CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Medical College of Georgia Hospital	**Provider Cost Reimbursement Determination for Cost Year Ending: 06/30/2003 and 06/30/2004**
Provider	
vs.	**Review of:**
Blue Cross Blue Shield Association/ Cahaba Government Benefits Administrators-GA	**PRRB Dec. No. 2010-D30 and PRRB Dec. No. 2010-D31**
Intermediary	**Dated: May 25, 2010**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in § 1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). The parties were notified of the Administrator's intention to review the Board's decision. No comments were submitted by any of the parties. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISIONS

The issue was whether the Board had jurisdiction over the Provider's appeals of the question of whether the disproportionate share (DSH) adjustment was incorrectly determined due to a significant error in the Supplemental Security Income (SSI) percentage where the request for hearing was filed more than three years after the issuance of the notice of program reimbursement (NPR).

The Board found that it lacked jurisdiction over the appeals, and thus dismissed the cases. The Board found that §1878(a) of the Social Security Act (42 U.S.C. §1395oo(a)) establishes that a provider has a right to a hearing before the Board with respect to a timely filed cost report if it "files a request for a hearing within 180 days after notice of the intermediary's final determination" and meets other jurisdictional criteria. The Board stated that it has consistently

treated the statutory criteria—dissatisfaction, amount in controversy, and timeliness—as jurisdictional requirements, and that Federal courts have supported that view.[1]

The Board noted that while the Provider relied only on the reopening regulation dealing with fraud as the basis to excuse the late filing, the Board also considered whether the Provider's filings were timely under general equitable tolling principles and under the good cause provisions of 42 C.F.R. §405.1836. The Board found that jurisdiction could not be granted under either theory.

SUMMARY OF COMMENTS

No comments were submitted in this case.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. The Administrator has reviewed the Board's decision. All comments timely received have been considered and included in the record.

The Medicare program was established to provide health insurance to the aged and disabled. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), 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 out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS.[2]

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare.[3] The fiscal 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).[4] A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board)

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[1] *St. Joseph's Hospital v. Heckler*, 786 F.2d 848 (8th Cir. 1986). The Court noted, "Clearly, had Congress intended the 180 day limitation of section 1395oo(a)(3) to be less than mandatory, it could have easily provided that a request for a hearing be filed 'within days…or within such further time as the Secretary may allow'…Because section 1395oo(a) specifically defines those situations in which a provider may seek review, it also necessarily defines those situations in which the Board will have jurisdiction to review a claim."

[2] Section 1816 of the Act, 42 C.F.R. §§413.20(b) and 413.24(b).

[3] 42 C.F.R. §413.20.

[4] 42 C.F.R. §405.1803.

within 180 days of the issuance of the NPR.[5] The regulation at 42 C.F.R. §405.1836[6] notes that a request for a Board hearing that the Board receives after the applicable 180-day time limit prescribed in §405.1835(a)(3) of this subpart must be dismissed by the Board, except that the Board may extend the time limit upon a good cause showing by the provider. It further notes that the Board may find good cause:

> 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), and the provider's written request for an extension is received by the Board within a reasonable time (as determined by the Board under the circumstances) after the expiration of the applicable 180-day limit…[7]

Finally, the regulation states:

> (c) The Board may not grant a request for an extension under this section if--
> (1) The provider relies on a change in the law, regulations, CMS Rulings, or general CMS instructions (whether based on a court decision or otherwise) or a CMS administrative ruling or policy as the basis for the extension request; or
> (2) The date of receipt by the Board of the provider's extension request is later than 3 years after the date of the intermediary or other determination that the provider seeks to appeal.[8]

The Medicare regulations at 42 C.F.R. §405.1885(a) provide that an intermediary may reopen a previous determination with respect to findings on matters at issue in a cost report. Such a reopening must be made within three years of the date of notice of the intermediary determination.[9] No intermediary reopening is permitted after three years unless it is established that such determination was procured by fraud or similar fault of any party to the determination.[10] While "fraud" has not been defined in the regulation, CMS has noted that fraud shows intentionally false oral or written representation of a matter or fact, or concealment of a matter that should have been disclosed [11] Notably, 42 C.F.R. §405.1885(c) provides that jurisdiction for reopening an intermediary determination decision rests exclusively with the intermediary except as qualified by paragraph (c)(1).

Title VI of the Social Security Amendments of 1983[12], adding § 1886(d) to the Act, established the inpatient prospective payment system (IPPS) for reimbursement of inpatient hospital

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[5] Section §1878(a) of the Act; 42 C.F.R. §405.1835.
[6] *See* 73 Fed. Reg. 30,205 (May 23, 2008).
[7] 42 C.F.R. §405.1835(b).
[8] 42 C.F.R. §405.1835(c).
[9] 42 C.F.R. §405.1885(b).
[10] 42 C.F.R. §405.1885(d) and (e).
[11] 73 Fed. Reg. 30,190, 30,233 (May 23, 2008).
[12] Pub. L. No. 98-21.

operating costs for all items and services provided to Medicare beneficiaries other than physician's services associated with each discharge. These amendments changed the method of payment for inpatient hospital services for most hospitals under Medicare. Under IPPS, hospitals and other health care providers are reimbursed their inpatient operating costs on the basis of prospectively determined national and regional rates for each discharge rather than reasonable operating costs. The purpose of IPPS was to reform the financial incentives hospitals face, promoting efficiency by rewarding costs effective hospital practices.[13]

Pursuant to § 1886(d)(5)(F)(i) of the Act, Congress directed the Secretary to provide, for discharges occurring after May 1, 1986, "for an additional payment amount for each subsection (d) hospital" serving "a significantly disproportionate number of low-income patients..."[14] To be eligible for the additional DSH payment for each prospective payment, a hospital must meet certain criteria concerning, inter alia, its disproportionate patient percentage. The Act states that the term "disproportionate patient percentage" means the sum of two fractions which is expressed as a percentage.

The first fraction, commonly known as the "Medicare fraction", used to compute the DSH payment is set forth at 42 C.F.R. § 412.106(b)(2). The regulation at 42 C.F.R. § 412.106(b) provides that:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS-
> (i) Determines the number of covered patient days that-
> (A) Are associated with discharges occurring during each month; and
> (B) Are furnished to patients who during that month were **entitled to both Medicare Part A and SSI**, excluding those patients who received only State supplementation.[15] [emphasis added]

Also known as the "SSI fraction", this fraction captures the number of Medicare patients who are also eligible for SSI. CMS calculates the fraction and notifies the provider and Intermediary. The second fraction, commonly known as the "Medicaid fraction", used to compute the DSH payment, is set forth at 42 C.F.R. § 412.106(b)(2).[16]

In this case, the Provider appealed its NPRs, asserting that the SSI percentages used to calculate its DH adjustments for fiscal years 2003 and 2004 were understated due to several flaws in the data collection and matching process. The appeals were filed October 16, 2008, more than 180 days after the issuance of the NPRs which were issued on August 5, 2005 for FY 2003 and September 28, 2006 for FY 2004. The appeal was filed more than three years after the FY 2003 NPR was issued, but within the reopening period defined in 42 C.F.R. § 405.1885 for fraud or

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[13] H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983).
[14] Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-2725). See also 51 Fed. Reg. 16772, 16773-19776- (1986).
[15] *See also* Section 1886(d)(5)(F)(vi)(I) of the Act.
[16] *See also* Section 1886(d)(5)(F)(vi)(II) of the Act.

similar fault. The Provider requested the Board consider both the appeals timely filed under 42 C.F.R. §405.1885(b)(3).

In light of the Provider's vague claims of being mislead, the Board considered these claims in the context of the doctrine of equitable tolling.[17] The Board was proper in finding that the doctrine of equitable tolling was not applicable. As the Board correctly noted, it is a firmly established principle of law that an agency may not assert any power greater than that delegated to it by Congress. Congress imposed time limits for filing appeals to the Board, and did not confer any right to equitable powers to CMS, including the right to apply equitable tolling remedies. In addition, even assuming, *arguendo*, were the Board to apply the principles that Provider is asserting, the Board correctly noted that the Providers would still not be entitled to relief. The Provider was on notice of potential flaws in its SSI calculations as early as 1993, when the Board issued a decision on the SSI issue in *Loma Linda Community Hospital* (PRRB Dec. No. 93-D50). Additionally, the details of the flaws that the Provider now relies on as a basis for its appeals were analyzed in the Board's decision in *Baystate Medicial Center*, PRRB Dec. 2006-D20, issued on March 17, 2006. There is no documentation that the Provider made any attempt to examine the accuracy of its SSI percentage until October of 2008.

While the Provider asserted that under 42 C.F.R. §405.1885(b)(3) the Board has the authority to permit late filing as the result of CMS' actions, the Board correctly found that the decision in *Baystate* does not support this contention. In addition, the Board correctly pointed out that the reopening provision at 42 C.F.R. §405.1885(b)(3) only permits reopening of an intermediary determination by an intermediary or by CMS. The Board also noted that it does not have jurisdiction of an appeal of a denial of reopening.[18] The Board properly stated that nothing in the reopening authority provides for extending the Board's filing deadlines beyond the times expressly granted in the regulations.

The Board also properly found that the good cause exception found in 42 C.F.R. § 405.1836 is not an unlimited power given to the Board to permit untimely appeals. The powers conferred by Congress to the Secretary allowing a right to hearing occur only with specific conditions, one of which is the specified filing time. The regulations also provide that the Board may not grant an extension for good cause based on a change arising from a court decision.[19]

Thus, because the appeals in this case were filed more than 180 days from the issuance of the NPRs, the Board properly found that it lacked jurisdiction in these appeals. The Board also properly found it does not have jurisdiction over reopening matters raised by the Provider in this case under 42 C.F.R. §405.1885. Moreover, among other things, as the appeals were filed more than three years from the date of the NPRs, the Board properly determined the good cause provision was inapplicable.

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[17] In this instance, the Provider was not represented by attorney counsel.
[18] *Your Home Visiting Nurse Services, Inc. v. Shalala*, 525 U.S. 449 (1998).
[19] 42 C.F.R. §405.1836(c).

Accordingly, as the Board's decisions are supported by the record and are consistent with the governing regulations, the Administrator affirms the decisions of the Board.

The Administrator notes that the underlying issue on the merits is one of the three DSH issues subject to CMS Ruling No: CMS-1498-R (April 28, 2010). However, because the Administrator finds that the jurisdictional requirements were not met for these appeals, these claims are not subject to the Ruling.

DECISION

The Administrator affirms the decisions of the Board in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 07/13/2010 /s/

Marilyn Tavenner
Principal Deputy Administrator
Centers for Medicare & Medicaid Services