medicare results [in an] unconscionable contract . . . resulting in a Regulatory Taking . . . (42 CFR 418.26);
- c. The Agreement between [the Provider] and Medicare is a Regulatory Taking . . . causing [the Provider] to subsidize Medicare patients in the Hospice Program, who have clearly exhausted all their Hospice Benefits, yet [the Provider] does not have the ability, and in fact is prevented by regulation (42 CFR 418.26 from attempting to discharge such . . . patients who [have] clearly exhausted their Hospice benefits. (42 CFR 418.26);
- d. The Agreement between [the Provider] and Medicare, is an unfair and deceptive business practice, resulting in a Regulatory Taking of the Assets of [the Provider]. (42 C.F.R. 418.26).

Provider's Cover letter to the Hearing Requests in each case at 2.

The Provider's EJR requests in the above-referenced appeals reiterated the points set forth above and also asserts that the Medicare contract requiring compliance with the regulations which allegedly prevents removal of patients which have exhausted their benefits from the hospice program is an unfair and deceptive business practice.<sup>3</sup> On June 28, 2013, the Board requested that the Provider explain whether the Board had jurisdiction over the issues of (1) the inability to discharge patients as a matter covered under the provisions of 42 C.F.R. §§ 418.301-418.311 and (2) whether the Board had jurisdiction over the conditions of the Provider Agreements to which the Provider and the Centers for Medicare & Medicaid Services (CMS) were parties.

Through correspondence dated August 6, 2013, the Provider responded by explaining that the inability to discharge patients was encompassed in its Notices of Program Reimbursement [sic Notice of Effect of Inpatient Day Limitation and Hospice Cap Amount]. The Provider complained that hospice patients can be recertified for an unlimited period of time without any provisions for payment beyond the 6-month hospice benefit period available to each hospice patient. With respect to the Board's jurisdiction over the provider agreements, the Provider asserts that the Board has jurisdiction over the issue because it was dissatisfied with the total amount of program reimbursement.

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<sup>3</sup> Provider's May 31, 2013 EJR Request at 2.

## Statutory and Regulatory Background

### Hospice Reimbursement under Medicare

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

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

In 1983, the Secretary adopted a rule that allocates hospice care on an aggregate basis by allocating each beneficiary entirely to the cap year in which he or she would be likely to receive the preponderance of his or her care. 48 Fed. Reg. 56,008, 56,022 (December 16, 1983). Once a beneficiary is counted for a given hospice, the beneficiary is not counted in the cap in subsequent years if services continue into more than one cap year.<sup>4</sup>

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

In 2006, Providers began filing appeals objecting to the current counting methodology used in calculating hospice reimbursement, seeking to have the overpayment determination calculated under the methodology described above invalidated. The Federal district courts and courts of appeals that ruled on the question have issued decisions concluding that the methodology is in consistent with the plain language of the Medicare statute and set aside the overpayment determinations.<sup>5</sup>

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

<sup>4</sup> Ruling 1355-R at 3-5.

<sup>5</sup> *See e.g. Lion Head Health Services v. Sebelius*, 689 F. Supp. 2d 849 (N.D. Tex. 2010); *Los Angeles Haven Hospice*, 2009 WL 5868513 (C.D. Cal.); *Hospice of New Mexico v. Sebelius*, 691 F. Supp. 2d 1275 (D.N.M. 2010); *IHG Healthcare, Inc. v. Sebelius*, 717 F. Supp. 2d 696 (S.D. Tex. 2010).

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

Under the Ruling intermediaries and Medicare Administrative Contractors (MACs) were to identify properly pending appeals and recalculate the aggregate cap using the patient-by-patient methodology using the best available data. For hospices which had not filed appeals challenging the cap, the intermediaries and MACs were to use the reimbursement methodology that appeared in the regulation at 42 C.F.R. § 418.309(b)(1) for any cap year ending on or before October 31, 2011, unless CMS adopted a rule providing otherwise.<sup>6</sup>

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

In the August 4, 2011 Federal Register<sup>7</sup> the Secretary announced changes to calculations of hospice cap calculation for cap years before October 31, 2011 and on or after October 31, 2012. This notice included a change in the hospice payment regulation, 42 C.F.R. § 418.309, allowing providers reimbursement to be calculated under either the new patient-by-patient proportional methodology or the streamlined methodology (the existing methodology). These changes were made as a result of the litigation resulting in Ruling 1355-R, described above, and the Secretary's requests for comments on potential modernization of the hospice cap calculation.<sup>8</sup>

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

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

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

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<sup>6</sup> Ruling at 9-11.

<sup>7</sup> 76 Fed. Reg. 47302, 47308 (August 4, 2011).

<sup>8</sup> See note 5.

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

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

### **Decision of the Board**

The Board concludes that it lacks jurisdiction over the challenge to the validity of 42 C.F.R. § 418.26 because this is not a reimbursement matter governed by the provisions of 42 C.F.R. § 418.311. Section 418.311 permits appeals of hospice cap payments where a provider believes that its payments were not made in accordance with the regulations found in Subpart G of Part 418 of Title 42 of the Code of Federal Regulations. The provider agreement is a contract between the Provider and CMS and is not governed by Subpart G nor is the Provider's alleged inability to discharge payments from its hospice program. Since the Board lacks jurisdiction over the issues for which EJR was requested, the Board hereby denies the Provider's request for EJR in the above-referenced appeals. *See* 42 C.F.R. § 405.1842 (jurisdiction over an issue is a prerequisite to granting a request for EJR).

### **Appeal of the Streamlined Methodology**

In its hearing requests the Provider asked that the hospice cap amount be recalculated using the patient-by-patient proportional methodology described in 42 C.F.R. § 418.309(c) rather than the streamline method found in § 418.309(b). The Board notes that MAC recalculated the Provider's cap amount using the proportional methodology for the cap period ending October 31, 2009 and issued a revised Cap Amount to effectuate this change in reimbursement methodologies. This revised determination was appealed in case number 13-2297. Since the Provider's reimbursement has been calculated using the method requested, the Board finds the request for reimbursement under the proportional methodology in case number 13-2297 is moot and hereby dismisses the issue from the appeal.

### **Remand<sup>9</sup> in Case Numbers 13-2294 and 13-2295 as the Result of the Requirements of 42 C.F.R. § 418.309(d)(1)**

The Board is bound by the regulations issued under Title XVII of the Social Security Act. The hospice cap regulations found in Subpart G of Part 418 of Title 42 of the Code of Federal Regulations were issued under that authority. *See* 42 C.F.R. § 405.1867.

With respect to the request for payment under the patient-by-patient proportional method in case numbers 13-2294 and 13-2295, the Board notes that 42 C.F.R. § 418.309(d)(1)(ii) requires once a hospice has elected to have its cap reimbursement calculated using the patient-by-patient proportional methodology, all subsequent years must be calculated using this methodology.

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<sup>9</sup> The Board's remand authority is found in 42 C.F.R. § 405.1845(h).

Since the Provider cap reimbursement was paid under the proportional methodology in cap year ending October 31, 2009 (case number 13-2297), the Board concludes that the later cap years in case numbers 13-2294 and 13-2295 must be paid under the proportional methodology as well.

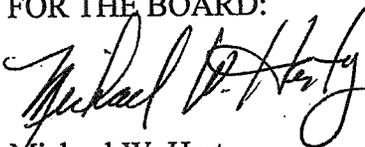
Since the Board is bound by this regulation giving rise to this decision, the Board finds that it is appropriate to remand the appeals of cap calculation for Provider's cap years ending October 31, 2010 and 2011 (case numbers 13-2294 and 13-2295, respectively) to the MAC for determination of reimbursement under the patient-by-patient proportional methodology described in 42 C.F.R. § 418.309(c). The Board hereby remands case numbers 13-2294 and 13-2295 to the MAC to revise the methodology under which the Provider is reimbursed to comport with the requirements of 42 C.F.R. § 418.309(d)(1)(ii).

Since there is no other action for the Board to take in these appeals, the Board hereby closes the cases. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating

Michael W. Harty  
John Gary Blowers, CPA  
Clayton J. Nix, Esq.  
L. Sue Andersen, Esq.

FOR THE BOARD:

  
Michael W. Harty  
Chairman

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

cc: Kevin Shanklin, BCBSA



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Refer to: 13-2296, 13-0589, 13-2293

**AUG 30 2013**

Certified Mail

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RE: Southeast Arkansas Hospice  
Provider No. 04-1566  
PRRB Case Nos.

13-2296 Cap Period November 1, 2008-October 31, 2009  
13-0589 Cap Period November 1, 2009-October 31, 2010  
13-2293 Cap Period November 1, 2010-October 31, 2011

Dear Mr. Trimble and Ms. Huggins:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's May 31, 2013 request for expedited judicial review (EJR) (received June 6, 2013) and the Provider's August 6, 2013 response (received August 12, 2013) to the Board's June 28, 2013 request for additional information. The Board determination with respect to its jurisdiction over the appeals and EJR is set forth below.

**Procedural Background**

The Provider filed timely appeals<sup>1</sup> of its hospice cap determinations for each respective cap periods referenced above. In each hearing request, the Provider challenged the amount of the cap overpayment and requested that the cap determination be recalculated using the patient-by-patient proportional methodology described in 42 C.F.R. § 419.309(c). In addition, the Provider asserted that:

- a. The Agreement between [the Provider] and Medicare results [in a] regulatory taking . . . (42 CFR 418.26);

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<sup>1</sup> Case number 13-2296, cap period ending October 31, 2009, appealed a revised cap determination dated January 3, 2013, hearing request received June 6, 2013 (the revised cap determination does not appear to be calculated using the proportional methodology); case number 13-0589, cap period ending October 31, 2010, appeal of a cap determination dated January 3, 2013, hearing request received February 4, 2013; case number 13-2293, cap period ending October 31, 2011, appeal of a cap determination dated May 2, 2013, hearing request received June 6, 2013.

- b. The Agreement between [the Provider] and Medicare results [in an] unconscionable contract . . . resulting in a Regulatory Taking . . . (42 CFR 418.26);
- c. The Agreement between [the Provider] and Medicare is a Regulatory Taking . . . causing [the Provider] to subsidize Medicare patients in the Hospice Program, who have clearly exhausted all their Hospice Benefits, yet [the Provider] does not have the ability, and in fact is prevented by regulation (42 CFR 418.26 from attempting to discharge such . . . patients who [have] clearly exhausted their Hospice benefits. (42 CFR 418.26;
- d. The Agreement between [the Provider] and Medicare, is an unfair and deceptive business practice, resulting in a Regulatory Taking of the Assets of [the Provider]. (42 C.F.R. 418.26).

Provider's Hearing Requests in case numbers 13-2296 and 13-2293 at 2. Provider's May 31, 2013 EJR request in case number 13-0589 (Tab 1).

The Provider's EJR requests in the above-referenced appeals reiterated the points set forth above and also asserted that the Medicare contract requiring compliance with the regulations which allegedly prevents removal of patients which have exhausted their benefits from the hospice program is an unfair and deceptive business practice.<sup>2</sup> On June 28, 2013, the Board requested that the Provider explain the whether the Board had jurisdiction over the issues of (1) the inability to discharge patients as a matter covered under the provisions of 42 C.F.R. §§ 418.301-418.311 and (2) whether the Board had jurisdiction over the conditions of the Provider Agreements to which the Provider and the Centers for Medicare & Medicaid Services (CMS) were parties.

Through correspondence dated August 6, 2013, the Provider responded by explaining that the inability to discharge patients was encompassed in its Notices of Program Reimbursement [sic Notice of Effect of Inpatient Day Limitation and Hospice Cap Amount]. The Provider complained that hospice patients can be recertified for an unlimited period of time without any provisions for payment beyond the 6-month hospice benefit period available to each hospice patient. With respect to the Board's jurisdiction over the provider agreements, the Provider asserts that the Board has jurisdiction over the issue because it was dissatisfied with the total amount of program reimbursement.

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<sup>2</sup> *Id.*

## Statutory and Regulatory Background

### Hospice Reimbursement under Medicare

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

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

In 1983, the Secretary adopted a rule that allocates hospice care on an aggregate basis by allocating each beneficiary entirely to the cap year in which he or she would be likely to receive the preponderance of his or her care. 48 Fed. Reg. 56,008, 56,022 (December 16, 1983). Once a beneficiary is counted for a given hospice, the beneficiary is not counted in the cap in subsequent years if services continue into more than one cap year.<sup>3</sup>

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

In 2006, Providers began filing appeals objecting to the current counting methodology used in calculating hospice reimbursement, seeking to have the overpayment determination calculated under the methodology described above invalidated. The Federal district courts and courts of appeals that ruled on the question have issued decisions concluding that the methodology is inconsistent with the plain language of the Medicare statute and set aside the overpayment determinations.<sup>4</sup>

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

<sup>3</sup> Ruling 1355-R at 3-5.

<sup>4</sup> *See e.g. Lion Head Health Services v. Sebelius*, 689 F. Supp. 2d 849 (N.D. Tex. 2010); *Los Angeles Haven Hospice*, 2009 WL 5868513 (C.D. Cal.); *Hospice of New Mexico v. Sebelius*, 691 F. Supp. 2d 1275 (D.N.M. 2010); *IHG Healthcare, Inc. v. Sebelius*, 717 F. Supp. 2d 696 (S.D. Tex. 2010).

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

Under the Ruling intermediaries and Medicare Administrative Contractors (MACs) were to identify properly pending appeals and recalculate the aggregate cap using the patient-by-patient methodology using the best available data. For hospices which had not filed appeals challenging the cap, the intermediaries and MACs were to use the reimbursement methodology that appeared in the regulation at 42 C.F.R. § 418.309(b)(1) for any cap year ending on or before October 31, 2011, unless CMS adopted a rule providing otherwise.<sup>5</sup>

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

In the August 4, 2011 Federal Register<sup>6</sup> the Secretary announced changes to calculations of hospice cap calculation for cap years before October 31, 2011 and on or after October 31, 2012. This notice included a change in the hospice payment regulation, 42 C.F.R. § 418.309, allowing providers reimbursement to be calculated under either the new patient-by-patient proportional methodology or the streamlined methodology (the existing methodology). These changes were made as a result of the litigation resulting in Ruling 1355-R, described above, and the Secretary's requests for comments on potential modernization of the hospice cap calculation.<sup>7</sup>

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

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

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

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<sup>5</sup> Ruling at 9-11.

<sup>6</sup> 76 Fed. Reg. 47302, 47308 (August 4, 2011).

<sup>7</sup> See note 5.

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

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

### **Decision of the Board**

The Board concludes that it lacks jurisdiction over the challenge to the validity of 42 C.F.R. § 418.26 because this is not a reimbursement matter governed by the provisions of 42 C.F.R. § 418.311. Section 418.311 permits appeals of hospice cap payments where a provider believes that its payments were not made in accordance with the regulations found in Subpart G of Part 418 of Title 42 of the Code of Federal Regulations. The provider agreement is a contract between the Provider and CMS and is not governed by Subpart G nor is the Provider's alleged inability to discharge patients from its hospice program. Since the Board lacks jurisdiction over the issues for which EJR was requested, the Board hereby denies the Provider's request for EJR in the above-referenced appeals. *See* 42 C.F.R. § 405.1842 (jurisdiction over an issue is a prerequisite to granting a request for EJR).

In its hearing requests the Provider asked that the hospice cap amount be recalculated using the patient-by-patient proportional methodology described in 42 C.F.R. § 418.309(c). The Board concludes that it is required to order the MAC to calculate reimbursement under 42 C.F.R. § 418.309(c), the patient-by-patient, proportional methodology because the regulation, 42 C.F.R. § 418.309(d)(1) (2011), mandates that:

For cap years ending October 31, 2011 and for prior cap years, a hospice's aggregated cap is calculated using the streamlined methodology described in paragraph (b) of this section subject to the following:

(i) A hospice that has not received a cap determination for a cap year ending on or before October 31, 2011 as of October 1, 2011, may elect to have its final cap determination for such cap years calculated using the patient-by-patient methodology described in paragraph (c) of this section; or

(ii) *A hospice that has filed a timely appeal regarding the methodology used for determining the number of Medicare beneficiaries in its cap calculation for any cap year is deemed to have elected that its cap determination for the challenged year, and all subsequent cap years be calculated using the patient-by-patient proportional methodology described in paragraph (c) of this section. (emphasis added)*

Remand<sup>8</sup> as the Result of the Requirements of 42 C.F.R. § 418.309(d)(1)

The Board is bound by the regulations issued under Title XVII of the Social Security Act and the hospice cap regulations found in Subpart G of Part 418 of Title 42 of the Code of Federal Regulations were issued under that authority. *See* 42 C.F.R. § 405.1867. Pursuant to the regulation, 42 C.F.R. § 418.309(d)(ii), a timely appeal of the methodology used for determining the number of Medicare beneficiaries a cap calculation, is deemed to be an election requiring the provider's cap determination be calculated using the patient-by-patient proportional methodology described in 42 C.F.R. § 418.309(c). Since the Board is bound by this regulation, it finds that it must remand the appeals to the MAC for determination of reimbursement under the patient-by-patient proportional methodology described in 42 C.F.R. § 418.309(c). Since there is no other action for the Board to take in these appeals, the Board hereby 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

Michael W. Harty  
John Gary Blowers, CPA  
Clayton J. Nix, Esq.  
L. Sue Andersen, Esq.

FOR THE BOARD:



Michael W. Harty  
Chairman

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

cc: Kevin Shanklin, BCBSA

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<sup>8</sup> The Board's remand authority is found in 42 C.F.R. § 405.1845(h).

Remand<sup>9</sup> as the Result of the Requirements of 42 C.F.R. § 418.309(d)(1)

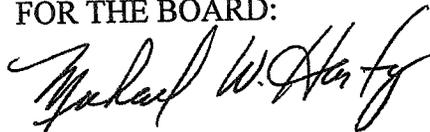
The Board is bound by the regulations issued under Title XVII of the Social Security Act and the hospice cap regulations found in Subpart G of Part 418 of Title 42 of the Code of Federal Regulations were issued under that authority. See 42 C.F.R. § 405.1867. Pursuant to the regulation, 42 C.F.R. § 418.309(d)(ii), a timely appeal of the methodology used for determining the number of Medicare beneficiaries a cap calculation, is deemed to be an election requiring the provider's cap determination be calculated using the patient-by-patient proportional methodology described in 42 C.F.R. § 418.309(c). Since the Board is bound by this regulation, it finds that it must remand the appeals to the MAC for determination of reimbursement under the patient-by-patient proportional methodology described in 42 C.F.R. § 418.309(c). Since there is no other action for the Board to take in these appeals, the Board hereby closes the cases.

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FOR THE BOARD:



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Chairman

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<sup>9</sup> The Board's remand authority is found in 42 C.F.R. § 405.1845(h).