PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2015-D3

PROVIDERS –
Rural Family DGME Group Appeals
Provider Nos.: See Appendix I

vs.

INTERMEDIARY –
Blue Cross and Blue Shield Association
See Appendix I

DATE OF HEARING –
March 13-14, 2013

Cost Reporting Periods Ended -
See Appendix I

CASE NOs.: 01-0004GE
04-1492GE
06-0509GE
09-2040G

INDEX

ISSUES:

This case was remanded to the Board[1] and the parties presented the following issues pursuant to the decision of the U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") in *Providence Yakima Med. Ctr. v. Sebelius* ("*Providence Yakima*").[2] The case involves the amount of Medicare reimbursement due a provider of medical services.

Issue 1: Was the use of CMS's sequential geography methodology ("SGM") for setting the Providers' base year per resident amounts for Medicare reimbursement of certain graduate medical education costs valid and consistent with 42 U.S.C. § 1395ww(h)(2)(F) and 42 C.F.R. § 413.86(e)(4)(i) (1989)?

Issue 2: If the SGM is invalid, what relief can or should the Board order?[3]

MEDICARE 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"), formerly the Health Care Financing Administration ("HCFA"),[4] 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 known as fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs"). FIs and MACs[5] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS.[6]

Providers are required to submit cost reports annually, with reporting periods based on the provider's accounting period. A cost report shows the costs incurred during the reporting period and the portion of those costs allocated to the Medicare program.[7] Each intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement ("NPR").[8] A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board ("Board") within 180 days of the receipt of the NPR.[9]

Under 42 U.S.C. § 1395ww(h) and implementing regulations, the Medicare program pays hospitals for the direct cost of graduate medical education on the basis of per resident costs

[1] Copy included as Intermediary Exhibit I-3.
[2] 611 F.3d 1181 (9th Cir. 2010) (copy included as Intermediary Exhibit I-4), *aff'g in part, vacating in part, remanding* No. CV-03-3096-FVS, 2000 WL 991494 (E.D. Wash Mar. 29, 2007) (copy included as Intermediary Exhibit I-5).
[3] *See* Transcript at 5-6 (Mar. 13, 2013).
[4] In 2001, the agency name was changed from HCFA to CMS. For simplicity, this decision generally will use CMS to refer to the agency.
[5] FIs and MACs are hereinafter referred to as intermediaries.
[6] *See* 42 U.S.C. §§ 1395h and 1395kk-1; 42 C.F.R. §§ 413.20, 413.24.
[7] *See* 42 C.F.R. § 413.20.
[8] *See* 42 C.F.R. § 405.1803.
[9] *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835.

established using a 1984 base year. If a hospital did not have residents or did not participate in the Medicare program during the 1984 base period, 42 U.S.C. § 1395ww(h)(2)(F) specifies that the Secretary shall determine the hospital's approved FTE resident amount *based on approved FTE resident amounts for comparable programs*.[10] In the final rule published on September 29, 1989 ("September 1989 Final Rule"), CMS specified that intermediaries calculate a per resident amount ("PRA") based on the *lower* of the hospital's actual costs for its first cost reporting period for the residency program or a weighted average of all the hospitals in the same geographic wage area unless the hospital falls into an exception.[11] If there are fewer than three hospitals in the same geographic wage area, the exception applies and the intermediary "must contact the [CMS] Central Office for a determination of the appropriate [weighted average] amount to use."[12] All hospitals in this appeal have fewer than three hospitals in their geographic area and are subject to the exception. The method used to determine the exception, or the weighted average per resident amount, "APRA," is the subject of this appeal.

CMS developed an *ad hoc* policy to determine the appropriate weighted amount to use when the exception applies. This *ad hoc* policy is known as the "Sequential Geographic Methodology" ("SGM" or "*Ad Hoc* Policy"). In connection with this case, CMS described the SGM in a June 9, 1997 letter to the reimbursement manager of Blue Cross of Montana:

> If there are less than three teaching hospitals in the same geographic wage area, we include all hospitals in contiguous wage areas. If we continue to have fewer than three hospitals for this calculation, we use the statewide average, in the case of St. Vincent's and Deaconess, there are fewer than three hospitals with teaching programs in the entire state so we calculated a weighted average among all hospitals with teaching programs in contiguous states.[13]

The dispute in this case involves the Intermediary's use of the SGM. For each of the Providers, the Intermediary determined an APRA using the SGM and, as each of the Providers' APRA was lower than its actual costs for the residency program's first cost reporting period, the APRA became each Providers' base year PRA.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

This appeal involves five hospitals and various cost reporting years as detailed in Appendix 1 attached to this decision. The Providers include Deaconess-Billings Clinic Health System located in Billings, Montana; St. Vincent Hospital and Health Center, located in Billings, Montana; Merle West Medical Center located in Klamath Falls, Oregon; Providence Yakima Medical Center in Yakima, Washington; and and Yakima Valley Memorial Hospital in Yakima,

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[10] (Emphasis added.)
[11] *See* 42 C.F.R. § 413.86(e)(4). The term "same geographic wage area" refers to an urban area ("a metropolitan statistical area" (MSA) as defined by the Office of Management and Budget, certain urban areas specified by the Social Security Amendments) or rural area (any area outside of urban area), in the hospital-specific wage index as calculated by the Secretary. *See* 42 C.F.R. §§ 412.62(f), 412.63.
[12] *Id.*
[13] Provider Exhibit P-13 at 2.

Washington("Providers"). Noridian Administrative Services (the "Intermediary") serves as the lead intermediary for these group appeals.

The Providers are Medicare-participating, not-for-profit hospitals that established new residency training programs in family medicine after the end of fiscal year end ("FYE") 1984; more specifically, between 1993 and 1997. The Providers receive Medicare direct graduate medical education ("DGME") payments for their approved family medicine residency programs.[14] This group appeal challenges the validity and lawfulness of the sequential geography methodology ("SGM") used by CMS and its FI to establish the base year DGME average per resident amount for each of the five Providers, as well as the application of the Providers' base year per resident amount to calculate subsequent DGME payments.[15]

The Providers timely appealed their base year PRA determinations and the PRRB granted the Providers' request for expedited judicial review ("EJR") "over the issue of whether [the 1989 regulation], as applied by the Intermediaries to each of the Providers in this appeal, violates 42 U.S.C. § 1395ww(h)(2)(F) by failing to base the Providers' [APRAs] on the 'approved [FTE] resident amount of comparable residency programs.'"[16] On July 23, 2010, the United States Court of Appeals for the Ninth Circuit determined [in *Providence Yakima*] that the PRRB improvidently granted the Providers' EJR request, vacated the District Court's invalidation of the SGM, remanded the appeal to District Court with instructions to dismiss the Providers' appeal, and further remanded the case to the agency (CMS) for it to determine the validity of the SGM.[17] CMS remanded the case back to the Board on January 12, 2011, directing that "the PRRB will conduct a hearing to determine whether the SGM, which was utilized to determine the Providers' respective per resident amounts, is valid and consistent with Sections 1886 (h)(2)(F) of the Social Security Act and 42 CFR § 413.86 (e)(4)(i) (1989)."[18]

St. Vincent and Billings Clinic each had their APRAs set based on the weighted average of the PRAs of 16 other teaching hospitals located in states contiguous to Montana, none of which are located in the same geographic wage area as St. Vincent and Billings Clinic.[19] Providence Yakima and YVMH each had their APRAs set based on the weighted average of the APRAs of the 20 other teaching hospitals in Washington State, none of which are located in the same geographic wage area as Providence Yakima and YVMH.[20] Merle West had its PRA set based on the weighted average of the APRAs of seven other teaching hospitals in Oregon State, none of which are located in the same geographic wage area as Merle West.[21] As each of the Providers' PRA was lower than its actual costs for the first cost reporting period of its residency program, the Intermediary adopted each Providers' APRA as its base year PRA pursuant to 42 C.F.R. § 413.86(e)(4)(i).[22]

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[14] Stipulation of Facts at ¶2, March 13, 2013
[15] *Id.*, at ¶3
[16] *Id.*, at ¶6.
[17] Medicare Administrative Contractor's Final Position Paper, Tab I-3
[18] *Id.*, at Tab I-2.
[19] Stipulations at ¶17
[20] *Id.*, at ¶18
[21] *Id.*, at ¶19
[22] Provider Groups' Consolidated Final Position Paper, at 12-16. Medicare Administrative Contractor's Post Hearing Brief, at 6, 8, 10.

The Providers were represented by Michael Madden, Esq., of Bennett Bigelow & Leedom, P.S. The Intermediary was represented by Robin Sanders, Esq., of the Blue Cross and Blue Shield Association.

PROVIDERS' CONTENTIONS:

The Providers contend that the SGM did not identify comparable programs and, therefore, it is inconsistent with both the governing statute at 42 U.S.C. § 1395ww(h)(2)(F) and the logic of the implementing regulation at 42 C.F.R. § 413.86(e)(4)(i) (1989).

First, the Providers assert that the SGM is inconsistent and conflicts with the governing statute because it is not "based on approved FTE resident amounts for comparable programs." The Providers maintain that, although the Ninth Circuit vacated the district court's invalidation of the SGM in *Providence Yakima*,[23] the Board should adopt the district court's position.[24] The Providers maintain that the district court determined that the requirement to set Providers' PRAs based on the costs of "comparable programs" requires consideration of additional items such as: (a) locations (rural vs. urban); (b) single vs. multiple specialty; (c) facility costs; (d) ability to offset cost by professional fees; (e) other operational costs, including recruitment, transportation, and housing; and (f) actual costs, including first year costs, of operation for the residency program.[25] The Providers' expert witness suggests that there should be two additional comparability criteria: (1) program sponsorship; and (2) "generation" of the comparable program.[26]

The Providers further believe that the SGM is inconsistent with the articulated rationale of the controlling regulation[27] for identifying comparable programs. The Providers point out that CMS provides no authority to justify its assertion that, if program costs within a given geographic area or MSA are comparable, program costs within adjoining wage areas are sufficiently comparable to justify the SGM which went far beyond continguous wage areas. The application of the SGM resulted in CMS identifying and comparing one hospital to every other hospital in two large western states and compared another hospital to sixteen hospitals in four other contiguous states. The Providers argue that while the use of geographic wage areas that correspond with the Office of Management and Budget MSAs make sense because they reflect a "high degree of integration" between a "recognized population nucleus and adjacent communities."[28] and have a commonality of conditions which bears on the costs of operating residency programs (*e.g.*, building and capital costs, recruitment and travel costs, transportation, housing and other infrastructure items), the SGM areas lack similar comparability. By treating programs as comparable that are not, the Providers argue that the SGM not only ignores the rationale of the

[23] *See Providence Yakima*, 611 F.3d at 1188.
[24] *See Providence Yakima*, No. CV-03-3096-FVS, 2007 WL 991494 at *13-*14 (E.D. Wash., Mar. 29, 2007) (order granting summary judgment to the providers) (copy included at Providers Exhibit P-5).
[25] *See* Providers Post-Hearing Brief at 3-5 (citing to *Providence Yakima*, No. CV-03-3096-FVS, 2007 WL 991494 at *3, *14 (E.D. Wash., Mar. 29, 2007); Providers Exhibit P-6 at 15-16 (district court order in *Providence Yakima* remanding the case with instructions)).
[26] Tr. at 59-62, 73-79 (Mar. 13, 2013).
[27] *See* 42 C.F.R. § 413.86(e)(4) (1989); 42 C.F.R. § 412.63(b)(1) (applying the definition of OMB MSAs to federal fiscal years following federal fiscal year 1984).
[28] *Id.*

rule, it defies it.[29] The Providers list specific reasons each Provider does not compare with the residency programs that were in the SGM area assigned to that Provider.[30]

The Providers request that the Board set their base year PRAs based on the programs' allowable costs under the Board's authority set forth in 42 U.S.C. § 1395oo(d). The Providers assert that it is obvious that the Intermediary, CMS, HHS, or the Justice Department has not demonstrated any reasonable prospect of identifying comparable programs.[31] The Providers also request interest be paid pursuant to 42 U.S.C. § 1395oo(f)(2).

INTERMEDIARY'S CONTENTIONS:

The Intermediary asserts that the Providers bear the burden of proving by a preponderance of evidence that the Secretary abused her Congressionally-conferred discretion by using the SGM as a means of identifying "comparable programs" for the purposes of setting the Providers' base year PRAs.[32] The Intermediary argues that, in order for the Providers' base year PRAs to have been set "based on comparable programs" as required by 42 U.S.C. § 1395ww(h)(2)(F), the Secretary was only required to identify "one or two salient points" of comparison between the Providers' residency programs and the residency programs relied upon by CMS through its use of the SGM.[33]

The Intermediary believes that the implementing regulation reasonably relies on labor markets, as identified through geographic wage areas, as the salient point of comparison for setting the base year PRAs for new residency programs.[34] This salient point of comparison is explicitly incorporated into the implementing regulation when there are three or more programs in a single geographic wage area.[35] The Intermediary argues that, when there were less than three residency programs in a single geographic wage area and, therefore, an insufficient data pool from which to arrive at a mean value, CMS continued to use this same salient point of comparison through its application of the SGM.

The Intermediary asserts that testimony of the residency program director for Yakima Providence and Yakima Valley Memorial Hospital during the time at issue confirms that it was reasonable for CMS to adopt and use the SGM because "geography matters" for purposes of comparing the costs incurred by residency programs, including wage and benefit costs.[36] In addition, the wages and benefits paid by these Providers' rural residency programs are

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[29] Providers' Post Hearing Position Paper at 6.
[30] *See* 7-11.
[31] *See* Provider Exhibit P-6 at 12.
[32] *See LAC & USC Med. Center Los Angeles, CA v. Blue Cross Blue Shield Association*, PRRB Dec. 2003-D26 at 7 (Feb. 13, 2003). *See also* 5 U.S.C. § 556(d) ("the proponent of a rule or order has the burden of proof").
[33] *See* Intermediary Post-Hearing Brief at 12 (quoting the definition of "comparable" from *Webster's Third International Dictionary* at 461 (1981)).
[34] *See* 53 Fed Reg 36589, 36595 (Sept. 21, 1988) (copy of excerpt included at Intermediary Exhibit I-8). *See generally Providence Yakima Med. Center v. Sebelius*, 611 F.3d 1181 (9th Cir. 2010).
[35] *See* 42 C.F.R. § 413.86(e)(4)(i) (1989).
[36] *See generally* Tr. at 270:2-272:1 (Mar. 13, 2013) (testimony from Dr. Maples explaining statements in his Declaration (Providers Exhibit P-40) that programs on the east coast are not comparable to those in Washington because geography is "a factor" in terms of costs).

comparable to those paid by residency programs in surrounding areas because the Providers need to compete for the same labor force.[37]

The Intermediary argues the opinion of the Providers' expert witness is fundamentally flawed. First, it focuses solely on certain dissimilarities between the residency programs while ignoring similarities in other respects.[38] The Intermediary finds it significant that the Providers' expert report and testimony did not look at or otherwise review the wages and benefits paid by the Providers' programs and those included in CMS's SGM analysis for this case.[39] As discussed above, CMS explicitly recognized that labor markets, as identified through geography, was an appropriate point of comparison for determining a new program's base year APRA.

The Intermediary asserts that, if the Board disagrees with the Intermediary and invalidates the Providers' base year PRAs, the only relief that may be awarded under the statute and regulation is a remand to the Intermediary to determine the appropriate APRA to be used in determining the base year PRA. The scope of the Board's legal authority is plainly set out in the Medicare statutes and regulations – "the Board must comply with all of the provisions of Title 18 of the Social Security Act and the Regulations issued thereunder, . . . and the Board shall afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure or practice established by CMS."[40] Therefore, the only course of action available would be for the Intermediary to "contact [CMS] Central Office for a determination of the appropriate amount to use" for each Providers' APRA. Any other relief would be outside the scope of the Board's authority and contrary to the valid statue and regulation controlling the manner in which the Providers' base year PRAs are to be determined.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

Issue 1: Was the use of CMS' sequential geography methodology for setting the Providers' base year per resident amounts for Medicare reimbursement of certain graduate medical education costs valid and consistent with 42 U.S.C. 1395ww(h)(2)(F) and 42 C.F.R. 413.86(e)(4)(i)(1989)?

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Board finds and concludes that CMS' use of the SGM for setting the

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[37] *See* Tr. at 274:8-15 (Mar. 13, 2013) ("Q. But what other hospitals in your geographic region are paying is a factor as far as recruiting residents and what the pay . . . A. Yes. Q. . . . to the residents is? A. Yes."). *See also* Tr. at 17-20 (Mar. 14, 2013) (testimony from Lee Crooks explaining that "the SGM seems like a logical extension of what the Secretary was [already] doing when . . . there were more than three [programs] in an MSA" because, particularly for rural areas and based on prior testimony, it does not appear that labor markets for rural programs are always contained within a single wage area).

[38] *See e.g.* Expert Witness Report of Kiki Nocella, Ph.D., M.H.A. *See also* Tr. at 124:9-16 (Mar. 13, 2014) ("Q. And you would agree with me that just because a residency program has differences doesn't actually mean that they don't [also] have . . . the similarities? A. Yes. By virtue of accreditation, they have to have similarities."); *id.* at 122-124 (agreeing that her expert report and opinion does not consider, compare or take into account every possible "characteristic of a GME residency program," "characteristic of a rural family residency program," "non-rural setting family residency program," *etc.*).

[39] *See* Tr. at 188:20-189:4 (Mar. 13, 2013) ("MR. NIX: So you didn't look at the wage index. DR. NOCELLA: No. MR. NIX: . . . relative to any of the comparators? DR. NOCELLA: No."), 123:12-124:8 (acknowledging that her report "did not do any comparison of wages and salaries," both between just the Providers and the comparators relied upon by CMS when using the SGM to arrive at the Providers' base year PRAs.).

[40] 42 C.F.R. § 405.1867.

Providers' base year PRA is valid and consistent with 42 U.S.C. § 1395ww(h)(2)(F) and 42 C.F.R. § 413.86(e)(4)(i) (1989).

The Board notes that, in the *Providence Yakima* decision, the Ninth Circuit upheld 42 C.F.R. § 413.86(e)(4) (1989) as a substantively and procedurally valid regulation, found the SGM to be an *ad hoc* policy, and remanded the case to CMS to determine the validity of the SGM.[41] In assessing the validity of the SGM pursuant to CMS' remand order, the Board must give it great weight because 42 C.F.R. § 405.1867 requires the Board to give "great weight" to CMS' "interpretive rules, general statements of policy, and rules of agency . . . procedure, or practice established by CMS."

To assess the validity of the SGM, the Board first reviewed the governing statute at 42 U.S.C. § 1395ww(h)(2)(F) to determine if the SGM is consistent with it. In this regard, the Board finds that § 1395ww(h)(2)(F) gives the Secretary broad discretion to develop the method to approve a per resident amount for a newly-approved residency program. The only requirement outlined by the statute is that the new PRA be "based on approved per resident amount*s* for comparable programs."[42] Although the statute does not define the term "comparable programs," the Board notes that the use of plural, "programs," confirms that the PRA must be based on more than one comparable program. In this regard, the Board finds that the SGM is consistent with the statute in that it uses at least three comparators.

To resolve the ambiguity in the statute, the Board looked to the implementing regulation at 42 C.F.R. § 413.86(e)(4) (1989) to determine how the Secretary exercised her discretion in defining "comparable programs." In § 413.86(e)(4) (1989), the Secretary chose to identify comparable programs by geographic wage area and determined that, for purposes of calculating the APRA, the minimum number of programs in a geographic wage area against which to compare a new program was three. The Secretary explained this approach in the preamble to the proposed rule issued on September 21, 1988:

> We believe that, *since the major component of direct GME costs is the salaries of residents and teaching physicians, it is appropriate to use the geographic wage area classifications as used by the Medicare prospective payment system as a guide in making these determinations*. However, the amounts paid to hospitals for new GME programs should bear some relationship to the actual costs of the program, especially for the first year's costs. Therefore, we believe that it is a reasonable approach to consider both the hospital-specific costs of the program and the costs of programs of other teaching *hospitals located in the same geographic area* to establish imputed per resident amounts for hospitals that did not have approved medical residency training programs or were not participating in Medicare during a cost reporting period that began on or after October 1, 1983 and before October 1, 1984.[43]

[41] *See Providence Yakima*, 611 F.3d at 1186, 1190-1191.
[42] (Emphasis added.)
[43] 53 Fed. Reg. at 36595 (emphasis added).

This preamble discussion confirms that, because the wages of residents and teaching physicians are the main cost of residency programs, the sole means of identifying comparators would be through wages and benefits based on geographic proximity to the new program using the geographic wage area classification system.

The Board recognizes that the Provider presented testimony on how the new residency programs were not "comparable" based on characteristics other than the wage geography comparison mandated by the Secretary through the regulation. However, using these other characteristics as a basis for comparability would be inconsistent with the regulatory requirement that wages and benefits of other programs based on geographic proximity to the new program be used in identifying comparators (*i.e.*, "us[ing] the geographic wage area classifications . . . as a guide"). Indeed, the Providers' expert did not address the comparability of the wages and benefits paid by the Providers' programs and those included in CMS' SGM analyses for this case,[44] even though both of the Providers' program director witnesses agree that "wages and benefits are the single largest cost" of their respective residency program.[45] Moreover, testimony from both of the Providers' program director witnesses suggests that they recognize that the comparators used by CMS in determining the base year PRAs at issue were competitors for purposes of recruiting residents and teaching physicians and setting their wages.[46] On this basis, the Board rejects the Providers' argument that the SGM is invalid and that other factors should be considered in identifying "comparable programs."[47]

Issue 2: If the SGM is invalid, what relief can or should the Board order?

Finally, assuming *arguendo* that the Board found that the SGM was invalid, the Board would have been bound by 42 C.F.R. § 413.86(e)(4)(i)(B), and required to remand this case back to CMS Central Office "for a determination of the appropriate amount [*i.e.*, APRA] to use" for purposes of determining the PRA.[48] The Board does not believe that it has the authority to

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[44] *See* Tr. at 123-124, 188-189 (Mar. 13, 2013). The Board notes that the comparators' PRAs may be very different from their actual costs. For example, if a comparator's base year PRA was set in 1984, its PRA for 1993 to 1997 (the years at issue in this case) would likely be much lower than its actual costs for those years because, consistent with Congressional intent, the base year PRA is only updated by inflation for subsequent years and most likely will not keep pace with a provider's teaching program changing operational needs and costs. *See* 54 Fed. Reg. at 40309-40310 (responding to concern that the PRA-setting process "fails to take into account rapid changes that are taking place in GME training" by stating that "Congress intended to freeze direct GME financial arrangements as they existed during the base year subject to update factor," thereby, having "the effect of tying payments to financial arrangement that existed in the base year, regardless of any future changes in such arrangements"). Thus, any challenge to the validity of a comparator used in the SGM would need to assess the comparator's actual costs because the comparator's PRA only reflect Medicare reimbursement rates and likely would not reflect the comparator's actual costs.

[45] *See id.* at 267, 319.

[46] *See id.* at 223-225, 319.

[47] The August 1997 Final Rule eliminated the SGM policy but continued the Secretary's definition of comparable hospital PRAs based on geographic comparison. CMS stated that the old SGM policy was still applicable to prior decisions but for "simplicity" reasons SGM was being replaced by the nine census regions established by the Bureau of Census for geographical comparison of Providers whose MSA geography did not contain at least three residency programs. *See:* 62 Fed. Reg. 45966, 46004 (Aug. 29, 1997).

[48] 42 C.F.R. § 413.86(e)(4)(i)(B) (1989). "If there are fewer than three amounts that can be used to calculate the mean value, the intermediary must contact HCFA Central Office for a determination of the appropriate amount to use."

award Providers' the actual costs of their residency programs during their first cost reporting periods.

DECISION AND ORDER:

The use of CMS's sequential geography methodology for setting the Providers' base year per resident amounts is valid and consistent with section 42 U.S.C. § 1395ww(h)(2)(F) and 42 C.F.R. § 413.86(e)(4)(i) (1989). The Intermediary's adjustments are affirmed.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, C.P.A.

FOR THE BOARD:

/s/
Michael W. Harty
Chairman

DATE: FEB 06 2015

Appendix I

RURAL GME GROUP APPEAL CASE NO. 01-0004G

SCHEDULE OF PROVIDERS ON APPEAL – Schedule A

Date Prepared: 7/2/03 9:24 AM

	Provider Number	Provider Name	Cost Report Period	Fiscal Intermediary	A Date of NPR	B Date of Hearing Request	C Number of Days	D Audit Adj. No.	E Estimated Amount of Reim.	F Orig. Case No.	G Date of Add/Transfer
1.	27-0004	Deaconess – Billings Clinic Health System Billings, MT Yellowstone County	6/30/97	Blue Cross Blue Shield of Montana	6/4/97*	11/26/97	175	N/A**	$494,610	98-0296M	10/3/00
2.	38-0050	Merle West Medical Center Klamath Falls, OR Klamath County	9/30/95	Medicare Northwest	6/12/98	8/24/98	73	110	$185,005	98-3389	10/3/00
3.	38-0050	Merle West Medical Center Klamath Falls, OR Klamath County	9/30/96	Medicare Northwest	9/30/98	3/19/99	170	123	$253,689	99-2370	10/3/00
4.	38-0050	Merle West Medical Center Klamath Falls, OR Klamath County	9/30/97	Medicare Northwest	9/15/00	11/13/00	59	102	$282,624	01-0415	8/15/01
5.	38-0050	Merle West Medical Center Klamath Falls, OR Klamath County	9/30/98	Medicare Northwest	9/29/00	11/13/00	59	65	$227,676	01-0362	8/15/01

RURAL GME GROUP APPEAL CASE NO. 01-0004G

SCHEDULE OF PROVIDERS ON APPEAL – Schedule A

Date Prepared: 7/2/03 9:24 AM

	Provider Number	Provider Name	Cost Report Period	Fiscal Intermediary	A Date of NPR	B Date of Hearing Request	C Number of Days	D Audit Adj. No.	E Estimated Amount of Reim.	F Orig. Case No.	G Date of Add/Transfer
6.	50-0012	Providence Yakima Medical Center Yakima, WA Yakima County	12/31/95	Premera - Blue Cross	4/10/00	10/3/00	176	1	$470,303	Appealed directly into group	10/3/00
7.	50-0012	Providence Yakima Medical Center Yakima, WA Yakima County	12/31/96	Premera-Blue Cross	9/20/00	3/13/01	174	50	$360,624	01-0640	2/21/02
8.	50-0012	Providence Yakima Medical Center Yakima, WA Yakima County	12/31/97	Premera-Blue Cross	9/27/00	3/13/00	167	5	$323,999	01-0641	2/21/02
9.	50-0012	Providence Yakima Medical Center Yakima, WA Yakima County	12/31/98	Premera-Blue Cross	9/27/01	2/25/02	151	9	$439,857	Appealed directly into group	2/25/02
10.	27-0049	St. Vincent Hospital and Health Center Billings, MT Yellowstone County	5/31/98	Blue Cross Blue Shield of Montana	6/4/97*	11/26/97	175	N/A**	$562,898	98-0295M	10/3/00

RURAL GME GROUP APPEAL CASE NO. 01-0004G

SCHEDULE OF PROVIDERS ON APPEAL – Schedule A

Date Prepared: 7/2/03 9:24 AM

Provider Number	Provider Name	Cost Report Period	Fiscal Intermediary	A Date of NPR	B Date of Hearing Request	C Number of Days	D Audit Adj. No.	E Estimated Amount of Reim.	F Orig. Case No.	G Date of Add/Transfer
11. 27-0049	St. Vincent Hospital Billings, MT Yellowstone County	5/31/99	Blue Cross Blue Shield of Montana	9/24/01	2/25/02	154	144	$562,898	Appealed directly into group	2/25/02
12. 50-0036	Yakima Valley Memorial Hospital Yakima, WA Yakima County	10/31/95	Premera - Blue Cross	9/29/98	3/25/99	177	38	$354,287	99-2522	10/3/00
13. 50-0036	Yakima Valley Memorial Hospital Yakima, WA Yakima County	10/31/97	Premera -Blue Cross	9/21/00	2/20/01	152	1	$226,062	01-1274	9/20/01
14. 50-0036	Yakima Valley Memorial Hospital Yakima, WA Yakima County	10/31/98	Premera-Blue Cross	9/21/01	2/25/02	157	9	$376,137	Appealed directly into group	2/25/02
15. 50-0036	Yakima Valley Memorial Hospital Yakima, WA Yakima County	10/31/99	Premera-Blue Cross	9/10/02	3/3/03	174	9, 14, 15	$372,188	Appealed directly into group	3/3/03

* Date of Per Resident Amount Determination
** Per Resident Amount Determination letter

BBL DIRECT GME REIMBURSEMENT GROUP APPEAL, PRRB CASE NO. 04-1492G

SCHEDULE OF PROVIDERS ON APPEAL – Schedule A

Date Prepared: July 28, 2005

	Provider Number	Provider Name	Cost Report Period	Fiscal Intermediary	A Date of NPR	B Date of Hearing Request	C Number of Days	D Audit Adj. No.	E Estimated Amount of Reim.	F Orig. Case No.	G Date of Add/Transfer
1.	27-0004	Deaconess – Billings Clinic Health System Billings, MT Yellowstone County	6/30/01	Blue Cross Blue Shield of Montana	9/24/03	3/22/04	180	N/A[1]	$20,553	04-1182	3/26/04
2.	27-0004	Deaconess – Billings Clinic Health System Billings, MT Yellowstone County	6/30/02	Blue Cross Blue Shield of Montana	9/8/04	3/7/05	180	N/A[1]	$19,835	05-0922	5/2/05
3.	27-0004	Deaconess – Billings Clinic Health System Billings, MT Yellowstone County	6/30/03	Blue Cross Blue Shield of Montana	9/28/04	3/28/05	181[2]	N/A[1]	$18,084	05-1307	5/2/05

[1] No audit adjustment because cost report was filed with the Per Resident Amount the fiscal intermediary instructed the provide to use.

[2] Per the Provider Reimbursement Review Board Instructions issued March 1, 2002, the Request for Hearing must be filed within 180days of the date of receipt of the NPR. Since the Board presumes that the receipt date of the NPR is within 5 days of the date ofits issuance, this appeal was timely filed.

BBL DIRECT GME REIMBURSEMENT GROUP APPEAL, PRRB CASE NO. 04-1492G

SCHEDULE OF PROVIDERS ON APPEAL – Schedule A

Date Prepared: July 28, 2005

	Provider Number	Provider Name	Cost Report Period	Fiscal Intermediary	A Date of NPR	B Date of Hearing Request	C Number of Days	D Audit Adj. No.	E Estimated Amount of Reim.	F Orig. Case No.	G Date of Add/Transfe
4.	50-0012	Providence Yakima Medical Center Yakima, WA Yakima County	12/31/00	Noridian Administrative Services	9/29/03	2/27/04	151	78	$313,000	04-0881	3/26/04
5.	50-0012	Providence Yakima Medical Center Yakima, WA Yakima County	12/31/01	Noridian Administrative Services	9/20/04	12/30/04	101	11	$326,000	Appealed directly into group	12/30/04
6.	50-0036	Yakima Valley Memorial Hospital Yakima, WA Yakima County	10/31/00	Noridian Administrative Services	9/30/03	3/26/04	178	11-12 and 37-39	$218,780	Appealed directly into group	3/26/04
7.	50-0036	Yakima Valley Memorial Hospital Yakima, WA Yakima County	10/31/01	Noridian Administrative Services	9/7/04	11/10/04	64	6-7	$173,375	Appealed directly into group	11/10/04

RURAL FAMILY GME GROUP APPEAL - CASE NO. 06-0509G

SCHEDULE OF PROVIDERS ON APPEAL – Schedule A

Last Updated: 3/29/07

	Provider Number	Provider Name	Cost Report Period	Fiscal Intermediary	A Date of NPR	B Date of Hearing Request	C Number of Days	D Audit Adj. No.	E Estimated Amount of Reim.	F Orig. Case No.	G Date of Add/Transfer
1.	27-0004	Deaconess Billings Clinic Billings, Yellowstone County, Montana	6/30/04	Blue Cross/ Blue Shield of Montana	9/29/05	12/14/05	76	3	$17,184	N/A	N/A
2.	38-0050	Merle West Medical Center Klamath Falls, Klamath County, Oregon	9/30/02	Noridian Administrative Services	1/10/06	1/18/06	8	2	$227,119	N/A	1/18/06
3.	38-0050	Merle West Medical Center Klamath Falls, Klamath County, Oregon	9/30/03	Medicare Northwest	9/29/05	12/14/05	75	7, 31	$214,740	N/A	N/A
4.	38-0050	Merle West Medical Center Klamath Falls, Klamath County, Oregon	9/30/04	Medicare Northwest	9/27/06	1/3/07	173	6, 12, 25, 35, 36	$250,854	N/A	1/3/07
5.	50-0012	Providence Yakima Medical Center Yakima, Yakima County, Washington	12/31/02	Noridian Administrative Services	9/23/05	12/20/05	89	6, 31	$313,287	N/A	12/20/05
6.	27-0004	Providence Yakima Medical Center Yakima, Yakima County, Washington	8/15/03	Noridian Administrative Services	9/22/05	12/20/05	88	5	$240,635	N/A	12/20/05
7.	27-0049	St. Vincent Hospital & Health Center Billings, Yellowstone County, Montana	5/31/02	Blue Cross/Blue Shield of Montana	9/8/04	2/23/05	168	75, 76, 125	$368,349	05-0833	1/26/06
8.	27-0049	St. Vincent Hospital & Health Center Billings, Yellowstone County, Montana	5/31/03	Blue Cross/Blue Shield of Montana	3/29/05	9/9/05	164	12	$370,272	05-2146	1/26/06

P-3 001

Schedule A

RURAL FAMILY GME GROUP APPEAL - CASE NO. 06-0509G

SCHEDULE OF PROVIDERS ON APPEAL – Schedule A

Last Updated: 3/29/07

	Provider Number	Provider Name	Cost Report Period	Fiscal Intermediary	A Date of NPR	B Date of Hearing Request	C Number of Days	D Audit Adj. No.	E Estimated Amount of Reim.	F Orig. Case No.	G Date of Add/Transfer
9.	50-0036	Yakima Valley Memorial Hospital Yakima, Yakima County, Washington	10/31/02	Noridian Administrative Services	8/29/05	12/14/05	107	36, 37	$206,266	N/A	N/A
10.	50-0036	Yakima Valley Memorial Hospital Yakima, Yakima County, Washington	10/31/03	Noridian Administrative Services	7/14/06	1/3/07	173	39, 40	$201,459	N/A	1/3/07
11.	50-0036	Yakima Valley Memorial Hospital Yakima, Yakima County, Washington	10/31/04	Noridian Administrative Services	4/13/06	10/4/06	174	33, 34, 41	$209,184	07-0013	1/8/07

BBL DIRECT GME PRA ADJUSTMENT GROUP – PRRB Case No. 09-2040G

SCHEDULE OF PROVIDERS IN GROUP

Date: August 9, 2011

	Provider Number	Provider Name / Location (City/County/State)	FYE	Intermediary	A Date of Final Determination	B Date of Appeal	C Number of Days	D Audit Adj. No.	E Estimated Amount of Reim.	F Orig. Case No.	G Date of Add/Transfer
1.	27-0004	Billings Clinic *Yellowstone County* *Billings Montana*	6/30/07	Noridian Administrative Services	12/15/08	6/9/09	176	39, 40	$271,056	09-1868	11/18/09
2.	38-0050	Sky Lakes Medical Center *Klamath County* *Klamath Falls, Oregon*	9/30/05	Noridian Administrative Services	10/25/07	4/17/08	175	N/A	$228,161	08-1781	7/16/09
3.	38-0050	Sky Lakes Medical Center *Klamath County* *Klamath Falls, Oregon*	9/30/06	Noridian Administrative Services	10/28/08	4/23/09	177	26	$242,322	09-1560	7/16/09
4.	~~50-0036~~	~~Yakima Valley Memorial Hospital~~ ~~*Yakima County*~~ ~~*Yakima, Washington*~~	~~10/31/05~~	~~Noridian Administrative Services~~	~~2/18/2011~~	~~5/6/2011~~	~~77~~	~~1~~	~~$274,218~~	~~11-0598~~	~~8/9/11~~

Dismissed

** This Schedule of Providers includes Yakima Valley Memorial Hospital FYE 10/31/05 pursuant to Provider's August 9, 2011 Request to Transfer Issue to Group Appeal to which the PRRB has not yet responded.

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PROVIDER REIMBURSEMENT REVIEW BOARD