DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to: 14-3831, 15-2719

Certified Mail

APR 05 2017

Kenneth J. Marcus, Esq.
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Detroit, MI 48226-3506

RE: Oakland Regional Hospital
Provider No. 23-0301
FYEs 12/31/2009, 12/31/2010
PRRB Case Nos. 14-3831 and 15-2719

Dear Mr. Marcus:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's March 8, 2017 request for expedited judicial review (EJR) (received March 9, 2017). The Board's decision with respect to EJR is set forth below.

Issue

Whether the Medicare Administrative Contractor (the "MAC") appropriately conducted a cost outlier reconciliation, and recovered Medicare payment, relating to outpatient services.[1]

Outpatient Prospective Payment Outlier Payments

The July 18, 2008, proposed outpatient prospective payment system (OPPS) proposed rule explained that OPPS pays outlier payments on a service-by-service basis. For calendar year (CY) 2008, the outlier threshold is met when the cost of furnishing a service or procedure by a hospital exceeds 1.75 times the Ambulatory Payment Classification (APC)[2] payment amount and exceeds the APC payment rate plus a $1,575 fixed-dollar threshold. The Secretary[3] introduced a fixed-dollar threshold in CY 2005 in addition to the traditional multiple threshold in order to better target outliers to those high cost and complex procedures where a very costly service could present a hospital with significant financial loss. If a hospital meets both of these conditions, the

[1] Provider's March 8, 2017 EJR Request at 2.
[2] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HospitalOutpaysysfctsht.pdf (In most cases, the unit of payment under the OPPS is the APC. CMS assigns individual services (Healthcare Common Procedure Coding System [HCPCS] codes) to APCs based on similar clinical characteristics and similar costs. The payment rate and copayment calculated for an APC apply to each service within the APC.)
[3] of the Department of Health and Human Services.

multiple threshold and the fixed-dollar threshold, the outlier payment is calculated as 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment rate.[4]

As provided in section 42 U.S.C. § 1395(t)(5), and described in the CY 2001 final rule,[5] the Secretary initiated the use of a provider-specific overall cost-to-charge ratio (CCR)[6] to estimate a hospital's billed charges on a claim to determine whether a service's cost was significantly higher than the APC payment to qualify for outlier payments. In 2008, these facility-specific overall CCRs were determined using the most recently settled or tentatively settled cost report for each facility. At the end of the cost reporting period, the hospital submits a cost report to its Medicare contractor, who then calculates the overall CCR that is used to determine outlier payments for the facility. The Secretary believes the intent of the statute is that outlier payments would be made only in situations where the cost of a service provided is extraordinarily high. For example, under the 2008 outlier methodology, a hospital's billed current charges may have been significantly higher than the charges included in the hospital's overall CCR that was used to calculate outlier payments, while the hospital's costs are more similar to the costs included in the overall CCR. In this case, the hospital's overall CCR used to calculate outlier payments was not representative of the hospital's current charge structure. The overall CCR applied to the hospital's billed charges would estimate an inappropriately high cost for the service, resulting in inappropriately high outlier payments. This is contrary to the goal of outlier payments, which are intended to reduce the hospital's financial risk associated with services that have especially high costs. The reverse could be true as well, if a hospital significantly lowered its current billed charges in relationship to its costs, it would result in inappropriately low outlier payments.[7]

For CY 2009, the Secretary proposed to address vulnerabilities in the OPPS outlier payment system that leads to differences between billed charges and charges included in the overall CCR used to estimate costs. The Secretary's proposal would apply to all hospitals paid under the OPPS. The main vulnerability in the OPPS outlier payment system is the time lag between the CCRs from the latest settled cost report and current charges that create the potential for hospitals to set their own charges to exploit the delay in calculating new CCRs. A facility can increase its outlier payments during this time lag by increasing its charges significantly in relation to its cost increases. The Secretary believed that the time lag may lead to inappropriately high CCRs relative to billed charges that overestimate costs, and as a result, greater outlier payments. Therefore, the Secretary took steps to ensure that outlier payments appropriately account for financial risk when providing an extraordinarily costly and complex service, while only being made for services that legitimately qualify for the additional payment.[8]

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[4] 73 Fed. Reg. 41,416, 41, 471 (July 18, 2008).

[5] 65 FR 18434, 18,498 (Apr. 7, 2000).

[6] A hospital cost-to-charge ratio is the total amount of money required to operate a hospital, divided by the sum of the revenues received from patient care and all other operating revenues. *See medical-dictionary.thefreedictionary.com/hospital+cost-to-charge+ratio.*

[7] 73 Fed. Reg. at 41463.

[8] *Id.*

To address these vulnerabilities in the area of the OPPS outlier payment methodology, the Secretary updated the regulations to codify two existing OPPS policies. The method for implementing these regulations was set forth in Pub 100–04, Chapter 4, section 10.11.1 of the Internet-Only Manual, as updated via Transmittal 1445, Change Request 5946, dated February 8, 2008. To be consistent with the manual instructions, for CY 2009, the Secretary proposed to revise 42 C.F.R. § 419.43 to add two new paragraphs (d)(5)(ii) and (d)(5)(iii). Specifically, she proposed to add new paragraph (d)(5)(ii) to incorporate rules governing the overall ancillary CCR applied to processed claims and new paragraph (d)(5)(iii) to incorporate existing policy governing when a statewide average CCR may be used instead of an overall ancillary CCR.[9] These proposed changes were finalized in the November 18, 2008 Federal Register.[10]

Provider's Request for EJR

Provider Background

The Provider explains that it became a new Medicare provider in late 2006 and filed its first full-year cost report in 2007. As a new provider, the Provider experienced wide variation annually in its volumes, payor mix, patient utilization and cost structure from 2007-2013. This, the Provider alleges, created a challenge in identifying a pattern for financial projections. Further, the revenue cycle presented additional challenges including consistent financial reporting and identifying charges by department. This included the establishment of an appropriate charge master that accurately reflected all overhead costs and direct costs in addition to charges not limited by payor fee screens. As a result, in 2009 the Provider discovered a need to increase charges to avoid limitations imposed by Workers' Compensation payments. The Provider maintains that this action was not based on any intention to impact its outlier payment, but in combination with other factors, it believes the cost outlier payment reconciliation audit was triggered.

The Request for EJR

The Provider explains that it is challenging the outlier reconciliation process to which it was subjected. The Medicare statute requires the Secretary to provide outlier payments to hospitals for outpatient cases that are extraordinarily expensive to treat.[11]

The Medicare regulation, 42 C.F.R. § 419.43(d)(6),[12] provides as follows regarding reconciliation:

> (6) *Reconciliation.*—

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[9] *Id.*
[10] 73 Fed. Reg. 68,502, 68,591-68,599 (Nov. 18, 2008).
[11] *See* 42 U.S.C. § 1395(t)(5); *see also* 42 C.F.R. § 419.43(d).
[12] Provider's EJR Ex. 1

> For hospital outpatient services furnished during cost reporting periods beginning on or after January 1, 2009—
>
> (i) Any reconciliation of outlier payments will be based on an overall ancillary cost-to-charge ratio calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the service is settled.
>
> (ii) At the time of any reconciliation under paragraph (d)(6)(i) of this section, outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Any adjustment will be based on a widely available index to be established in advance by CMS, and will be applied from the midpoint of the cost reporting period to the date of reconciliation.

The Provider points out that this regulation is silent with regard to the outpatient outlier audit and reconciliation process. Instead, the outlier reconciliation process conducted for the Provider's 2009 and 2010 fiscal years was based on:

- Centers for Medicare and Medicaid Services Pub. 100-04, Medicare Claims Processing Manual, Transmittal No. 1657 (December 31, 2008) (the "2008 Transmittal");[13]
- Centers for Medicare and Medicaid Services Pub. 100-04, Medicare Claims Processing Manual, Transmittal No. 2111 (December 3, 2010) (the "2010 Transmittal");[14] and
- Centers for Medicare and Medicaid Services Pub. 100-04, Medicare Claims Processing Manual, Ch. 4, §§ 10.7.2.1 through 10.7.2.4 (December 3, 2010) (the "Manual").[15]

The Provider notes that neither the 2008 Transmittal, the 2010 Transmittal nor the Manual was adopted with advance notice and comment, as required by the Administrative Procedure Act ("APA"), 5 U.S.C. § 553, and the Medicare statute, 42 U.S.C. § 1395hh(a)(1).

The Provider notes that in an analogous case, *Clarian Health West, LLC v. Burwell*,[16] the D.C. District Court held that, with respect to inpatient outlier reconciliation, the 2010 manual provision used to identify hospitals as candidates for outlier reconciliation, needs to be subject to notice and comment rulemaking prior to adoption. The criteria in the manual are not sufficiently

[13] Provider's EJR Request, Ex. 2.
[14] Provider's EJR Request, Ex. 3.
[15] Provider's EJR Request Ex. 4
[16] 2016 WL 4506969 (D.D.C. 2016), (D.C. Cir. October 27, 2016).

grounded in any statutory or regulatory text to fall within the interpretative rule exemption and the qualifying rule cannot be construed as a procedural rule.[17] The Board issued an order granting EJR in that case.

OPPS Outliers

The Provider explains that OPPS outlier reconciliation is authorized through the regulation 42 C.F.R. § 419.42(d). The standards and processes for conducting the reconciliation are found in the manuals and transmittal referenced above. This case is a challenge to CMS's failure to comply with the notice and comment rulemaking requirements of the APA, 5 U.S.C. § 553 and the Medicare Act, 42 U.S.C. § 1395hh(a)(1). The Provider contends that the Board is bound by the regulation, the 2008 and 2010 Transmittals and the Manual, and consequently, lacks the authority to grant the relief sought and should grant EJR.

Decision of the Board

The Board has reviewed the Provider's requests for hearing and EJR. The regulation at 42 C.F.R. § 405.1842(a) permits the Board to consider whether it lacks the authority to decide a legal question relevant to the matter at issue once it has made a finding that it has jurisdiction to conduct a hearing under the provisions of 42 C.F.R. §§ 405.1835 and 405.1840(a). The Board concludes that the Provider timely filed its requests for hearing from the issuance of its Notices of Program Reimbursement for fiscal years 2009 and 2010, and the amount in in controversy in each case exceeds the $10,000 threshold necessary for an individual appeal.[18] Consequently, the Board has determined that it has jurisdiction over the Provider's appeals. Further the Board finds that it lacks the authority to determine whether the Secretary violated the APA by failing to codify the standards and processes for conducting the outlier reconciliation found in the manuals and transmittal referenced above in the regulation, 42 C.F.R. § 419.42. Consequently, EJR is appropriate for the issue under dispute in these cases.

The Board finds that:

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

2) based upon the Provider's assertions regarding the outlier regulation, 42 C.F.R. § 412.42, there are no findings of fact for resolution by the Board;

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

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

4) it is without the authority to decide the legal question of whether the Secretary's failure to codify the standards and processes for conducting the outlier reconciliation in 42 C.F.R. § 412.42 is valid.

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

Board Members Participating

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

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

Enclosures: 42 U.S.C. § 1395oo(f)

cc: Byron Lamprecht, WPS
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APR 0 6 2017

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RE: Toyon 2009 Rural Floor Budget Neutrality Group, PRRB Case No. 09-1313G
Daughters of Charity 2009 Rural Floor Budget Neutrality Group, PRRB Case No. 09-1316GC
John Muir 2009 Rural Floor Budget Neutrality Group, PRRB Case No. 09-1307GC
Northbay 2009 Rural Floor Budget Neutrality Group, PRRB Case No. 09-1303GC
Providence 2009 Rural Floor Budget Neutrality Group, PRRB Case No. 09-1311GC
St. Joseph Health System 2009 Rural Floor Budget Neutrality Group, PRRB Case No. 09-1309GC
UC 2009 Rural Floor Budget Neutrality Group, PRRB Case No. 09-1301GC
CHW FY 2009 Rural Floor Budget Neutrality Group, PRRB Case No. 11-0610GC
Toyon FY 2010 Rural Floor Budget Neutrality Group, PRRB Case No. 10-0730G
John Muir FY 2010 Rural Floor Budget Neutrality Group, PRRB Case No.10-0731GC
Northbay FY 2010 Rural Floor Budget Neutrality Group, PRRB Case No.10-0732GC
Dignity Health 2010 Rural Floor Budget Neutrality Group, PRRB Case No. 12-0340GC

Dear Mr. Knight and Mr. Olszewski,

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

Issue under Appeal

This is a challenge to the Centers for Medicare & Medicaid Services' ("CMS's") application of the statewide rural floor budget neutrality adjustment factor made to the federal fiscal year ("FFY") 2009 [and 2010] wage index used to determine inpatient prospective payment system payments to Medicare Providers. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4410(a), 42 U.S.C. § 1395ww note.

Factual Background and Parties' Arguments

The Medicare statute requires the Secretary of HHS to adjust prospective payment system ("PPS") payments to a hospital to reflect the hospital's labor-related costs relative to the national average labor cost. To account for variances in local labor markets relative to the national average, the

Secretary assigns hospitals located within a geographic region an area wage index that adjusts the base payment rate upward or downward to reflect average wage levels in the hospital's local labor market relative to the national average. The Secretary uses census-related proxies to identify local labor markets, which is necessarily inexact. There are numerous exceptions and adjustments in order to account for the inexact use of census areas as proxies, one of which is the rural floor.[1]

The purpose of the rural floor is to raise the urban area wage indexes relative to the national average and thereby raise payments to urban hospitals. Congress required that the rural floor have a budget neutral effect on aggregate Medicare payments nationwide. The Secretary's inpatient PPS final rule for FFY 2009 changed the way the Secretary applied the budget neutrality aspect of the rural floor adjustment. Instead of continuing to adjust the area wage indexes for all hospitals nationwide, the Secretary proposed adjusting wage area indexes on a State-specific level. In response to concerns about the methodology change, the Secretary implemented a transition to the change that would take place over three years using a blended rural floor adjustment.[2]

The Providers argue that the State-specific rural floor budget adjustment is invalid for two reasons. First, the Secretary's decision exceeds her statutory authority because it is at odds with Congressional intent. Secondly, the State-specific method is an arbitrary and capricious approach lacking substantial evidence in the rulemaking record.[3]

The Medicare Contractor and Federal Specialized Services ("FSS") have not yet submitted their final position paper to the Board. Instead, FSS has submitted a request that the Board consider issuing an own-motion EJR because it does not think the Board has the authority to grant the relief sought. FSS has also asked for a postponement of its final position paper deadline until the EJR question is resolved.

BOARD'S DECISION

Jurisdiction

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2007), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date the notice of the intermediary's determination was mailed to the provider.

Jurisdictional Challenge in Case No. 11-0610GC

7 challenged providers: Appeal from untimely NPR "premature"

The Medicare Contractor has challenged jurisdiction over seven Providers in case number 11-0610GC based on the argument that their appeals from the untimely issuance of NPRs is "premature." The challenged Providers filed their appeal requests in accordance with 42 C.F.R.

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[1] Providers' Final Position Paper at 2-3.
[2] *Id.* at 4-6.
[3] *Id.* at 7.

§ 405.1835(a)(3)(ii) which allows a provider to file an appeal request if the Medicare contractor has not issued a final determination within 12 months of the date of receipt of the provider's perfected cost report. However, each of the 7 challenged Providers filed an **amended** cost report which the Medicare Contractor accepted. According to the Medicare Contractor, the Providers must have filed appeal requests based on those amended cost reports and have not.

Provider Number	Provider Name	Amended Cost Report Received	End of 12 month period
05-0036	Bakersfield Memorial Hospital	10/22/2010	10/22/2011
05-0149	California Hospital Med. Center	5/1/2012	5/1/2013
05-0242	Dominican Santa Cruz Hospital	12/21/2012	12/21/2013
05-0058	Glendale Memorial Hospital	8/15/2011	8/15/2012
05-0017	Mercy General Hospital	7/23/2013	7/23/2014
05-0444	Mercy Medical Center Merced	9/27/2010	9/27/2011
05-0191	St. Mary's Med. Ctr. – Long Beach	12/2/2010	12/2/2011

Each of the Providers filed their appeal request with the Board on **May 19, 2011**. These appeal requests were all submitted prior to the end of the 12-month period the Medicare Contractor had to issue a final determination based on the **amended** cost reports. The Medicare Contractor argues that the Providers must meet the timely filing requirements based on the **amended** cost reports, which the Providers did not do.

Board's Decision

The Board finds that it does not have jurisdiction over the seven challenged Providers. The Providers, above, filed their appeals from the submission of the as-filed cost report, as identified on the model form used to establish an individual case or addition to the group. None of the Providers filed appeals from the submission of their amended cost reports.

The Board finds that the amended cost report replaces and supersedes the originally filed cost report (*e.g.*, if the provider drops a cost or a protested item in the amended cost report that had been in the original, then the provider's rights relative to that cost or protested item are extinguished). To this end, the Medicare Contractor will only issue a final determination on the most recently filed and accepted cost report. So where a provider files an amended cost report that is accepted, the Medicare Contractor will not issue a final determination for any previously filed cost report.[4]

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

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

Based on this rationale, the Board finds that it does not have jurisdiction over the seven Providers that filed appeals based on as-filed cost reports but subsequently submitted amended cost reports that were accepted.

Two challenged Providers: NPR didn't adjust or protest issue

Two Providers in this group appeal filed their appeal requests based on NPRs: Mercy Hospital of Folsom (provider no. 05-0414, FYE 6/30/2009) and St. John's Pleasant Valley Hospital (provider no. 05-0616, FYE 6/30/2009). The Medicare Contractor argues that it does not have jurisdiction over these two Providers because their NPRs did not adjust the RFBNA reimbursement at issue, and the Providers did not file the issue under protest. The Medicare Contractor argues that the Board does not have jurisdiction over these two Providers because they have not met the requirements of 42 C.F.R. § 405.1835(a)(1).

Board's Decision

The Board finds that it does not have jurisdiction over the two challenged Providers. The Providers are appealing from 6/30/2009 cost reports, which means that they either had to claim the cost at issue or it is subject to the protest requirement in order for the Board to have jurisdiction.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination. The jurisdictional issue presented here is whether or not these hospitals have preserved their rights to claim dissatisfaction with the amount of Medicare payment. "A provider. . . has a right to a Board hearing . . . only if – (1) the provider **has preserved its right to claim dissatisfaction . . . by . . . [i]ncluding a claim for specific item(s) on its cost report . . . or . . . self-disallowing the specific item(s) by . . . filing a cost report under protest.**[5]

The Board finds that it does not have jurisdiction over these two challenged Providers because

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separate process from filing an amended cost report.
[5] 42 C.F.R. § 405.1835(a) (emphasis added).

they did not claim the within-state budget neutrality or protest the claim on their cost reports pursuant to 42 C.F.R. § 405.1835(a)(1)(ii).

Jurisdictional Challenge in Case No. 12-0340GC

11 challenged providers: Appeal from untimely NPR "premature"

The Medicare Contractor has made the same challenges over Providers in case number 12-0340GC as it made in case no. 11-0610GC. It first argues that the Board does not have jurisdiction over 11 Providers that appealed from the untimely issuance of a final determination from their as filed cost reports, but then later submitted amended cost reports.

Provider Number	Provider Name	Amended Cost Report Received	End of 12 month period
05-0036	Bakersfield Memorial Hospital	8/18/2011	8/18/2012
05-0149	California Hospital Medical Ctr.	5/1/2012	5/1/2013
05-0058	Glendale Memorial Hospital	3/12/2012	3/12/2013
05-0017	Mercy General Hospital	7/16/2013	7/16/2014
05-0295	Mercy Hospital Bakersfield	9/15/2011	9/15/2012
05-0444	Mercy Medical Center Merced	8/15/2011	8/15/2012
05-0280	Mercy Medical Center Redding	6/21/2011	6/21/2012
05-0152	Saint Francis Memorial Center	10/24/2011	10/24/2012
05-0129	St. Bernadine Medical Center	9/20/2011	9/20/2012
05-0042	St. Elizabeth Community Hospital	6/21/2011	6/21/2012
05-0084	St. Joseph's Medical Center	9/13/2011	9/13/2012

Each of the Providers filed their appeal request with the Board on **May 11, 2012**. These appeal requests were all submitted prior to the end of the 12-month period the Medicare Contractor had to issue a final determination based on the amended cost reports. The Medicare Contractor argues that the Providers must meet the timely filing requirements based on the amended cost reports, which the Providers did not do.

Board's Decision

The Board finds that it does not have jurisdiction over the eleven challenged Providers based on

the same rationale discussed above. The Providers filed their appeals from the submission of the as-filed cost report, as identified on the model form used to establish an individual case or addition to the group. None of the Providers filed appeals from the submission of their amended cost reports.

Two challenged Providers: NPR didn't adjust or protest issue

Two Providers in this group appeal filed their appeal requests based on NPRs: Mercy Hospital of Folsom (provider no. 05-0414, FYE 6/30/2010) and St. John's Pleasant Valley Hospital (provider no. 05-0616, FYE 6/30/2010). The Medicare Contractor argues that it does not have jurisdiction over these two Providers because their NPRs did not adjust the RFBNA reimbursement at issue, and the Providers did not file the issue under protest. The Medicare Contractor argues that the Board does not have jurisdiction over these two Providers because they have not met the requirements of 42 C.F.R. § 405.1835(a)(1).

Board's Decision

The Board finds that it does not have jurisdiction over the two challenged Providers. The Providers are appealing from 6/30/2009 cost reports, which means that they either had to claim the cost at issue or it is subject to the protest requirement in order for the Board to have jurisdiction. The two challenged Providers did not claim the RFBNA reimbursement at issue and did not file the claim under protest on their cost reports. Therefore, the Board finds that the two Providers did not meet the requirements of 42 C.F.R. § 405.1835(a)(1).

EXPEDITED JUDICIAL REVIEW

The regulation at 42 C.F.R. § 405.1842(a) permits the Board to consider whether it lacks the authority to decide a legal question relevant to the matter at issue once it has made a finding that it has jurisdiction to conduct a hearing under the provisions of 42 C.F.R. §§ 405.1840(a) and 405.1837(a). As discussed above, the Board finds that it does not have jurisdiction over 9 providers in case number 11-0610GC and thirteen Providers in case number 12-0340GC. For the remaining Providers in case numbers 11-0610GC and 12-0340GC and the other ten group appeals at issue, the Board finds that it has jurisdiction but does not have the authority to grant the relief sought by the Providers.

The Providers' representative, Toyon Associates, Inc., originally requested EJR of these cases on November 30, 2016. The Board denied these requests on December 12, 2016 due to an insufficient EJR request. Subsequently, on December 28, 2016, the Board issued a letter to the parties indicating that it was considering whether the group appeal issue is suitable for EJR on its own motion and requesting comment. Toyon responded to this letter on January 27, 2017.
The statement of the issue in these group appeals reads:

> This is a challenge to the Centers for Medicare & Medicaid Services' ("CMS's") application of the statewide rural floor budget neutrality adjustment factor made to the federal fiscal year ("FFY") 2009 [and 2010] wage index used to determine inpatient prospective payment system payments to Medicare Providers. *See*

Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4410(a), 42 U.S.C. § 1395ww note.

Provider's Contentions

The Providers argue that the issue in these group appeals is suitable for EJR because the Board has jurisdiction over the Providers and issue but does not have the authority to grant the relief sought. The Providers contend that the application of the within-state (or statewide) rural floor budget neutrality adjustment for FFY 2009 and 2010 is contrary to the Medicare statute and that CMS promulgated that regulation in violation of the Administrative Procedures Act.[6]

The Providers have made three arguments against the within-state rural floor budget neutrality adjustment. First, the Providers argue that the adjustment is invalid because it conflicts with the language of § 4410(b) of the Balanced Budget Act of 1997 and congressional intent. Second, the Providers contend that CMS' adoption of the rule did not comply with the procedural requirements of the Administrative Procedures Act. Third, the Providers claim that the rule is arbitrary and capricious.[7]

According to the Providers, the within-state rural floor adjustment is contrary to statute because it applies the rural floor adjustment to hospitals that it should not have. Section 4410(b) of the Balanced Budget Act states that CMS is to apply the rural floor budget neutrality adjustment to hospitals not described in § 4410(a), which are: urban hospitals with a wage index below the rural floor and rural hospitals in the state where those urban hospitals are located. The Providers argue that they fall into the § 4410(a) and therefore should not have the within-state adjustment applied to them.[8]

The Providers next argue that the within-state RFBNA violated the Administrative Procedures Act (APA) because the proposed rule did not adequately describe "the terms or substance of the proposed rule or a description of the subjects and issues involved" pursuant to 5 USC § 553(b)(3). The proposed rule did not explain how it calculated the within state adjustment and did not explain any alternatives that were considered.[9]

Finally, the Providers contend that the rule is arbitrary and capricious because it leads to wide variations in the wage index in the same area, which the Providers argue is "a result that Congress does not favor."[10]

RFBNA Statutory and Regulatory Background

The Medicare program was established under Title XVIII of the Social Security Act, as amended ("Act"), to provide health insurance to eligible individuals. Title XVIII of the Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. The Centers for Medicare & Medicaid Services ("CMS"),

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[6] Provider's Response to EJR letter at 2.
[7] *Id.* at 9.
[8] *Id.* at 9-10.
[9] *Id.* at 10-11.
[10] *Id.* at 11.

formerly known as the Health Care Financing Administration ("HCFA"),[11] is the operating component of the Department of Health and Human Services ("DHHS") charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations know as fiscal intermediaries ("FIs") and Medicare Administrative Contractors ("MACs"). FIs and MACs determine payment amounts due the providers under Medicare law, regulation and interpretive guidelines published by CMS.[12]

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the Prospective Payment System (PPS). The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[13] This case involves the annual changes to the PPS rates for hospital inpatient operating costs (IPPS) and the methodology for determining those rates.

Standardized Amount

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 and they were used in computing 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). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that effects certain sources of 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.[14]

Section 1395ww (d)(3)(E) of the Act requires the Secretary from time-to-time to estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and non-labor-related amounts; only the portion considered the labor related amount is adjusted by the wage index. Section 1395ww(d)(3)(E) 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.[15]

Budget Neutrality

Budget neutrality is determined by comparing aggregate IPPS payments before and after making changes that are required to be budget neutral (i.e., reclassifying and recalibrating diagnostic related groups ("DRGs")). Outlier payments are also included in the simulations. 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

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[11] In 2001, the agency name was changed from HCFA to CMS.
[12] *See* 42 U.S.C. §§ 1395h and 1395kk-1; 42 C.F.R. §§ 413.20, 413.24.
[13] *See* 42 U.S.C. § 1395ww(d)(5).
[14] 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994).
[15] 71 Fed. Reg. 47870, 48146 (August 18, 2006).

adjustments.[16]

Beginning in FFY 2009, one of the fiscal years currently under appeal, the Secretary applied State level rural floor budget neutrality adjustments to the wage index. This method used a three-year phase-in, transitioning from the national budget neutrality adjustment to a State level budget neutrality adjustment. In FFY 2009, hospitals received a blended wage index that is 20 percent of the State-specific adjustment and 80 percent of a national adjustment to the wage index. In FFY 2010, the blended rate was 50 percent of a State level adjustment and 50 percent of a national adjustment; and for FFY 2011, the adjustment would be made using the State-specific approach entirely.[17] Congress preempted the Secretary's State-specific methodology in the Patient Protection and Affordable Care Act of 2010 (PPACA), Pub. L. No. 111-148. Section 3141 of PPACA restored a "uniform, national adjustment to the area wage index" for "all discharges occurring on or after October 1, 2010" (FFY 2011).

The within-state method was incorporated into the regulations at 42 C.F.R. § 412.64(e)(4) (2009) which provides:

> CMS makes an adjustment to the wage index to ensure that aggregate payments after implementation of the rural floor under section 4410 of the Balanced Budget Act of 1997 (Pub.L. 105–33) and the imputed floor under paragraph (h)(4) of this section are equal to the aggregate prospective payments that would have been made in the absence of such provisions. Beginning October 1, 2008, such adjustment will transition from a nationwide to a statewide adjustment, with a statewide adjustment fully in place by October 1, 2010.

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

Analysis and Decision

Board Finding Regarding Authority

Pursuant to 42 C.F.R. § 405.1867, the Board must comply with Title XVIII of the Act and its supporting regulations. The Providers contend that the application of the within-state (or statewide) rural floor budget neutrality adjustment for FFY 2009 and 2010 is contrary to the Medicare statute and that CMS promulgated that regulation in violation of the Administrative Procedures Act. The Board finds it lacks the authority to examine this legal question as it pertains to the issue in these group appeals.

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[16] *Id.* at 48147.
[17] 74 Fed. Reg. 43754, 43825-27 (Aug. 27, 2009); 75 Fed. Reg. 50042, 50160 (Aug. 16, 2010).

Conclusion

Regarding the own motion EJR, the Board finds that:

1) based upon the Providers' assertion regarding the invalidity of the within-state rural floor budget neutrality adjustment, there are no findings of fact for resolution by the Board;

2) it is bound by Title XVIII of the Social Security Act and the regulations issued thereunder; and

3) it is without the authority to decide the legal question of whether the within-state RFBN adjustment is valid.

Accordingly, the Board finds on its own motion that the challenge to CMS' application of the statewide rural floor budget neutrality adjustment factor for FFYs 2009 and 2010 properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants expedited judicial review on its own motion for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. The twelve above-referenced group appeals are hereby closed and removed from the Board's docket.

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

FOR THE BOARD

L. Sue Andersen, Esq.
Chairperson

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

cc: Evaline Alcantara, Appeals Coordinator – Jurisdiction E
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APR 11 2017

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RE: Rush University Medical Center
Provider No.: 14-0119
FYE: 6/30/02
PRRB Case No.: 06-0871

Dear Mr. Flynn and Ms. Hartley,

The Provider Reimbursement Review Board ("Board") has reviewed jurisdiction in the above-captioned appeal in response to the Provider's request that the Board reconsider its previous jurisdictional finding with respect to the Indirect Medical Education ("IME") Prior Year Resident-to-Bed Ratio issue in the appeal. The Board also revisited its previous jurisdictional finding with respect to the IME and the Direct Graduate Medical Education ("DGME") prior year and penultimate year FTE counts issues in the appeal. The Board's jurisdictional decision is set forth below.

Background

The parties submitted a Partial Administrative Resolution for this case on March 15, 2017. All of the issues in the appeal have been accounted for with the exception of the IME and DGME prior year and penultimate year FTE counts issues that remain open.[1]

The Board issued a jurisdictional decision in this case on December 22, 2015 that granted jurisdiction over the IME and DGME prior year and penultimate year FTE counts issue. The Board found that the prior and penultimate year FTE counts were raised in the appeal request, adjusted in the NPR, and briefed in the Provider's final position paper. In that same decision, the Board determined that it did not have jurisdiction over the IME prior year resident to bed ratio as the Provider failed to explain the facts or make any arguments with respect to the issue in its final position paper, and as such, had abandoned the issue. The Board dismissed the IME prior year resident to bed ratio from the appeal. In its Second Supplemental Position Paper submitted on October 18, 2016, the Provider requested that the Board reconsider its jurisdictional finding with respect to the IME Prior Year Resident-to-Bed Ratio issue and set forth several arguments in that regard.

[1] The remaining issues have either been resolved, withdrawn, transferred to group appeals, or dismissed by the Board on jurisdictional grounds.

Provider's Position on Board Jurisdiction over the IME Prior Year Resident-to-Bed Ratio

The Provider argues that the Board has the authority and discretion to reconsider its jurisdictional decision should it choose to do so. The Provider explains that it is important to confirm what issue has been appealed by the Provider. The Provider contends that though the exact wording has changed slightly between the February 20, 2006 hearing request to the October 18, 2016 supplemental position paper, the issue has always focused on the proper implementation of the prior administrative resolutions on the indirect medical education ("IME") calculations of the Provider's FY 2002 reimbursement.[2]

With respect to its November 1, 2006 final position paper, the Provider states that the issues identified by the Provider were not specific to the prior year resident-to-bed ratio, because the issues under appeal pertained to correct IME reimbursement and to correct implementation of the FY 1996 partial administrative resolutions. The prior year resident-to-bed ratio was one aspect, but not the only aspect, of the implementation of those issues. The Provider did not dispute the calculation of the prior year resident-to-bed ratio per se, but the input variables used in that calculation depended on the resolution of the issue actually under dispute – specifically, the proper implementation of the FY 1996 partial administrative resolutions.[3]

The Provider believes the Board parsed the Board's requirements too finely when it required the Provider's position paper to identify each and every way the proper implementation of the FY 1996 partial administrative resolutions would have resulted in recalculated reimbursement for the Provider's FY 2002 cost report. The Provider argues that Board Rule 8, containing specific requirements for "framing issues for adjustments involving multiple components", was inapplicable to the Provider in this case for at least two reasons. First, it was not in effect when the Provider initiated its FY 2002 appeal nor when the Provider filed it November 1, 2006 final position paper. Second, even if it did exist, the issue in dispute was still the proper implementation of the FY 1996 partial administrative resolutions and not the number of days, FTEs, beds or other factors used in the calculation of the prior year resident-to-bed ratio.[4]

The Provider contends that, given what the issue in dispute is, how that issue has been consistently framed in this appeal, and the Board's rules around issue identification, the Provider's appeal of the implementation of the FY 1996 partial administrative resolutions seeks a finding from the Board that the Medicare Contractor is, in fact, required to incorporate those prior resolutions into the Provider's FY 2002 IME reimbursement. The Board has already determined that it has jurisdiction over the Provider's appeal of this issue. Since the proper calculation of the prior year resident-to-bed ratio is but one of several aspects of the actual *effect* of this issue – i.e., a step to be taken in the correction of a finding of MAC error – the Provider believes the Board has the same jurisdiction over this step in the correction of the error as it does with steps the Board has confirmed it has jurisdiction to consider.[5]

The Provider argues that as it currently stands, the Board will be exercising jurisdiction over all of the variables for the calculation of the prior year resident-to-bed ratio, but not the ratio itself. This

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[2] Provider's Second Supplemental Position Paper at 8-9.
[3] Provider's Second Supplemental Position Paper at 10.
[4] Provider's Second Supplemental Position Paper at 11-12.
[5] Provider's Second Supplemental Position Paper at 12.

inconsistency cannot be reconciled with the facts and circumstances. The ratio is calculated for both the current year – FY 2002 – and for the prior year – FY 2001. The Board is exercising jurisdiction over the number of FTE residents for both the current year and the prior year. Thus, the ratio is merely a mathematical calculation using variables that are either not in dispute or over which the Board has jurisdiction. The calculation automatically flows from the inputting of corrected variables. In this case, the Board will be deciding on whether the variables are correct, but is restraining from exercising jurisdiction over the automatic calculation that flows from it. The Provider believes this jurisdictional "thin-slicing" exceeds the intent and express language of jurisdictional authority conferred upon the Board.[6]

Board's Decision

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

Board Jurisdiction over the IME Prior Year Resident to Bed Ratio

The Board reaffirms its December 22, 2015 jurisdictional decision that the Provider failed to explain the facts or make any arguments with respect to the IME Prior Year Resident-to-Bed Ratio issue in its final position paper. The Provider's final position paper addressed the rolling average, however the Prior Year Resident-to-Bed Ratio is not part of the rolling average. As the IME Prior Year Resident- to-Bed Ratio was not briefed, the Board considered the issue to be abandoned. Board Rule 41.2 states that the Board may dismiss an issue on its own motion if it has a reasonable basis to believe that the issue has been fully settled or abandoned.

Furthermore the Board rejects the Provider's argument that the Board will be exercising jurisdiction over all of the variables for the calculation of the IME Prior Year Resident-to-Bed Ratio, but not the ratio itself. The Partial Administrative Resolution submitted for this case states that the current year IME FTE counts issues were withdrawn. And as noted below, the Board finds that it does not have jurisdiction over the prior year IME FTE counts (FY 2001) as the current year IME FTE counts for FY 2001were never appealed.

Board Jurisdiction over the IME and DGME Prior Year and Penultimate Year FTE Counts

In the December 10, 2013 Federal Register, the Secretary announced the "Clarification of Reopening of Predicate Facts in Intermediary Determinations of Provider Reimbursement (§ 405.1885)." [7] The Secretary noted that factual underpinnings of a specific determination of the amount of reimbursement due a provider may arise in the cost reporting period that forms the basis for the determination, for example the calculation of the disproportionate share adjustment. In the alternative, the factual underpinnings of a specific determination may first arise in or be determined for a

[6] Provider's Second Supplemental Position Paper at 12-13.
[7] 78 Fed. Reg. 74826, 75162 (December 10, 2013).

different fiscal period than the cost reporting period under review. Factual determinations made in another cost reporting period are referred to as "predicate facts."

The predicate facts in this case relate to IME and DGME FTE counts determined in an earlier cost reporting period, specifically the prior year and the penultimate year. With respect to IME and DGME costs, the predicate facts were determined based on information from an earlier cost reporting period, and then applied as part of the reimbursement formula for several fiscal periods thereafter. The facts are not reevaluated annually to determine whether they support the determination that a particular cost is reasonable because the formula is a proxy for reasonable costs. Instead, the formula itself will provide for changes in costs through an updating factor or otherwise.[8]

The Secretary noted that a specific matter at issue may involve a predicate fact that first arose in, or was determined for, an earlier fiscal period and that factual data could be used differently or applied to different reimbursement in one or more later fiscal periods. She noted that the "longstanding policy, interpretation and practice" is that the relevant provisions of the statute and regulations provide for review and potential redetermination of such facts only where there is a timely appeal or reopening of: (1) the NPR for the cost reporting period in which the predicate fact first arose or was determined; or (2) the NPR for the period for which such predicate fact was first used or applied by the intermediary to determine reimbursement.[9]

The Secretary explained that if a provider disputes a base period cost determination, it can either appeal the determination or seek a reopening of its cost report. Unless the appeal or reopening results in a different finding as to the predicate fact in question, there cannot be a finding as to the predicate fact in the base period and a different finding about the same fact in a later cost reporting period. Once the 3-year reopening period for revision of a final determination has expired,[10] neither the intermediary nor provider can revisit the predicate fact in the base period that was not changed through appeal or reopening.[11]

This change to the regulation was the result of the decision in *Kaiser Foundation Hospitals*. In that case, the Court held that providers could appeal predicate facts even though such predicate facts were not timely appealed or reopened for the periods where they first arose or were first applied to determine the providers' reimbursement. The Court held that the reopening regulation allows for modification of predicate facts in closed years provided the change will only impact the total reimbursement determination in open years.[12] The Court concluded that the Secretary acted arbitrarily in treating similarly situated parties differently and noted that the Secretary routinely championed a permissive interpretation of the reopening regulations when correction of predicate facts resulted in a windfall to the agency.[13]

The changes to 42 C.F.R. § 405.1885, effectuating the above considerations, were effective for appeals or reopening requests pending on or after the effective date of the final rule even if the intermediary determination preceded the effective date of the rule. The Secretary also stated that if the revisions to § 405.1885 were deemed retroactive, she would consider the retroactive application necessary to comply

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[8] *Id.* at 75163.
[9] *Id.* at 75163-75.
[10] *See* 42 C.F.R. § 405.1885(2008).
[11] 78 Fed. Reg. at 75163.
[12] *Kaiser* at 232-233.
[13] *Id.*

with the statutory requirements and failing to take such action would be contrary to the public interest.[14] The effective date of the regulation was January 27, 2014.[15]

In a jurisdictional decision issued June 16, 2016 for PRRB Case No. 07-1187, Rush University Medical Center's FYE 6/30/2003 appeal, the Board concluded that it did not have jurisdiction over the Penultimate Year (FYE 6/30/01) IME and DGME FTE Counts as the Board found that a predicate fact issue existed, i.e. the Provider did not appeal the current year IME and DGME FTE Counts in FY 2001. As a result, the Board draws the same conclusion with respect to the Prior Year IME and DGME FTE Counts (FYE 6/30/01) in this FYE 6/30/02 appeal and determines that it does not have jurisdiction over the issue.

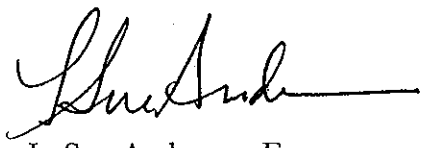
Additionally, the Board finds that a predicate fact issue also exists for the penultimate year, FYE 6/30/00. The Provider withdrew its FY 6/30/00 appeal (PRRB Case No. 04-1267) entirely via a letter submitted to the Board on July 31, 2015. Thus, the Provider has no appeal of current year IME and DGME FTE Counts in FYE 6/30/00. As such, the Board concludes that it does not have jurisdiction over the Penultimate Year IME and DGME FTE Counts in this FYE 6/30/02 appeal.

As a result, the Board concludes that the Provider has no basis upon which to base its current appeal of the IME and DGME Prior Year and Penultimate Year FTE Counts and dismisses the issues from the appeal. As no issues remain in the case, the Board closes the case and removes it from the Board's docket.

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

Board Members Participating:
L. Sue Andersen, Esq.
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler

FOR THE BOARD



L. Sue Andersen, Esq.
Chairperson

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

cc: Federal Specialized Services
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[14] 78 Fed. Reg. at 75165.
[15] *Id.* at 75195.

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Refer to: 16-1497

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RE: Jurisdictional Decision
Provider No.: 14-5734
PRRB Case No.: 16-1497
FYE: 12/31/2013

Dear Ms. Zoellick and Ms. Hartley:

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

Background

The Villa at Evergreen Park ("the Provider") was issued a Notice of Program Reimbursement ("NPR") for fiscal year end ("FYE") 12/31/2013 on September 29, 2015.

On April 5, 2016, the Provider requested a reopening ("Reopening Request") of the cost report for review of the Medicare bad debts adjustment. The Medicare Contractor considered and denied the Reopening Request the same day it was received, i.e., April 5, 2016.

The Provider filed an appeal with the Board on April 20, 2016 - 204 days after the issuance of the NPR and 15 days after the issuance of the Reopening Request denial. In its appeal request, the Provider acknowledges that the appeal was untimely filed and requests that the Board find that it meets the criteria for a good cause extension of the filing deadline.[1]

The Provider asserts that it would have filed a timely appeal if it had known that the Medicare Contractor was going to deny its Reopening Request, and states the Reopening Request denial "came just days after the 180 day deadline."[2]

[1] Provider's letter to Board dated April 18, 2016.
[2] *Id.*

Medicare Contractor's Contentions

On June 20, 2016, the Medicare Contractor filed a Jurisdictional Challenge ("Challenge") in which it argues that the Board lacks jurisdiction over this case because the appeal was not timely filed.[3] The Medicare Contractor also contends that the Provider does not meet the criteria for a good cause extension of the filing deadline.[4] The Medicare Contractor notes that its denial of the Reopening Request was issued after the appeal deadline for this case because the Provider's Reopening Request was filed four days after the expiration of the appeal filing deadline.[5]

The Medicare Contractor further claims that "the Board does not have jurisdiction over this case [because] the appeal is based on a denial of a reopening."[6]

Board's Decision

The Board finds that it does not have jurisdiction over this appeal because the Provider did not timely file its appeal and does not qualify for a good cause extension. Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. § 405.1835(a)(3), unless the Provider qualifies for a good cause extension, the Board must receive a Provider's hearing request no later than 180 days after the date of receipt of the final determination, with a five-day presumption for mailing.

As noted above, the Provider's NPR was issued on September 29, 2015. An appeal of that final determination was due to be filed with the Board within 180 days after issuance of the NPR, including a five-day mailing presumption, i.e., on or before April 1, 2016. However, the Provider filed its appeal on April 20, 2016 – 204 days after issuance of its NPR. As previously stated, the Provider concedes that its appeal was filed untimely.[7] Therefore, the Board finds that the appeal was not timely filed.

The Board further finds that the Provider failed to meet the good cause extension standard enunciated in 42 C.F.R. § 405.1836(b), which states that "[t]he Board may find good cause to extend the time limit only if the provider demonstrates in writing it could not reasonably be expected to file timely due to extraordinary circumstances beyond its control (such as a natural or other catastrophe, fire, or strike) ...."[8]

As noted above, the Provider asserts that it would have filed a timely appeal if it had known that the Medicare Contractor was going to deny its Reopening Request.[9] The Board finds that the Provider's explanation does not rise to the level of the good cause criteria cited above. Indeed, this explanation is particularly unavailing since the Provider states that the Reopening Request denial "came just days after the 180 day deadline" when in fact the Reopening Request is dated

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[3] Challenge at 2-3.
[4] Challenge at 3.
[5] *Id.*
[6] *Id.*
[7] *Id.*
[8] 42 C.F.R. § 405.1836(b)(2008)(emphasis added).
[9] Provider's letter to Board dated April 18, 2016.

four days after the appeal deadline, i.e., April 5, 2016. The Provider could not reasonably believe that it would receive a decision regarding its Reopening Request prior to the appeal deadline when it filed the Reopening Request after the appeal deadline expired. Thus, the Board finds that the Provider failed to demonstrate that it could not reasonably be expected to file timely due to extraordinary circumstances beyond its control.

Finally, the Medicare Contractor asserts that the Provider's "appeal is based on a denial of a reopening."[10] Although the Provider's appeal seems to reference the denial of its Reopening Request as a basis for receiving a good cause extension, to the extent that the Provider seeks review of the denial of its Reopening Request, the Board reiterates its longstanding policy that the Board may not review a Medicare contractor's denial of a reopening request.[11]

Because the appeal request was not received by the Board within 180 days as required by 42 C.F.R. § 405.1835(a)(3), the Board finds that it was not timely filed. Moreover, the Board finds that the Provider failed to demonstrate that it could not reasonably be expected to file timely due to extraordinary circumstances beyond its control. As such, the Board hereby: 1) denies the Provider's request for a good cause extension; and 2) dismisses this appeal.

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

Board Members Participating
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Gregory H. Ziegler

FOR THE BOARD

L. Sue Andersen, Esq.
Chairperson

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

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

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[10] Challenge at 3.

[11] *See Your Home Visiting Nurse Services, Inc. v. Shalala*, 119 S.Ct. 930, (1999)(holding that the Board does not have jurisdiction to review a Medicare contractor's refusal to reopen a reimbursement determination); 42 C.F.R. § 405.1885(c) ("jurisdiction for reopening an intermediary determination ... rests exclusively with the intermediary..."); 42 C.F.R. § 405.1885(a) (6) (reopening denial is "not a final determination ... and is not subject to further administrative or judicial review").

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Refer to: 17-0600

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APR 11 2017

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Byron Lamprecht
Cost Report Appeals
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RE: Jurisdictional Decision
Provider: Southeast Michigan Surgical Hospital
Provider No.: 23-0264
FYE: 12/31/2017
PRRB Case No: 17-0600

Dear Ms. Doetzkies and Mr. Lamprecht:

The Provider Reimbursement Review Board ("the Board") has reviewed the jurisdictional documents in the above-referenced case. For the reasons stated below, the Board: 1) finds that it lacks jurisdiction over this appeal wherein the amount in controversy is $1,300; and 2) refers the appeal request to the Medicare Contractor Hearing Officer for consideration.

Background

In a decision dated March 14, 2016, the Centers for Medicare and Medicaid Services ("CMS") informed Southeast Michigan Surgical Hospital ("the Provider") that it failed to fully meet the requirements of the Hospital Inpatient Quality Reporting ("IQR") Program with regard to emergency department ("ED") information.[1] As a result, the Provider received a one-fourth reduction of its annual payment update ("APU") for Fiscal Year ("FY") 2017.[2]

In response to CMS's decision, the Provider filed an APU Reconsideration Request Form ("Reconsideration Request") in which it stated that it does not have an ED.[3] The Provider further stated that despite the fact that it does not have an ED, it was informed that it must nevertheless provide ED data to comply with the IQR.[4] The Provider explained that it attempted to submit ED data as instructed by the contractor that manages online IQR reporting for CMS, but that it was unable to do so due to technological problems despite numerous contacts with the contractor.[5]

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[1] Provider's Appeal Request to Board, Tab 3, Attachment L at 1-2.
[2] *Id.*
[3] Provider's Appeal Request to Board, Tab 3, Attachment M at 2.
[4] *Id.*
[5] *Id., see also* Provider's Appeal Request, Tab 3, 1-4; Attachments B-K.

CMS upheld the one-fourth reduction of the Provider's APU for FY 2017 in a decision dated June 21, 2016 ("Decision"). In the Decision, CMS informs the Provider that it "may appeal this decision through the Provider Reimbursement Review Board (["Board"]) within 180 days of the date of this letter."[6]

On December 9, 2016, the Board received the Provider's appeal of CMS's Decision to uphold the reduction.

Medicare Contractor's Contentions

On December 16, 2016, the Medicare Contractor filed a Jurisdictional Challenge ("Challenge") in which it argues that the Board lacks jurisdiction over this case because the amount in controversy does not meet the $10,000 threshold established by 42 C.F.R. § 405.1835(a)(2).[7]

Decision of the Board

The Board finds that it does not have jurisdiction over this appeal because it does not meet the $10,000 threshold required for Board jurisdiction. Pursuant to 42 U.S.C. § 1395oo(a)(2) and 42 C.F.R. § 405.1835(a)(2), a provider has a right to a hearing before the Board with respect to a final contractor or Secretary determination if: 1) it is dissatisfied with the final determination of the total amount of reimbursement due the provider; 2) the amount in controversy is $10,000 or more; and 3) the request for a hearing is received by the Board within 180 days of the date of receipt of the final determination.

Based on the Provider's appeal request, it is clear that the amount in controversy in this case, $1,300, does not meet the $10,000 threshold required for an individual appeal.[8] Therefore, the Board finds that it lacks jurisdiction over this case and dismisses the above-referenced appeal for failure to comply with the amount in controversy requirement.

However, since the amount in controversy in this appeal is at least $1,000, but less than $10,000, the Provider may be entitled to a hearing before a Medicare Contractor Hearing Officer pursuant to 42 C.F.R. § 405.1809. As noted above, the Decision upon which this appeal is based informs the Provider that it "may appeal [the] decision through the ... Board" but fails to note that appeals involving an amount in controversy of at least $1,000 but less than $10,000 should be filed with a Medicare contractor Hearing Officer.[9]

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[6] Provider's Appeal Request to Board, Tab 1 at 1.
[7] Challenge at 1.
[8] Appeal request at 3, 7.
[9] Provider's Appeal Request to Board, Tab 1 at 1.

Due to the Decision's lack of instruction as to the proper venue based on the amount in controversy thresholds and the Provider's well-documented good-faith effort to comply with the IQR, the Board hereby refers the appeal request to the Medicare Contractor Hearing Officer at the following address:

Federal Specialized Services
1701 S. Racine Avenue
Chicago, IL 60608-4058
intermediary@fssappeals.com

Thus, for the reasons stated above, the Board finds that it lacks jurisdiction over this appeal because the amount in controversy requirements of 42 U.S.C. § 1395oo (a)(2) and 42 C.F.R. § 405.1835(a)(2) have not been met. The Board therefore: 1) dismisses the appeal; and 2) refers the appeal to the Medicare Contractor Hearing Officer for consideration.

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

Board Members Participating
L. Sue Andersen, Esq.
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA
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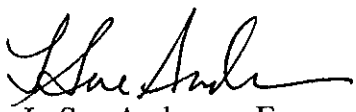
FOR THE BOARD



L. Sue Andersen, Esq.
Chairperson

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

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

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

APR 11 2017

Mark D. Polston, Esq.
King & Spalding, LLP
1700 Pennsylvania Avenue, NW
Washington, D.C. 20006-4706

RE: King & Spalding 2017 2-Midnight IPPS Rate Appeals
FFY 2017
PRRB Case Nos. 17-0870GC, 17-0871GC,17-0875GC, 17-0876GC, 17-0881GC, 17-0882GC, 17-0883GC, 17-0884GC, 17-0885GC, 17-0886GC, 17-0887GC, 17-0888GC, 17-0889GC, 17-0890GC, 17-0891GC, 17-0892GC, 17-0905GC, 17-0906G, 17-0914GC, 17-0915GC, 17-0916GC, 17-0917GC, 17-0918GC, 17-0920GC, 17-0921GC, 17-0922GC

Dear Mr. Polston:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' March 15, 2017 request for expedited judicial review (EJR) (received March 16, 2017) submitted in the above-referenced appeals. The decision of the Board is set forth below.

Issue under Dispute

Whether the Secretary[1] acted arbitrarily and capriciously, and violated the Administrative Procedure Act [(APA)] by failing to adopt a permanent and positive adjustment to the [F]ederal fiscal year [(FFY)] 2017 Inpatient Prospective Payment System [(IPPS)] rates, 81 Fed. Reg. 56,760 (Aug. 22, 2016), to offset the aggregate decline in IPPS payments resulting from the Two-Midnight inpatient coverage rule.[2]

Statutory and Regulatory Background

In the final IPPS rule for FFY 2014, the Secretary indicated that she had expressed concern in the proposed calendar year (CY) Outpatient PPS (OPPS) rule[3] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving observation services. In recent years, the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours increased from approximately 3 percent in 2006 to 8 percent in 2011. This raised a concern about the financial impact on Medicare beneficiaries who may incur greater financial liability than they would if they were admitted to the hospital as inpatients.[4]

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[1] of the Department of Health and Human Services.
[2] Providers' March 15, 2017 EJR Request at 3.
[3] 77 Fed. Reg. 45,061, 45,155-57 (July 30, 2012) and the final rule with comment period, 77 Fed. Reg. 68,210, 68,426-33 (Nov. 15, 2012).
[4] 78 Fed. Reg. 50,496, 50,907 (Aug. 19, 2013).

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

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

Medicare Part A

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

In the FFY 2014 IPPS proposed rule,[9] the Secretary proposed a new benchmark for purposes of medical review of hospital inpatient admissions (Medicare Part A payment). Under this proposal, beneficiaries who were expected to remain in the hospital to receive medically necessary care surpassing 2-midnights after the initiation of care would generally be appropriate for inpatient admission and inpatient payment (known as the "2-midnight rule"). Medicare contractors were to consider all the time after the initiation of care at the hospital in applying the

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

benchmark that inpatient admissions are generally reasonable and necessary (as long as a hospital was not prolonging the provision of care to surpass the 2-midnight timeframe).[10]

Medicare Part B

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

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

The 2-Midnight Rule

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

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

receive consistent application of their Part A benefits to whatever clinical services were medically necessary.[15]

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

The Secretary's actuaries estimated that the 2-midnight rule would increase IPPS expenditures by approximately $220 million. These additional expenditures would result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving from OPPS to IPPS and some encounters of less than 2 midnights moving from IPPS to OPPS. The actuaries estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient from the approximately 11 million encounters paid under IPPS. This shift of 40,000 net encounters represents an increase of approximately 1.2 percent in the number of shorter stay hospital inpatient encounters paid under IPPS. This additional expenditure would be partially offset by reduced expenditures from the shift of shorter stay hospital inpatient encounters to hospital outpatient encounters. The actuaries estimated that, on average, the per encounter payments for these hospital outpatient encounters would be approximately 30 percent of the per encounter payments for the inpatient encounters. In light of the impact of the 2-midnight rule on IPPS and the systematic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, the Secretary decided it was appropriate to use her exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i) to offset the $220 million in additional IPPS expenditures associated with the 2-midnight policy. Consequently, the standardized amount was reduced by 0.2 percent.[18] The Secretary made the same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[19] In the final IPPS rules for 2015 and 2016, the Secretary did not reverse the 0.2 percent reduction to the standardized amount made in 2014, and, therefore, continued to apply the contested reduction for the FFY 2015 and 2016 period.[20]

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[15] *Id.* at 50,944.
[16] *Id.*
[17] *Id.* at 50,945.
[18] *Id.* at 50,952-53.
[19] *Id.* at 50,990.
[20] 79 Fed. Reg. 49,854, 50,011 (Aug. 22, 2014) and 80 Fed. Reg. 49,326, 49,593, 49,686 (Aug. 17, 2015).

In the FFY 2017 Final IPPS Rule, the Secretary announced that she proposed to permanently remove the 0.2 percent reduction to IPPS and to provide a temporary one-time prospective increase to the FY 2017 of 0.6 percent in the standardized amount to retroactively correct for the 0.2 percent reductions in FYs 2014, 2015 and 2016.[21]

Providers' EJR Request

The Providers explain that the Secretary has discontinued the 0.2 percent negative adjustment in the FFY 2017 IPPS Rules and adopted a 0.6 percent increase in the IPPS rates, to "address the effects" of the 0.2 percent rate cut in FFYs 2014, 2015 and 2016.[22] These actions do not address the Providers' claims in these appeals. The Providers are seeking a rate increase above the published rates to offset the alleged decline in IPPS expenditures which the Secretary purportedly ignored in FFY 2014 and has continued to ignore in subsequent years, including FFY 2017.

The Providers contend that the Secretary's alleged decision to ignore the data in front of him and his failure to adopt an upward adjustment to PPS payments in FFY 2017 violates the APA in several respects. The Providers assert that the Secretary has failed to provide a reasoned basis that would explain his decision to depart from his policy to use his adjustment authority to offset predictable changes brought about by the 2-midnight rule that are of sufficient magnitude and breadth to significantly impact IPPS. In the FFY 2014 IPPS rulemaking, the Secretary reviewed the Medicare claims data to predict the effect the 2-midnight policy would have on aggregate Medicare payments. The Providers point out that the Secretary incorrectly predicted that the 2-midnight rule would increase the net number of inpatient stays paid under Part A, resulting in a $220 million annual aggregate increase in Part A (IPPS) payments. The Secretary concluded that this estimate was of "sufficient magnitude and breadth to significantly impact the IPPS" and that it would be inappropriate to ignore in the development of IPPS rates. The Secretary then invoked her authority and imposed a 0.2 percent negative rate of adjustment to offset his predicted impact.[23]

The Providers allege that the Medicare claims data show that the Secretary's estimate was wrong by a significant amount. In response to the FFY 2017 IPPS proposed rule, commenters provided the Secretary with their analysis of the Medicare data which shows that more than 1 million inpatient stays would be expected to convert to outpatient payments, not the 360,000 cases predicted by the Secretary. Assuming that the Secretary was correct, that approximately 400,000 outpatient cases would convert to inpatient cases under the 2-midnight rule, the data did not support a 40,000 case net increase in inpatient cases. Rather, the Providers argue, the data supported a net decrease in inpatient cases that is 10 times the magnitude of the net increase incorrectly estimated by the Secretary. Rather than supporting the $220 million annual increase in IPPS payments (and a 0.2 percent rate cut), the data supported an annual decrease in IPPS expenditures of 10 times that amount. Commenters provided the Secretary with actual Medicare data for inpatient admissions in FFYs 2014 and 2015 that confirm that there had been a

[21] 81 Fed. Reg. at 57,059-60.
[22] *Id.*
[23] 78 Fed. Reg. 50952-54.

substantial decline in inpatient cases and IPPS expenditures since the implementation of the 2-midnight policy.[24]

Further, the Providers note the final rule for 2017 did not adopt a permanent and significant upward adjustment (above and beyond the status quo that existed prior to FFY 2014) in order to offset the decline in IPPS expenditures caused by the 2-midnight rule. This, the Providers assert, runs counter to the Medicare data submitted to the Secretary. The Secretary declined to adopt a rate adjustment to offset the impact of the 2-midnight rule.[25]

The Providers assert that the Secretary's decision not to adopt a permanent and significant upward rate adjustment to the FFY 2017 IPPS rule violates the APA because the Secretary failed to respond to comments that pointed out that the data supported a rate increase above the status quo prior to FFY 2014.[26] The Providers are requesting EJR because the Board has jurisdiction over the appeals, but does not have the authority to grant the relief described above. The Board is bound by the FFY 2017 IPPS final rule published in the Federal Register.

Decision of the Board

The Board has reviewed the submissions of the Providers pertaining to the requests for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy for each group appeal exceeds $50,000, as required for a group appeal and the appeals were timely filed from the issuance of the August 22, 2016 Federal Register.[27, 28] The estimated amount in controversy is subject to recalculation by the Medicare Administrative Contractor for the actual final amount in each case.

The Board finds that:

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

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

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[24] Providers' EJR Request at 6.
[25] 81 Fed. Reg. at 57,059-60.
[26] Providers' EJR Request at 7.
[27] *See District of Columbia Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993), *Medicare and Medicaid Guide (CCH)* ¶ 41,025 (the Administrator held that the publication of the wage index in the Federal Register was a final determination which can be appealed to the Board).
[28] The Board notes that one or more of the participants in these group appeals have cost report periods beginning on or after January 1, 2016, which would subject their appeals to the newly-added 42 C.F.R. § 405.1873 and the related revisions to 42 C.F.R. § 413.24(j) regarding submission of cost reports. *See* 80 Fed. Reg. 70298, 70555-70604 (Nov. 13, 2015). However, the Board notes that § 405.1873(b) has not been triggered because neither party has questioned whether any provider's cost report included an appropriate claim for the specific item under appeal. *See* 80 Fed. Reg. at 70556.

3) it is without the authority to decide the legal question of whether the Secretary's decision not to adopt a permanent and significant upward rate adjustment to the FFY 2017 IPPS rule violates the APA as it failed to respond to comments that data supported a rate increase beyond the status quo..

Accordingly, the Board finds that the above identified challenge to the FFY-17 2-midnight rule falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for expedited judicial review for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the cases.

Board Members Participating

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

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

cc: Byron Lamprecht, WPS (Certified Mail w/Schedules of Providers)
Bill Tisdale, Novitas Solutions (Certified Mail w/Schedules of Providers)
Pam Van Arsdale, NGS (Certified Mail w/Schedules of Providers)
Geoff Pike, First Coast Service Options (Certified Mail w/Schedules of Providers)
Laurie Polson, Palmetto GBS c/o NGS (Certified Mail w/Schedules of Providers)
Barb Hinkle, Cahaba GBA c/o NGS (Certified Mail w/Schedules of Providers)
James Ward, Noridian Healthcare Solutions (Certified Mail w/Schedules of Providers)
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APR 12 2017

Christopher L. Keough, Esq.
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Robert S. Strauss Building
1333 New Hampshire Avenue, N.W.
Washington, D.C. 20036-1564

RE: Southwest Consulting DSH Part C Days Groups
FYEs Various
PRRB Case Nos. 13-3568GC, 13-3569GC, 14-1448GC, 14-1450GC, 14-1725GC, 14-1726GC, 14-1771GC, 14-1772GC, 14-2189GC, 14-2960GC, 14-2961GC, 14-3060GC, 14-3061GC, 14-3451GC, 14-3454GC, 14-3494GC, 14-3495GC, 14-3966GC, 14-3970GC, 14-4038GC, 14-4039GC

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' March 20, 2017 request for expedited judicial review (EJR) (received March 21, 2017) for the above-referenced appeals. The Board's determination is set forth below.

The issue in these cases is:

> Whether the Medicare Part C patients are 'entitled to benefits' under Part A, such that they should be counted in the Medicare Part A/SSI fraction and excluded from the Medicaid fraction numerator [of the disproportionate share hospital (DSH) adjustment] or vice-versa.[1]

Statutory and Regulatory Background: Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system (PPS).[2] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[3]

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[1] Providers' March 20, 2017 EJR Request at 4.
[2] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[3] *Id.*

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[4] These cases involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients. [5]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage (DPP).[6] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[7] The DPP is defined as the sum of two fractions expressed as percentages.[8] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), defines the Medicare/SSI fraction as:

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

The Medicare/SSI fraction is computed annually by CMS, and the Medicare Administrative Contractors (MACs) use CMS' calculation to compute a hospital's DSH payment adjustment.[9]

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), defines the Medicaid fraction as:

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

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[4] *See* 42 U.S.C. § 1395ww(d)(5).
[5] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] 42 C.F.R. § 412.106(b)(2)-(3).

The MAC determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare part A, and divides that number by the total number of patient days in the same period.[10]

Medicare Advantage Program

The Medicare program permits its beneficiaries to receive services from managed care entities. The managed care statute implementing payments to health maintenance organizations (HMOs) and competitive medical plans (CMPs) is found at 42 U.S.C. § 1395mm. The statute at 42 U.S.C. § 1395mm(a)(5) provides for "payment to the eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter. . ." Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days

In the September 4, 1990 Federal Register, the Secretary[11] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[12]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[13]

With the creation of Medicare Part C in 1997,[14] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their

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[10] 42 C.F.R. § 412.106(b)(4).
[11] of Health and Human Services
[12] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).
[13] *Id.*
[14] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in

care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the intermediaries to calculate DSH payments for the FY 2001-2004.[15]

No further guidance regarding the treatment of Part C days in the DSH calculation was provided until the 2004 Inpatient Prospective Payment System (IPPS) proposed rules were published in the Federal Register. In that notice the Secretary stated that:

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicare fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction* . . . (emphasis added)[16]

The Secretary purportedly changed her position in the FFY 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[17] In response to a comment regarding this change, the Secretary explained that:

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A.* We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our

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Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.

[15] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).

[16] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).

[17] 69 Fed. Reg. at 49,099.

> regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[18] (emphasis added)

This statement would require inclusion of Medicare Part C inpatient days in the Medicare fraction of the DSH calculation.

Although the change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the Federal fiscal year (FFY) 2008 final rule was issued.[19] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule. As a result, Part C days were required to be included in the Medicare fraction as of October 1, 2004.

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius,*[20] vacated the FFY 2005 IPPS rule. However, the Providers point out, the decision is not binding in actions by other hospitals. Further, the Secretary has not acquiesced to that decision.[21]

Providers' Request for EJR

The issue under appeal in these cases involves the question of whether Medicare Part C patients are "entitled to benefits" under Part A, thereby requiring them to be counted in the Medicare Part A/SSI fraction and excluded from the Medicaid fraction numerator or vice versa.

Prior to 2004, the Secretary treated Part C patients as not entitled to benefits under Part A. From 1986-2004, the Secretary interpreted the term "entitled to benefits under Part A" to mean covered or paid by Medicare Part A. In the final rule for the FFY 2005, the Secretary reversed course and announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective October 1, 2004.[22]

In *Allina*, the Court affirmed the district court's decision "that the Secretary's final rule was not a logical outgrowth of the proposed rule."[23] Because the Secretary has not acquiesced to the decision, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

In these cases, the Providers contend that all Part C days should be excluded from the Part A/SSI fraction and the Medicaid-eligible Part C days should be included in the numerator of the

---

[18] *Id.*
[19] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[20] 746 F. 3d 1102 (D.C. Cir. 2014).
[21] Providers' EJR request at 1.
[22] 69 Fed. Reg. at 49,099.
[23] *Allina* at 1109.

Medicaid fraction. To obtain relief, the Providers seek a ruling on the procedural and substantive validity of the 2004 rule that the Board lacks the authority to grant. Since the Secretary has not acquiesced to the decision in *Allina*, the Board remains bound by the regulation. Hence, EJR is appropriate.

Decision of the Board

The Board has reviewed the submissions of the Providers pertaining to the requests for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy for each group appeal exceeds $50,000, as required for a group appeal and the appeals were timely filed from the issuance of the Providers' original Notices of Program Reimbursement. In these cases, the Providers protested the Medicare Part C day issue as required by the regulation, 42 C.F.R. § 405.1835(a)(1)(iii) and/or the Providers have an adjustment to the Supplement Security Income calculation which is reflected on their audit adjustment report. The estimated amount in controversy is subject to recalculation by the Medicare Administrative Contractor for the actual final amount in each case.

The Board finds that:

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

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

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

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for expedited judicial review for the issue and the subject year. The

Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the cases.

Board Members Participating

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

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

cc: Bill Tisdale, Novitas Solutions (Certified Mail w/Schedule of Providers)
Byron Lamprecht, WPS (Certified Mail w/Schedule of Providers)
Pam Van Arsdale, NGS (Certified Mail w/Schedule of Providers)
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APR 1 2 2017

Christopher L. Keough, Esq.
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Washington, D.C. 20036-1564

RE: Southwest Consulting DSH Part C Days Groups
FYEs Various
PRRB Case Nos. 13-0998GC, 13-1185GC, 13-1218GC, 13-1472GC, 13-1599GC, 13-1780GC, 13-1781GC, 13-2462GC, 13-2507GC, 13-2890GC, 13-2891GC, 13-2922GC, 13-2923GC, 13-3119GC, 13-3389GC, 13-3608GC, 13-3609GC, 14-0122GC, 14-0126GC, 14-0152GC, 14-0153GC, 14-0203GC, 14-0206GC, 14-0293GC, 14-0311GC

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' March 20, 2017 request for expedited judicial review (EJR) (received March 21, 2017) for the above-referenced appeals. The Board's determination is set forth below.

The issue in these cases is:

> Whether the Medicare Part C patients are 'entitled to benefits' under Part A, such that they should be counted in the Medicare Part A/SSI fraction and excluded from the Medicaid fraction numerator [of the disproportionate share hospital (DSH) adjustment] or vice-versa.[1]

Statutory and Regulatory Background: Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the

[1] Providers' March 20, 2017 EJR Request at 4.

prospective payment system (PPS).[2] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[3]

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[4] These cases involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients. [5]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage (DPP).[6] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[7] The DPP is defined as the sum of two fractions expressed as percentages.[8] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), defines the Medicare/SSI fraction as:

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

The Medicare/SSI fraction is computed annually by CMS, and the Medicare Administrative Contractors (MACs) use CMS' calculation to compute a hospital's DSH payment adjustment.[9]

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), defines the Medicaid fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the

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[2] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[3] *Id.*
[4] *See* 42 U.S.C. § 1395ww(d)(5).
[5] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(l).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] 42 C.F.R. § 412.106(b)(2)-(3).

> Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period. (emphasis added)

The MAC determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare part A, and divides that number by the total number of patient days in the same period.[10]

Medicare Advantage Program

The Medicare program permits its beneficiaries to receive services from managed care entities. The managed care statute implementing payments to health maintenance organizations (HMOs) and competitive medical plans (CMPs) is found at 42 U.S.C. § 1395mm. The statute at 42 U.S.C. § 1395mm(a)(5) provides for "payment to the eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter . . ." Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days

In the September 4, 1990 Federal Register, the Secretary[11] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[12]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[13]

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[10] 42 C.F.R. § 412.106(b)(4).
[11] of Health and Human Services
[12] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).
[13] *Id.*

With the creation of Medicare Part C in 1997,[14] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the intermediaries to calculate DSH payments for the FY 2001-2004.[15]

No further guidance regarding the treatment of Part C days in the DSH calculation was provided until the 2004 Inpatient Prospective Payment System (IPPS) proposed rules were published in the Federal Register. In that notice the Secretary stated that:

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicare fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction* . . . (emphasis added)[16]

The Secretary purportedly changed her position in the FFY 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[17] In response to a comment regarding this change, the Secretary explained that:

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A.* We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C*

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[14] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.

[15] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).

[16] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).

[17] 69 Fed. Reg. at 49,099.

> *beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[18] (emphasis added)

This statement would require inclusion of Medicare Part C inpatient days in the Medicare fraction of the DSH calculation.

Although the change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the Federal fiscal year (FFY) 2008 final rule was issued.[19] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule. As a result, Part C days were required to be included in the Medicare fraction as of October 1, 2004.

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius,*[20] vacated the FFY 2005 IPPS rule. However, the Providers point out, the decision is not binding in actions by other hospitals. Further, the Secretary has not acquiesced to that decision.[21]

Providers' Request for EJR

The issue under appeal in these cases involves the question of whether Medicare Part C patients are "entitled to benefits" under Part A, thereby requiring them to be counted in the Medicare Part A/SSI fraction and excluded from the Medicaid fraction numerator or vice versa.

Prior to 2004, the Secretary treated Part C patients as not entitled to benefits under Part A. From 1986-2004, the Secretary interpreted the term "entitled to benefits under Part A" to mean covered or paid by Medicare Part A. In the final rule for the FFY 2005, the Secretary reversed course and announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective October 1, 2004.[22]

In *Allina*, the Court affirmed the district court's decision "that the Secretary's final rule was not a logical outgrowth of the proposed rule."[23] Because the Secretary has not acquiesced to the decision, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

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[18] *Id.*
[19] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[20] 746 F. 3d 1102 (D.C. Cir. 2014).
[21] Providers' EJR request at 1.
[22] 69 Fed. Reg. at 49,099.
[23] *Allina* at 1109.

In these cases, the Providers contend that all Part C days should be excluded from the Part A/SSI fraction and the Medicaid-eligible Part C days should be included in the numerator of the Medicaid fraction. To obtain relief, the Providers seek a ruling on the procedural and substantive validity of the 2004 rule that the Board lacks the authority to grant. Since the Secretary has not acquiesced to the decision in *Allina*, the Board remains bound by the regulation. Hence, EJR is appropriate.

Decision of the Board

The Board has reviewed the submissions of the Providers pertaining to the requests for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy for each group appeal exceeds $50,000, as required for a group appeal and the appeals were timely filed from the issuance of the Providers' original Notices of Program Reimbursement. In these cases, the Providers self-disallowed the Medicare Part C Days issue and since all of the cost report periods under appeal precede the application of the regulation, 42 C.F.R. § 405.1835(a)(1)(iii), the Board has jurisdiction under *Bethesda Hospital Association v. Bowen.*[24] The estimated amount in controversy is subject to recalculation by the Medicare Administrative Contractor for the actual final amount in each case.

The Board finds that:

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

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

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

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

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

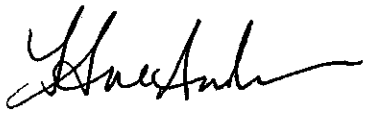
[24] 485 U.S. 399 (1988).

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

Board Members Participating

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

FOR THE BOARD:



L. Sue Andersen, Esq.
Chairperson

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

cc: Laurie Polson, Palmetto GBS c/o NGS (Certified Mail w/Schedule of Providers)
Byron Lamprecht, WPS (Certified Mail w/Schedule of Providers)
Pam Van Arsdale, NGS (Certified Mail w/Schedule of Providers)
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RE: U.C. Davis Medical Center
Provider No.: 05-0599
FYE: 6/30/1995
PRRB Case No.: 11-0483

Dear Mr. Knight and Ms. Alcantara,

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

Background

The Provider submitted a request for hearing on February 17, 2011, based on a Revised Notice of Program Reimbursement ("RNPR") dated August 27, 2010. The hearing request contained one issue – Adjustment to Total Patient Days – IME Capital Payment. The Medicare Contractor submitted a jurisdictional challenge on this issue on October 26, 2016. The Provider submitted a responsive brief on November 23, 2016.

Medicare Contractor's Position

The Medicare Contractor argues that the issue does not meet jurisdictional requirements as it did make an adjustment to Capital IME on the August 27, 2010 RNPR that is the subject of this appeal. The Medicare Contractor notes that the Provider identified adjustment numbers 1, 2, and 8 as the adjustments in controversy for this issue. The Medicare Contractor explains that these adjustments were to correct Medicare and Total Labor and Delivery Days, the DSH payment amount, and Capital DSH payment amount. They did not adjust the Capital IME payment amount.[1]

The Medicare Contractor cites to the regulation at 42 C.F.R. § 405.1889 that states:

> (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

[1] Medicare Contractor's jurisdictional challenge at 2-3.

> decision to which the provisions of 42 C.F.R. §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (b)(2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

The Medicare Contractor contends that the Provider already had the opportunity to appeal the Capital IME issue after the issuance of the original NPR and chose not to do so. The reopening of its cost report to include additional total patient days as related to a DSH issue does not create an opportunity for the Provider to circumvent the time limit for filing its appeal of this issue from its original NPR. The Provider's claim for the Capital IME reimbursement now in question was made on its original submitted Medicare cost report. That claim was addressed in the original NPR issued September 25, 1997, and would have needed to be appealed on a timely basis prior to the expiration in March 1998 of the 180 day time period after the issuance of that determination. The Provider's February 17, 2011 appeal request was not received by the Board within the required 180 days from the receipt of the September 25, 1997 final determination on the Capital IME issue.[2]

The Medicare Contractor argues that the adjustment to total patient days would not impact Capital IME as asserted by the Provider. The impact of the Medicare Contractor's adjustment to total patient days on the IME payment, in the RNPR determination under appeal, is less than the $10,000 threshold for a PRRB appeal.[3]

The Medicare Contractor agrees the Provider's Capital IME reimbursement appears to be understated. However, this understatement did not occur on the determination that is under appeal. The Medicare Contractor states that the Provider's Capital IME reimbursement was understated on the NPR and RNPRs issued prior to the August 27, 2010 issuance of the RNPR under appeal. It was originally understated on the As-Filed cost report.[4]

The Medicare Contractor contends that the adjustments made on the August 27, 2010 determination increased total patient days by 248 days. Capital IME reimbursement is based on a ratio of interns and residents to average daily census. An increase in total patient days results in an increase in the average daily census, which mathematically results in a decrease in the calculated Capital IME reimbursement. It would not result in an increase of Capital IME reimbursement of $210,656 as asserted by the Provider. The Provider's request for additional Capital IME reimbursement does not relate to the adjustment to increase total patient days by 248 days on the August 27, 2010 RNPR. The Medicare Contractor states that the actual impact of the adjustment is a decrease of $1,175 in Capital IME reimbursement.[5]

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[2] Medicare Contractor's jurisdictional challenge at 4-5.
[3] Medicare Contractor's jurisdictional challenge at 5.
[4] Medicare Contractor's jurisdictional challenge at 6.
[5] Medicare Contractor's jurisdictional challenge at 6-7.

Provider's Position

The Provider contends that the NPR issued on August 27, 2010 constitutes a final determination by the Medicare Contractor with respect to the provider's cost report. In 42 C.F.R. § 405.1801(a)(2), it defines a final determination as follows: "An intermediary determination is defined as a "determination of the total amount of payment due to the hospital, pursuant to § 405.1803 following the close of the hospital's cost reporting period..."[6]

The Provider argues that the Medicare Contractor posted adjustments to the Provider's items of costs claimed in the as-filed cost report in the final NPR, which satisfy the criteria of dissatisfaction at 42 U.S.C. § 1395oo(a) and 42 C.F.R. § 405.18359(a). The Provider explains that the Medicare Contractor issued the Provider's revised NPR updating the Provider's total Adult and Pediatric patient days on Worksheet S-3, Part I, Column 6, Line 1.01. The Medicare Contractor's adjustment revised the Provider's total Adult and Pediatric patient days from 85,137 to 85,385 in audit adjustment number 1, an increase of 248 days. The Medicare Contractor's adjustment to total Adult and Pediatric days corrected the total hospital patient days reported on Worksheet S-3, Part I, Column 6, Line 8. Total hospital patient days were 123,776 per the prior RNPR dated January 21, 2005. Total hospital patient days are now 124,024 per the RNPR dated August 27, 2010.[7]

The Provider notes that any changes in total patient days will have a direct impact to the Provider's IME capital reimbursement reported on Worksheet L, Part I, Line 4, as total patient days is a component of the IME capital reimbursement calculation. The Provider is dissatisfied with the Medicare Contractor's failure to update the Provider's IME capital payment with an updated total patient days of 124,024 in the RNPR dated August 27, 2010. The Provider argues that it is appealing an adjustment from a determination related to the issue in dispute and the Medicare Contractor did indeed adjust total patient days within the IME capital payment calculation. The Provider contends that in the revised NPR dated August 27, 2010, the IME capital payment reported $265,793, whereas the proper IME capital reimbursement should be $476,449, for a difference of $210,656, well above the materiality threshold of $10,000 set forth at 42 C.F.R. § 405.1835(a)(2).[8]

Board's Decision

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

[6] Provider's jurisdictional response at 2 (Emphasis included).
[7] Provider's jurisdictional response at 2.
[8] Provider's jurisdictional response at 3.

> 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).

In accordance with 42 C.F.R. § 405.1889 (2009), a revised NPR is considered a separate and distinct determination from which the provider may appeal. The regulation provides:

> (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 § 405.1811, § 405.1834, § 405.1835, § 405.1837, § 405.1875, § 405.1877 and § 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

Here, the Provider's cost report for FYE 6/30/1995 was reopened in order to adjust Medicaid and total labor and delivery room days for the DSH calculation.[9] The audit adjustment report shows adjustments to Medicaid labor and delivery room days, total labor and delivery room days, operating DSH payment, and capital DSH payment. The audit adjustment report does not show an adjustment to the Capital IME Payment.

The Board concludes that it does not have jurisdiction over the Capital IME Payment because the Medicare Contractor did not make an adjustment to these costs as part of the reopening. The regulations make clear that a Provider can only appeal items that are specifically adjusted from a revised NPR. The Provider argues that adjustments should have been made to IME capital payments because they are a flow through item on the cost report; however this argument does not satisfy the jurisdictional requirements of 42 C.F.R. §§ 405.1885, 405.1889.

As the Capital IME Payment was the sole remaining issue in this case, the Board closes the case and removes it from the Board's docket. Review of this determinations 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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Chairperson

[9] *See* Provider's Final Position Paper Exhibit P-4.

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

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RE: Jurisdictional Challenge
PRRB Case Number: 14-2693
St. Luke's Hospital
Provider Number: 36-0090
FYE: 12/31/2009

Dear Mr. Ruskin and Ms. Cummings,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal in response to the Medicare Contractor's jurisdictional challenge. The pertinent facts of the case, the Parties' positions and the Board's jurisdictional determination are set forth below.

Pertinent Facts

The Provider filed its 12/31/2009 Medicare cost report on June 1, 2010. The Provider included 4.71 FTEs and 6.28 FTEs on Worksheet E, Part A, line 3.17, column 0 and column 1, respectively, for residents in new training programs.[1] The Medicare Contractor made adjustments to remove FTEs from line 3.17 related to surgical residents.[2]

On January 17, 2014, the Provider filed an appeal[3] stating issue #1 as follows:

> "The MAC made an adjustment to the Medicare cost report to the Indirect Medical Education ("IME") resident count. The MAC used adjustment #14 to remove surgical IME FTEs of 2.03 claimed in connection with a new program on worksheet E Part A, line 103.17 in the final settled Medicare cost report ... it failed to consider 7.72 additional IME FTEs reported in the FYE 2009 IRIS. These IME FTEs are associated with a new Family Medicine and Geriatrics Program and should be

[1] Provider's Response to Jurisdictional Challenge at Exhibit A (March 4, 2015).
[2] Id. at Exhibit E.
[3] The initial appeal request included 2 issues. The provider withdrew the GME per resident amount issue in its final position paper.

> allowed... Deducting the surgical IME FTE count of 2.03, a total of 5.69 IME FTEs should be included on the Provider's settled Medicare cost report."[4]

On February 6, 2015, the Medicare Contractor filed a jurisdictional challenge for the IME FTEs issue. On March 4, 2015, the Provider filed its response to the jurisdictional challenge.

Medicare Contractor's Position

The Medicare Contractor asserts that the Board does not have jurisdiction over the IME FTE issue for numerous reasons.[5] [6] Specifically, the Medicare Contractor argues that the Provider's original appeal request only included the 2.03 surgical IME FTEs, adjustment #14. The Medicare Contractor contends that the Provider never included the issue of the additional 8.22 FTEs in the subject appeal until the Provider submitted its preliminary position paper.

Provider's Position

The Provider identified the issue under dispute as follows:

> "When the MAC effectuated this adjustment, it failed to consider 7.72 additional IME FTEs reported in the FYE 2009 IRIS. These IME FTEs are associated with a new Family Medicine and Geriatrics Program and should be allowed,...The Provider developed a new approved program and the resident count for IME associated with this program should have been included on worksheet E Part A, line 103.17, column 0."[6]

The Provider states that it had included a request for payment for FTEs in its new training programs on Worksheet E, Part A. These FTEs were included on two lines of Worksheet E, Part A including one that was adjusted by the Medicare Contractor. The Provider explains that "[a]lthough there may have been some cost report technicalities that had not been properly observed ... when completing the cost report, the Provider's intent to claim payment was clear."[7] The Provider state that the 4.71 FTEs and 6.28 FTEs on Worksheet E, Part A, line 3.17, column 0 and column 1, respectively, were soley included to account for Family Medicine and Geriatrics Program FTE's.

The Provider asserts that the surgery resident FTEs adjusted or removed by the Medicare Contractor, were done so incorrectly based on adjustment made to the prior year cost report. The MAC's adjustment to "properly handle" surgery residents reduced line 3.17 without asking the Provider if surgery residents were included in that line in the current year cost report. Therefore the adjustment to remove surgery residents only incorrectly further reduced the claimed Family Medicine and Geriatrics program residents.[8]

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[4] Provider's appeal request at Tab 3 (January 17, 2014).
[5] Medicare Contractor's Jurisdictional Challenge at 3 (February 6, 2015).
[6] Provider's appeal request at Tab 3 (January 17, 2014).
[7] Provider's Response to Jurisdictional Challenge at 2 (March 4, 2015).
[8] Provider's Response to Jurisdictional Challenge at 4; Exhibit D at 3 (March 4, 2015).

The Provider contends that it has met the regulatory requirements for an appeal since it included a claim for reimbursement for residents in the Family and Geriatric new program on Worksheet E, Part A and the Medicare Contractor made adjustments.

Finally, the Provider maintains that the Medicare Contractor should have "upheld its statutory duties" to educate the provider regarding how to submit claims for payment, including proper completion of the cost report. Therefore, the Provider and Medicare Contractor could have reached agreement for this issue.

Board Analysis and Decision

Pursuant to 42 C.F.R. § 405.1835(a)(i) –(ii) (2009), "[a] provider . . . has a right to a Board hearing . . . only if— (1) [t]he provider has preserved its right to claim dissatisfaction . . . by . . . [i]ncluding a claim for specific item(s) on its cost report . . . or . . . self-disallowing the specific item(s) by . . . filing a cost report under protest . . . ." Effective with cost report periods that end on or after December 31, 2008, CMS amended the regulations governing cost report appeals to incorporate Provider Reimbursement Manual (PRM) 15-2 § 115 *et seq.* into the regulations at 42 C.F.R. § 405.1835(a)(1)(ii) (2009). Thus, when a provider seeks payments that it believes may not be allowable or may not be in accordance with Medicare policy, the provider must claim the items as self-disallowed costs "by following the applicable procedures for filing a cost report under protest."[9]

The Board finds that the Medicare Contractor's argument that the Provider did not timely appeal the additional FTE issue in its initial appeal without merit. The Provider stated the issue as "The MAC made an adjustment to the Medicare cost report to the Indirect Medical Education ("IME") resident count. The MAC used adjustment #14 to remove surgical IME FTEs of 2.03 claimed in connection with a new program on worksheet E Part A, line 103.17 in the final settled Medicare cost report ... it failed to consider 7.72 additional IME FTEs reported in the FYE 2009 IRIS. These IME FTEs are associated with a new Family Medicine and Geriatrics Program and should be allowed... Deducting the surgical IME FTE count of 2.03, a total of 5.69 IME FTEs should be included on the Provider's settled Medicare cost report."[10]

However, the Board finds that it does not have jurisdiction over the additional 8.22 IME FTEs for the new Family Medicine and Geriatrics program because the appeal does not comply with the requirements of 42 C.F.R. § 405.1835(a)(1)(i)–(ii) (2009). The Provider's cost report was for Fiscal Year End (FYE) 12/31/2009, therefore the Provider was required to either claim the FTEs, ie. make a specific claim on their cost report, or file a cost report with a protested amount for items the provider deemed to be self-disallowed costs. While the Medicare Contractor made an adjustment to Worksheet E, Part A, line 3.17, to remove 2.03 surgery FTEs, by the Provider's own admission, the 8.22 IME FTEs in dispute are additional FTEs.[11]

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[9] 42 C.F.R. § 405.1835(a)(1)(ii) (2009).
[10] Provider's appeal request at Tab 3 (January 17, 2014).
[11] Provider's appeal request at Tab 3 (January 17, 2014). It should be noted that the initial appeal request was for 7.72 additional FTEs.

The Provider states that the 8.22 FTEs were originally identified on the as-filed cost report. However, it is unclear where the 8.22 FTEs were on the as-filed cost report. The Provider admits that the number of FTEs on worksheet E, Part A line 3.17 pertain to the prior year FTE count.[12] The Board notes that the Provider filed 4.71 FTEs on its as-filed cost report on Worksheet E, Part A, line 3.17, then requested 7.72 additional FTEs in its initial appeal request and in its preliminary position paper requested 8.22 additional FTEs. The Provider argues that the adjustment in dispute removed 2.03 FTEs for surgery residents when in fact these were Family Medicine FTEs.[13]

There is no evidence in the record that the Provider claimed the 8.22 FTEs on its as-filed Medicare cost report or that they were reported as a protested amount. While the Provider did claim some FTE's applicable to the Family and Geriatric program, it admittedly claimed the number of FTE's reported in the prior year, omitting a portion of the residents that trained in the current year. The Provider also states that it "could have more precisely indicated on its cost report exactly what its claim was for the residents in new programs".[14] The Provider is requesting the Board to find it has jurisdiction on FTE's that it failed to claim on its cost report although it could have, but the Board is specifically precluded from doing so by 42 C.F.R. § 405.1835(a)(1)(i)–(ii) (2009). As the additional 8.22 FTE's were not claimed by the Provider on the as-filed cost report nor were they filed under protest, the Provider has failed to preserve its right to claim dissatisfaction.[15]

The Board hereby dismisses the IME FTEs issue from the subject appeal. As there are no remaining issues, the Board closes Case No. 14-2693. 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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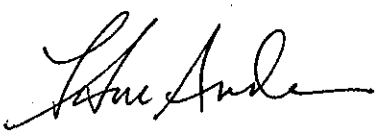

L. Sue Andersen, Esq.
Chairperson

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

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[12] Provider's Reply to Contractor's Final Position Paper at 5 (February 28, 2017).
[13] Medicare Contractor's Jurisdictional Challenge at Exhibit I-3 at C-17/3-4 (February 6, 2015).
[14] Id. at 3.
[15] *Banner Heart Hosp. v. Burwell* (DDC August 19, 2016).The District Court in *Banner* concluded that the Board "violates the administrative appeal provision of the Medicare statute and the key Supreme Court precedent interpreting it, *Bethesda*" *Bethesda* emphasizes the futility of presenting a legal challenge to an intermediary when the intermediary has no authority to entertain or decide such challenges. Here, the Providers have not documented that it would have been futile to claim these days, as the Provider itself argues that the regulations and CMS guidance allow for the inclusion of these type of days. Therefore, these Providers would stand on "separate" ground than those in *Bethesda*, as it was not futile (i.e., the provider was barred by neither statute nor regulation) to make the claim. Under the 2008 regulation, the Board is not able to grant jurisdiction over the days without the specific claim, but under the *Bethesda* test, the Providers still fail.

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