CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Coosa Valley Medical Center	**Provider Cost Reimbursement Determination for Cost Reporting Periods:**
Provider	**July 31, 2006; July 31, 2007**
vs.	**Review of:**
BlueCross BlueShield Association/ Cahaba Government Benefits Administrators, LLC	**PRRB Dec. No. 2011-D11**
Intermediary	**Dated: November 22, 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 mandated 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. The Provider submitted comments requesting the Board's decision on jurisdiction be reversed. Accordingly, this case is now before the Administrator for final agency review.

ISSUE

The issue was whether the Centers for Medicare and Medicaid Services reversal of the Provider's rural referral center (RRC) classification was proper.

BOARD'S DECISION

The Board majority found that it did not have jurisdiction over the appeal, as there was no payment amount in dispute for the fiscal years under appeal. The Board majority noted that there appeared to be no reimbursement effect as a result of the RRC determination itself, but rather than any reimbursement effect would depend on the determination that the provider be redesignated as urban, a determination that was

reached by a separate board, the Medicare Geographic Classification Review Board (MGCRB).

The Board majority noted that, at one time, an RRC designation guaranteed automatic urban redesignation for the purposes of using the other area's wage index value which would increase Medicare payments. However, CMS removed that provision from the regulation when it created the MGCRB in 1994. The revised regulation now requires providers to apply for redesignation based on various criteria. Although the RRC status approval had been revoked effective August 1, 2006, the MGCRB granted the provider's application for redesignation for FFYs 2008-2011 based on the Provider's own records and other criteria, including whether there had been any prior designation of the Provider as a RRC.

The Board majority noted that the Provider argued that designation as a RRC at any time allows a provider to "maintain" its designation as urban, and thus that revocation would involve a reimbursement effect that would meet the jurisdictional requirement for the amount in controversy. The Provider also cited the stipulation entered into by the Provider and Intermediary that the future impact satisfied the jurisdictional criteria for amount in controversy. The Board majority also noted that while the parties cited the preamble to the Secretary's new regulations[1] governing Board procedures, which lists RRC denials as an appealable "intermediary determination", the preamble also references that the intermediary determination is appealable subject to or depending on the amount in controversy. Since there is no cost report reimbursement effect based on a RRC determination, absent the MGCRB redesignation process, there is no payment amount in dispute for the fiscal years under appeal.

However, after finding that it lacked jurisdiction over the appeal, the Board majority went on to address the merits, assuming, *arguendo*, that it had jurisdiction. The Board majority claimed they were doing so because the Intermediary held a contrary position on jurisdiction.[2]

The Board majority stated that it was undisputed that the Provider would have qualified for RRC status under the old provider number, had it not refused to accept the assignment of the existing Medicare provider number, but that this was not done. Instead, the prior owner's records were used to justify the Provider's RRC application request, RRC status was granted, and CMS later determined that it had

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[1] 73 Fed. Reg. 30,190, 30,191 (May 23, 2008).

[2] The parties jointly stipulated that the Intermediary's June 20, 2006 rescission of the Provider's RRC status constitutes an "intermediary decision" within the meaning of 42 C.F.R. §405.1835(a)(1).

granted this status in error. The Board majority noted that the Provider argued that, regardless of whether its RRC status was granted in error, the Balanced Budget Act of 1997 (BBA) permanently removed CMS' authority to reverse RRC status after it has been granted. The Board majority did not find support for this position, noting that the BBA sections relied on for the premise that once RRC status is granted, it is permanent, only applies to providers with RRC status as of 1991.[3] The Board majority found no prohibition on CMS to terminate or reverse a decision regarding RRC status for providers after 1991. The Board majority also found that both the Intermediary and CMS allowed the Provider's 2006 RRC designation to remain in force. The June 20, 2006 letter sent to the Provider that stated CMS was reversing its RRC approval determination, noted that the reversal did not affect the Provider's reimbursement for the 2006 cost reporting period, during which time it was "determined to be a rural referral center."[4] Thus, the Board majority found, the Intermediary's action regarding RRC status for 2007 did not deprive the Provider of the criteria the MGCRB relies on for future years classification as to whether they were "ever" a RRC.

Finally, the Board majority noted that, while it found no basis or prohibition against the Intermediary/CMS to revoke, reverse, or suspend the prior decision regarding RRC status, the Intermediary did not follow the process detailed in 42 C.F.R. §405.1885, which outlines the specific requirements for reopening of an intermediary determination. Thus, the Intermediary is now barred by the three year reopening limitation. Therefore, the Board majority concluded, the Intermediary/CMS action reversing the Provider's RRC status was improper.

One member of the Board dissented, noting he believed the Provider did meet the jurisdictional requirements. He noted that while he agreed that the Board's decision alone would have no effect on reimbursement, the Board often renders decisions which do not have a "direct" reimbursement effect, such as decisions "subject to audit by the fiscal intermediary". He also claimed that requiring a "direct reimbursement impact" would render meaningless the preamble at 73 Fed. Reg. 30191 (May 23, 2008), which states that the denial of a hospital's request to be classified as a RRC is appealable to the Board, as in all such cases, a Board decision would still have to be followed by a positive decision of the MGCRB before reimbursement was affected, and requiring a "direct" effect would mean the Board would never have jurisdiction over RRC status. Finally, the dissent noted that the fiscal year should not be relevant, but the key should be that the decision being appealed is the cause of a payment reduction to the hospital, and hence an amount in controversy.

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[3] BBA at §4202(b).

[4] *See* Provider's Final Position Paper, Exhibit 6.

SUMMARY OF COMMENTS

The Provider commented, stating that it disagreed with the Board's decision that it lacked jurisdiction, but agreed with the Board's determination that the Intermediary/CMS failed to follow the reopening provisions required by the Secretary in 42 C.F.R. §405.1885. The Intermediary is thus barred by the three year limitation on reversing its July 2005 determination to grant RRC status.

The Provider argued that the "amount in controversy" requirement for a Board hearing under 42 C.F.R. §405.1835 was met because the rescission of the Provider's RRC status at issue would result in lost reimbursement of over one million dollars. In addition, both the Provider and Intermediary jointly stipulated that the matter satisfied the "amount in controversy" jurisdictional criterion. The Provider argued that it would face a "massive financial loss" if the Intermediary determination were allowed to stand.

The Provider also claimed that once CMS granted RRC status, it lacks the authority to reverse that determination, noting that CMS has only two sources of authority for revoking RRC status: by accepting a provider's voluntary request for cancellation, or upon reclassification of the provider's area as urban by OMB. Since the Provider did not voluntarily request cancellation of its previously granted RRC status, and the Provider's service area has not been reclassified as urban by the Office of Management and Budget, CMS had no authority to revoke its RRC status on June 20, 2006, and acted contrary to the clearly expressed intent of Congress in the statute, and to the Secretary's regulation.

Finally, the Provider stated that among the requirements for a valid reopening, as set forth in 42 C.F.R. §405.1885, a request to reopen a determination must be made within three years after the date of determination that is the subject of reopening. The Provider claimed that the Intermediary/CMS did not do this, and thus the Board was correct in finding that the Intermediary/CMS are now time-barred from attempting to reopen the matter.

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 submitted have been taken into consideration.

The Provider, a short term, acute care hospital located in Sylacauga, Talladega County, Alabama, was part of the Baptist Health System through August 1, 2004, when the hospital was purchased by Sylacauga Health Care Authority. At the time of this change of ownership, the Provider chose not to accept assignment of the prior owner's Medicare provider number and was issued a new provider number to satisfy the buyer's interest in liability limitation and assignment of billing responsibility.

On June 20, 2005, the Provider requested it be designated a rural referral center (RRC), for its fiscal year beginning August 1, 2005, under the alternative qualifications prescribed at 42 C.F.R. §412.96(c). This request was approved by CMS in a letter dated July 14, 2005. However, the supporting documentation data used by the Provider in its application was based on cost report information for fiscal years when the Provider was owned by Baptist Health System and participated in the Medicare program under the old provider number.

On June 20, 2006, a letter was sent to the Provider from the Intermediary, stating that CMS was reversing its RRC approval determination, effective with the beginning of the hospital's FY 2007, meaning effective August 1, 2006.[5] The letter stated that the reversal did not affect the Provider's reimbursement for the 2006 cost reporting period, during which time it was "determined to be a rural referral center." The reversal was based on information in a letter to Congressman Mike Rogers from Herb Kuhn, who at the time was the Director of CMS' Centers for Medicare Management. In that letter, Mr. Kuhn noted that the Provider was incorrectly awarded RRC status on the basis of data under the old provider number, and that its RRC status would be suspended until it could be reconsidered using data under the new provider number. The letter stated that the hospital could apply for RRC status once it acquired the necessary data under the new provider number from fiscal year (FY) 2005 later that year.[6]

Section 1878(a)(1) of the Social Security Act provides that any provider of services which has filed a required cost report may obtain a hearing with respect to such cost report by the Board if the provider:

> (A) (i) is dissatisfied with a final determination of the [intermediary] as to the amount of total program reimbursement due the provider ... for which payment may be made under this title for the period covered by such report ...
> (2) the amount in controversy is $10,000 or more, and

[5] *See* Provider's Final Position Paper, Exhibits 6 and 7.

[6] As of February 19, 2009, the Provider had not reapplied for RRC status. *See* Transcript of Oral Hearing, p. 196.

> (3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i).

Consistent with the statute, the regulations at 42 C.F.R. § 405.1835(a)[7] state that a provider has a right to a hearing before the Board on an intermediary's determination, if:

> (1) An intermediary determination has been made with respect to the provider;
> and
> (2) The provider has filed a written request for a hearing before the Board under the provisions described in 405.1841(a)(1); and
> (3) The amount in controversy (as determined in Section 405.1839(a)) is $10,000 or more.

According to 42 C.F.R. § 405.1801(a), an "intermediary determination" means the following:

> (1) With respect to a provider of services that has filed a cost report under
> §§ 413.20 and 413.24(f) of this chapter, the term means a determination of the amount of total reimbursement due the provider, pursuant to § 405.1803 following the close of the provider's cost reporting period, for items and services furnished to beneficiaries for which reimbursement may be made on a reasonable cost basis under Medicare for the period covered by the cost report.
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> (2) With respect to a hospital that receives payments for inpatient hospital services under the prospective payment system (part 412 of this chapter), the term means a determination of the total amount of payment due the hospital, pursuant to § 405.1803 following the close of the hospital's cost reporting period, under that system for the period covered by the determination.
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> (3) For purposes of appeal to the Provider Reimbursement Review Board, the term is synonymous with the phrases ''intermediary's final

[7] 10-1-05 Edition of the Code of Federal Regulations. The language at 42 C.F.R. § 405.1835(a) changed effective as of the 10-1-08 Code of Federal Regulations. However, as the Provider's appeal was filed June 28, 2006, the 10-1-05 Edition of the Code of Federal Regulations should be used for most of the jurisdiction matters.

> determination'' and ''final determination of the Secretary'', as those phrases are used in section 1878(a) of the Act.

42 C.F.R. §405.1839(a) states that the $10,000 amount in controversy required under § 405.1835 for a Board hearing is, as applicable to the matters for which the provider has requested a hearing, the combined total of the amounts computed as follows:

> (1) *Providers under prospective payment.* For providers that are paid under the prospective payment system, by deducting—
> (i) The total of the payment due the provider on other than a reasonable cost basis under the prospective payment system from the total amount that would be payable after a recomputation that takes into account any exclusion, exception, adjustment, or additional payment denied the provider under part 412 of this chapter, as applicable;
> (ii) The total of the payment due the provider on a reasonable cost basis under the prospective payment system from the total reimbursable costs claimed by the provider; and
> (iii) The adjusted total reimbursable costs due the provider on a reasonable cost basis under other than the prospective payment system from the total reimbursable costs claimed by the provider.
> (2*) Providers not under prospective payment.* For providers that are not paid under the prospective payment system, by deducting the adjusted total reimbursable program costs due the provider on a reasonable cost basis from the total reimbursable costs claimed by the provider.

In addition to a notice of amount of program reimbursement (NPR), other determinations made by the intermediary or CMS are appealable to the Board, including: A denial of a hospital's request for an adjustment to, or an exemption from, the Tax Equity and Fiscal Responsibility Act (TEFRA) rate of increase ceiling; a denial of a home health agency or skilled nursing facility's request for an adjustment to, or an exemption from, the routine cost limits (RCLs) that were in effect prior to a PPS for these providers; a denial of certain hospice payments; or a denial of a PPS hospital's request to be classified as a sole community hospital or rural referral center.[8]

In this case, the Provider was appealing CMS' decision to reverse the Provider's status as a RRC for fiscal year 2007. However, as the Board correctly stated, there is no amount in controversy for the fiscal years under appeal. Thus, the Provider did not meet the statutory or regulatory requirements for Board jurisdiction, and the Board properly found that it lacked jurisdiction over the appeal.

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[8] *See* 73 Fed. Reg. 30,190, 30,191 (May 23, 2008).

The reason there is no amount in controversy for this Provider is that since 1994, there is no adjustment to the prospective payment rates when a rural hospital is classified as a rural referral center, as the standard amount for rural and other urban hospital were equalized under the Omnibus Budget Reconciliation Act of 1993 (Pub. Law 103-66). Section 402 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (Pub. Law 108-173) also excepts RRCs from the 12 percent cap on Disproportionate Share Hospital Payments. Consequently, the termination of RRC status may have a direct reimbursement impact on a hospital, but apparently did not do so for this particular Provider. The Provider's Chief Executive Officer clearly acknowledged this, testifying that it was his understanding that "rural referral center status is the first step necessary that would then drive us toward geographic reclassification. The status as a rural referral center is required. We believe that it's a necessary step, though no financial benefits are associated with that,"[9] and that, ""[W]e do understand that the rural referral center status standing on its own would have no economic impact on the organization."[10]

The amount in controversy is necessarily determined by the impact of the issue on the Provider's Notice of Program Reimbursement, as it reflects the total amount due the Provider. To attempt to speculate on the possible reimbursement impact based on a separate board's determination on a reclassification request is improper.[11]

The parties stipulated "that the Intermediary's determination to rescind Provider's status as a rural referral center directly affects the Provider's ability to maintain its reclassification to the Birmingham-Hoover MSA," and that "Such reclassification involves payment amounts in excess of $10,000, and is, therefore, sufficient to meet the $10,000 amount in controversy requirement." The stipulation is in error as the Provider cannot demonstrate that the elimination of its RRC status decreases its reimbursement by at least $10,000 for FY 2006 and 2007. Were the Provider successful in this appeal, its reimbursement would not be increased by at least $10,000.

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[9] *See* Transcript of Proceeding, p. 62.

[10] *See* Transcript of Proceeding, p. 88

[11] Moreover, the language used at 42 C.F.R. § 405.1839 does not include "reclassification". Further, the clarification of the language in 2008 clearly requires that a Provider show it would have its payment increased by $10,000 if successful on appeal. Even assuming an MGCRB determination could have an impact and could be properly considered, the termination of the RRC status did not have an adverse impact on this Provider.

As the Board lacked jurisdiction over the appeal, it should not have proceeded to address the merits of the case. The mere fact that the Intermediary stipulated that the Intermediary's June 20, 2006 rescission of the Provider's RRC status constituted an "intermediary decision" with the meaning of 42 C.F.R. §405.1835(a)(1) does not provide jurisdiction for the Board to decide the case on the merits when the statutory and regulatory requirements for Board jurisdiction have clearly not been met. The determination of RRC status is intertwined with the cost report and does not absolve the Provider from meeting the $10,000 amount in controversy requirement for the cost reporting period under appeal. The RRC determination does not stand alone as a determination separate and apart from the cost report and hence the Notice of Program Reimbursement.[12] That RRC status is not a standalone determination is also apparent by CMS' approach to examining RRC status many years after an initial determination is made.[13]

[12] Similarly, both TEFRA and RCL exception request denials are appealable pursuant to the Notice of Program Reimbursement. *See, e.g.*, 42 C.F.R. §§ 413.30 and 413.40.

[13] *See, e.g.*, 72 Fed. Reg. 47,130, 47,371 (Aug. 22, 2007), "Furthermore, our amendment to the regulations eliminating the triennial review requirement was not intended to allow hospitals to retain RRC status indefinitely once obtained under § 412.96." *See also*, 54 Fed. Reg. 36,452, 36,486 (Sep. 1, 1989), "When we begin implementation of the provisions of § 412.96(f), some hospitals will have been classified as referral centers for more than 3 years without having been reviewed for continuing compliance with the referral center criteria. We proposed that the review process be limited to the hospital's compliance during the last 3 years."; "We continue to believe that it is equitable and reasonable to review periodically approved rural referral centers' compliance with the criteria in the statute and regulations to ensure that only those hospitals that are truly functioning as rural referral centers receive the special adjustment. Some hospitals qualified as rural referral centers based on their case-mix index values and number of discharges from 1981 and have not met the criteria since that time."

DECISION

The Board's decision regarding jurisdiction is affirmed consistent with the foregoing opinion. The Board's decision on the merits is vacated for lack of jurisdiction.

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

Date: 1/20/2011 /s/

Marilynn Tavenner
Principal Deputy Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services