DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2670

Internet: www.cms.gov/PRRBReview

FAX: 410-786-5298
Phone: 410-786-2671

Refer to: 05-1609

CERTIFIED MAIL

SEP 05 2013

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

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

RE: Doctor's Center, Inc.
PN: 40-0118
FYE: 12/31/1998
PRRB Case No.: 05-1609

Dear Mr. Roth and Mr. Pike,

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

Background

The Provider was issued a revised Notice of Program Reimbursement (NPR) for fiscal year 12/31/1998 on November 18, 2004. On May 11, 2005, the Provider filed a hearing request with the Board appealing the SSI% issue. Subsequently, the Provider added the Medicare + Choice Days issue to its individual appeal on December 21, 2007. In order to establish the Board's jurisdiction, the Provider submitted "Documents Confirming Board Jurisdiction Over RNPR Appeal" on May 20, 2008.

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

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

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

Provider's Position

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

Board's Decision

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

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

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

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

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

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

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

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

The Board finds that it does not have jurisdiction over the SSI% issue because it was not adjusted when the cost report was reopened. The audit adjustment report shows only an adjustment to DSH generally, not to the SSI% specifically. Furthermore, on Worksheet E Part A supplied by the Provider, it indicates that the SSI% remained at .20.

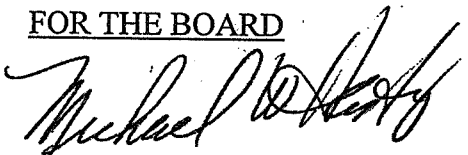
In addition, the Board also finds that it does not have jurisdiction over the Medicare + Choice issue that was added to the appeal. The Provider did not submit any documentation showing that Medicare + Choice days were adjusted in the reopening of the cost report, therefore the Board finds that it does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

The Board finds that it does not have jurisdiction over the two issues in this individual appeal because they were not specifically adjusted in the revised NPR. Therefore, the Board hereby dismisses the two issues and closes case number 05-1609.

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

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

FOR THE BOARD



Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, BCBSA

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Refer to: 05-0120

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

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

RE: Perea Hospital
PN: 40-0123
FYE: 12/31/1998
PRRB Case No.: 05-0120

Dear Mr. Roth and Mr. Pike,

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

Background

The Provider was issued a revised Notice of Program Reimbursement (NPR) for fiscal year 12/31/1998 on April 30, 2004. On October 29, 2004, the Provider filed a hearing request with the Board appealing the SSI% issue. Subsequently, the Provider added the Medicare + Choice Days issue to its individual appeal on December 21, 2007.

On December 14, 2004, the Intermediary's representative filed a "Motion to Dismiss" arguing that the Board did not have jurisdiction over the Provider's appeal because it was filed 182 days after the date of the revised NPR. The Provider submitted its answer to the motion to dismiss on March 1, 2005. On May 18, 2005, the Board issued a decision finding that it had jurisdiction over the Provider because the Provider had filed the appeal within 180 days plus the 5 day mailing presumption of the date of the revised NPR. In order to further establish the Board's jurisdiction, the Provider submitted "Documents Confirming Board Jurisdiction Over RNPR Appeal" on May 20, 2008.

This individual appeal is one of a number of appeals by hospitals in Puerto Rico that are currently before the Board on two common issues: the SSI% issue and the Medicare + Choice days issue. On August 13, 2007, the Board sent a letter to the various Providers requesting additional documentation related to the revised NPR appeals in order to determine whether it has jurisdiction over the issues. In the same letter, the Board explained that it was considering, on its own motion, an EJR because it was unsure whether it had the authority to decide the question before it (referring to the SSI% issue). The Board stated that the replacement of cash assistance

under Titles I, X, and XIV of the Social Security Act by Title XVI (SSI) in 1974 does not apply to Puerto Rico. The Provider, on the other hand, argued that anyone eligible for cash assistance under Titles I, X, and XIV would qualify for benefits under Title XVI. The Board requested that both parties submit comments regarding a potential EJR, in addition to the requested jurisdictional documents.

On February 7, 2008, the Board issued a decision finding that it had jurisdiction to determine whether eligibility under Title I, X, and XIV also satisfies eligibility under Title XVI, therefore an EJR was not granted. On that same date, the Board sent another letter to the Provider requesting additional documentation related to the appeal from a revised NPR. The Board specified what information it was requesting, including workpapers related to both the SSI% as well as Medicare + Choice Days. On May 20, 2008, the Provider submitted "Documents Confirming Board Jurisdiction Over RNPR Appeal." These documents, however, did not include any workpapers that the Board could use to determine whether there was an adjustment to the M+C days.

Provider's Position

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

Board's Decision

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

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

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

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

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

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

The Board finds that it does not have jurisdiction over the SSI% issue because it was not adjusted when the cost report was reopened. Adjustment number 6 shows that there was no adjustment made to the SSI%, though DSH was adjusted as the Provider argued. Following the audit adjustment report is a handwritten statement that the Provider was protesting the DSH adjustment and the SSI%, but that does not change the fact that the Intermediary made no adjustment to the SSI% specifically.

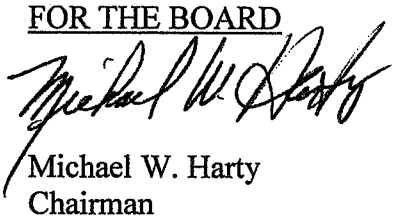
In addition, the Board also finds that it does not have jurisdiction over the Medicare + Choice issue that was added to the appeal. The Provider did not submit any documentation showing that Medicare + Choice days were adjusted in the reopening of the cost report, therefore the Board finds that it does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

The Board finds that it does not have jurisdiction over the two issues in this individual appeal because they were not specifically adjusted in the revised NPR. Therefore, the Board hereby dismisses the two issues and closes case number 05-0120.

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

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

FOR THE BOARD



Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, BCBSA

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CERTIFIED MAIL

Ober, Kaler, Grimes & Shriver
Thomas W. Coons, Esq.
100 Light Street
Baltimore, MD 21202

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

Re: Raritan Bay Medical Center, Provider No. 31-0039, (Participant #1),
Muhlenberg Regional Medical Center, Provider No. 31-0063, (Participant #3),
Hospital Center at Orange, Provider No. 31-0078, (Participant #6),
East Orange General Hospital, Provider No. 31-0083, (Participant# 7), and
Columbus Hospital, Provider No. 31-0093 (Participant #9)
FYE: 12/31/1993
As Participants in New Jersey 93 SSI Group, PRRB Case No.: 99-3232G

Dear Mr. Coons and Ms. Silvio:

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

Pertinent Facts:

Five providers appealed from revised Notices of Program Reimbursement (revised NPR).

Raritan Bay Medical Center, (Provider No. 31-0039) Participant #1, submitted a reopening request "for the Disproportionate Share adjustment as it relates to Medicaid days." The reopening notice referenced revisions to several categories of patient days resulting in an increase of 3433 Medicaid days.

Hospital Center at Orange (Provider No. 31-0078) Participant #6, noted that it is was unable to provide a copy of the reopening request but submitted the reopening notice that stated the cost report would be revised for disproportionate share – total Medicaid days, maintained bed count, and PS & R updated for revenue code 610.

East Orange General Hospital (Provider No. 31-0083) Participant #7, submitted a reopening request that referenced various categories of additional Medicaid days to be reviewed by the Intermediary as well as a reopening notice that states "the Intermediary will reopen . . . to include additional Medicaid paid days in the disproportionate share calculations."

Muhlenberg Regional Medical Center (Provider No. 31-0063) Participant # 3 and Columbus Hospital (Provider No. 31-0093) Participant #9, both assert "[n]o adjustment is required under *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988).

Board Determination:

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

The Board finds that it lacks jurisdiction over Participant #1, Raritan Bay Medical Center, Participant #6, Hospital Center at Orange, and Participant #7, East Orange General Hospital, as each appealed from a revised NPR and was unable to provide evidence to support a specific adjustment or revision to the SSI Percentage. The Board further finds that it lacks jurisdiction over Participant #3, Muhlenberg Regional Medical Center and Participant #9, Columbus Hospital, as both appealed from revised NPRs in which no adjustment was made to the SSI Percentage. Although both of these participants assert "[n]o adjustment is required under *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988), *Bethesda* is not applicable to appeals of revised NPRs.

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

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

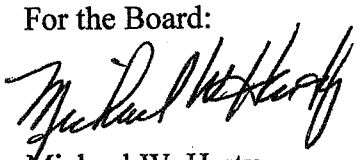
42 C.F.R. § 405.1889 (1996), stated "[w]here a revision is made in a determination or decision on the amount of program reimbursement after such a determination or decision has been reopened . . . such revision shall be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1835, 405.1875 and 405.1877 are applicable." This regulation has also been addressed and explained in the decision *HCA Health Services of Oklahoma v Shalala*, 27 F.3d 614 (D.C. Cir. 1994). In this case the Court held that when a fiscal intermediary reopens its original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening, and does not extend further to all determinations underlying the original NPR.

Therefore the Board hereby dismisses Participant #1, Raritan Bay Medical Center, Participant #3, Muhlenberg Regional Medical Center, Participant #6, Hospital Center at Orange, Participant #7 East Orange General Hospital, and Participant #9, Columbus Hospital from the group appeal. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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

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

For the Board:



Michael W. Harty
Chairman

Enclosures: Standard Remand of the SSI Fraction
Schedule of Providers
42 U.S.C. § 1395oo(f) and 42 C.F.R. §§405.1875 & 1877

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

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CERTIFIED MAIL

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

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

Re: Riley Memorial Hospital, Provider No. 25-0081 (Participant #11), FYE: 12/31/2005
As a Participant in QRS HMA 2005 DSH SSI Percentage CIRP Group, PRRB Case No. 13-0308GC

Dear Mr. Ravindran and Mr. Lamprecht:

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

Pertinent Facts:
Participant 11, Riley Memorial Hospital (Riley), Provider No. 25-0081 appealed from a revised NPR dated January 22, 2009. The Provider asserted that it "was precluded from utilizing its own internally generated SSI percentage and maintains that it validly self-disallowed such an internally generated Percentage in favor of that promulgated by CMS." The Provider failed to submit the revised NPR and the requisite documentation and worksheets to support its appeal. The Participant noted on the Schedule of Providers included with the jurisdictional documents submitted July 1, 2013, that "[t]his document will be submitted under separate cover."

The Board by letter dated December 4, 2012 directed the Group Representative to:

> [S]ubmit a complete Schedule of Providers, along with the required supporting jurisdictional documents. If any Providers are appealing a Revised NPR (RNPR), you must submit the Provider's original NPR, the original NPR adjustment pages, the request to reopen, the notice of reopening, and the work papers from the original and RNPRs....Please submit this documentation with (sic) 60 days of the date of this letter....Failure of the Group Representative to timely submit this information, may result in dismissal of this appeal.[1]

Board Determination:

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

The Board finds that it lacks jurisdiction over Riley Memorial Hospital (Provider No. 25-0081) as the Provider appealed from a revised NPR and supplied insufficient evidence of a specific adjustment to the SSI percentage.

[1] Board Letter Regarding Expansion of Group Appeal (December 4, 2012).

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

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

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

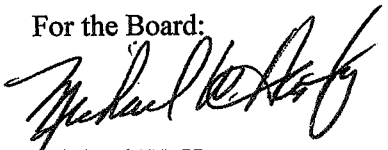
This regulation has also been addressed and explained in the decision *HCA Health Services of Oklahoma v Shalala*, 27 F.3d 614 (D.C. Cir. 1994). In this case the Court held that when a fiscal intermediary reopens its original determination regarding the amounts of reimbursement that a Medicare provider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

The Participant failed to submit documentation to support a specific adjustment to the SSI percentage within the revised NPR. Therefore the Provider does not meet the requirements of 42 C.F.R. § 405.1889 (b)(1). The Board hereby dismisses Participant 11, Riley Memorial Hospital (25-0081), from the group appeal. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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

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

For the Board:



Michael W. Harty
Chairman

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

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

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08-2900G

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

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

Re: University of Kansas, Provider No. 17-0040 (Participant #2)
Wilkes-Barre General Hospital, Provider No. 39-0137 (Participant #4)
FYE: 6/30/1997
As Participants in QRS 1997 DSH/SSI Proxy (3)
PRRB Case No.: 08-2900G

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

Pertinent Facts:

University of Kansas, Provider No. 17-0040

On April 12, 2008, the Board denied jurisdiction over the SSI percentage proxy in PRRB Case 03-0776 and denied the Provider's August 30, 2011 request to transfer to this group appeal. See attached Jurisdictional Challenge letter.

Wilkes-Barre General Hospital, Provider No. 39-0137

Wilkes-Barre General Hospital timely appealed from a revised Notice of Program Reimbursement (RNPR) dated August 20, 2002. The Provider does not reference an audit adjustment for this issue on the schedule of providers. Instead, documentation was provided referencing a request to reopen the cost report for multiple issues including Medicaid Days, Dual eligible days, the SSI %, Capital DSH, general assistance days, Intern and Resident costs, etc. The request to revise the SSI% was subsequently denied and the SSI% was not revised in the RNPR dated August 20, 2002.

Board Determination:

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

> A Secretary determination, an intermediary determination, or a decision by a reviewing entity (as described in §405.1801(a) of this subpart) may be reopened, for findings on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the intermediary (with respect to intermediary determinations) or by the reviewing entity that made the decision (as described in § 405.1885(c) of this subpart).
>
> 42 C.F.R. § 405.1889(b)(1) explains the effect of a cost report revision: "Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision."

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

University of Kansas, Provider No. 17-0040

University of Kansas is dismissed from the appeal, as the Board previously denied jurisdiction over this issue in PRRB Case 03-0776.

Wilkes-Barre General Hospital, Provider No. 39-0137

The Board finds it lack jurisdiction over Wilkes-Barre General Hospital, as the SSI percentage was not adjusted as part of the RNPR. The Provider had filed a request to reopen for the SSI%, but the Intermediary did not grant the reopening, nor was the issue incorporated into the RNPR. The Regulations state "[j]urisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision." [1]The Board finds that an Intermediary's refusal to reopen a cost report is not reviewable. See, Your Home Visiting Nurse Services, Inc. v. Shalala, 119 S.Ct. 930 (1999).

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

Board Members Participating:
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

For the Board:

Michael W. Harty
Chairman

Enclosures: Schedule of Providers

cc: Kevin Shanklin, Executive Director, BCBSA

---

1 42 C.F.R. §405.1885 (c).

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2670

Phone: 410-786-2671
Internet: www.cms.gov/PRRBReview **FAX: 410-786-5298**

Refer to:

CERTIFIED MAIL

SEP 05 2013

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

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

Re: Bethesda Memorial Hospital (10-0002), FYE 2004, Participant #5
Mary Lanning Memorial Hospital (28-0032), FYE 2004, Participant #10
Baptist St. Anthony Health System (45-0231), FYE 2004, Participant #14
As Participants in QRS 2004 Medicare DSH Labor Room Days Group, Case No.: 07-2324G

Dear Mr. Ravindran and Ms. Silvio,

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

Background:

The above-captioned group appeal was filed with the Board on June 27, 2007. The Providers contend that the Intermediary failed to include as Medicaid-Eligible Days, services to patients eligible for Medicaid such as Medicaid maternity patients who receive care in the Labor Room and similar units. They further argue that the Intermediary should not have excluded days deemed as labor room days for maternity patients who received care in the Labor/Delivery/Recovery/Post-Partum Unit (LDRP).

Bethesda Memorial Hospital (Provider No. 10-0002), Participant 5, appealed from a revised Notice of Program Reimbursement (NPR) dated April 20, 2010. The Provider raised audit adjustments # 5 and #6, and a statement of self-disallowance as the basis for its dispute of Labor Room days.

Mary Lanning Memorial Hospital (Provider No. 28-0032), Participant 10, filed an individual appeal on November 15, 2006 from an original NPR dated June 2, 2006. At that time there were two issues raised within the appeal request: DSH Medicaid eligible days and DSH SSI proxy. On October 8, 2008 the Provider filed Form C adding more issues to the appeal and noting that they self-disallowed DSH. However, the Provider failed to add the specific issue of Labor and Delivery Room days to its individual appeal prior to transferring to this group in 2011.

Baptist St. Anthony Health System (Provider No. 45-0231), Participant 14, appealed from a revised NPR, citing audit Adjustment #4 and a statement of self-disallowance as the basis for its dispute regarding Labor Room Days. Adjustment #4 notes that it is "[t]o adjust Medicaid days in accordance with the administrative resolution for PRRB Case No. 08-0357." Case No. 08-0357 was an individual

appeal filed by the Provider regarding FYE 12/31/2004. The case was closed on February 4, 2010 when the Provider sent a Withdrawal Request because of a settlement.

Board Determination:

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

The Board finds that it lacks jurisdiction over Participant 10, Mary Lanning Memorial Hospital (28-0032), in this group appeal as the issue was not timely raised within the individual appeal prior to the transfer to the group appeal. Providers that wished to add issues to their pending appeals were required to submit the request no later than 60 days after the effective date of the rule, or October 20, 2008. *See,* 73 Fed. Reg. 30190, 30240 (May 23, 2008). While the Provider did add issues to its individual appeal, it did not specifically raise the issue of Labor Room Days.

The Board finds that it lacks jurisdiction over Participants 5, Bethesda Memorial Hospital, and Participant 14, Baptist St. Anthony Health System, as they each appeal from revised NPRs that did not specifically adjust Labor and Delivery Days.

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

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

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

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

The Board hereby dismisses Bethesda Memorial Hospital, Mary Lanning Memorial Hospital, and Baptist St. Anthony Health System from this group appeal. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

The remaining participants in the appeal are subject to remand pursuant to CMS-1498-R. Enclosed please find the Board's remand under the standard procedure.

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

For the Board:

Michael W. Harty
Chairman

Enclosures: Standard Remand of LDR Days for case no. 07-2324G
Schedule of Providers
42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

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

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Refer to: 98-3328G

Certified Mail

SEP 05 2013

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

RE: Blumberg Ribner 83-84 TEFRA RCL Denial
Provider Nos. Various
FYEs 1983 and 1984
PRRB Case No. 98-3328G

Dear Mr. Ribner:

The Provider Reimbursement Review Board (Board) has reviewed the record in the above referenced appeal. The Board's jurisdictional determination is set forth below.

Background

The issue contained in the Providers' July 29, 1998 hearing request was:

> Whether the Intermediary abused its discretion in denying the Providers' requests for reopening of their Medicare cost reports for the TEFRA year to correct an error within the base year Routine Cost Limit (RCL) since the three year reopening requirement was equitably tolled due to fraud and other comparable fault in the procurement of the determination of the inpatient RCL? [42 C.F.R. § 405.1885]

Schedule of Providers and Jurisdictional Documents, Tab B for each Provider.

In their position paper, the Providers explain that for the fiscal years under appeal, the Intermediary applied the RCL to determine the Providers' Medicare reimbursement and then denied their request to reopen claiming the timeliness criteria of 42 C.F.R. § 405.1885.

In the jurisdictional documents accompanying the Schedule of Providers, the Provider's included the following documents under Tab A, the final determination:

1. Good Samaritan Hospital, provider number 05-0380, a Notice of Program Reimbursement (NPR) dated June 10, 1985;

2. Henry Mayo Newhall Memorial Hospital, provider number 05-0624, a November 28, 1990 Notice of Reopening and Correction [of the] Medicare Cost Report to exclude malpractice costs from the application of the RCL and to adjust the TEFRA Target Rate; and a December 23 1987 Notice of Reopening and Correction to adjust home office costs; a December 21 1987 Notice of Reopening to adjust home office costs which identified the original NPR date as June 30, 1985;

3 Pomona Valley Community Hospital, provider number 05-0231, a January 22, 1991 revised Notice of Program Reimbursement to adjust the base year Target Amount as the result of the issuance of the Health Financing Administration[1] Ruling 89-1, with an attachment delineating repayments with one date being identified as the NPR date for the fiscal year appealed as September 30, 1985;

4 St. Rose Hospital, provider number 05-0002, Intermediary's denial of the reopening of the cost report to revise the covered days of care adjustment factor identifying the last NPR date for the Provider's fiscal year September 30, 1993 as December 19, 1984.

With the exception of St. Rose Hospital, there is no evidence in the jurisdictional documents evidencing the remaining Providers requested a reopening to adjust the covered days of care adjustment factor.

Providers' Position

The Providers contend that the "timeliness" criteria of 42 C.F.R. § 405.1885(a) (dealing with reopenings) does not apply in circumstances where there is "fraud or similar fault." The Providers believe that fraud or similar fault exists in this case due to the use of the "covered days of care" adjustment factor used in determining the RCL. The covered day of care adjustment factor was used to neutralize regional differences in the average length of [hospital] stay (ALOS) of Medicare beneficiaries. The rationale behind this adjustment is that in areas where the ALOS is less, the intensity of medical services is greater and hospitals should not be penalized for this when compared to hospitals with a longer ALOS. California, the state where the Providers are located, is one of the states with shorter ALOSs.

The Providers are asserting that officials from HCFA had knowledge that the method used to calculate the covered days of care adjustment factor contained errors in the methodology. If

[1] HCFA, now the Centers for Medicare & Medicaid Services (CMS).

these errors were corrected they would increase the reimbursement to hospitals with short ALOS. If HCFA had disclosed the error in the calculation it could have corrected the reimbursement for the hospitals affected or notified them so they could have filed timely exceptions requests. However, hospitals were not notified and were unaware of the problem until a confidential 1989 settlement agreement surfaced in 1992 in a second court case filed by Hoag Memorial Hospital, one of the parties to the earlier settlement agreement. The Providers believe HCFA's actions were fraudulent and give rise to an exception to timely filing under the doctrine of equitable tolling.

Decision of the Board

The Board finds that the appeal was not timely filed and hereby dismisses the case. Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 and 405.1841 (1984), a provider has a right to a hearing before the Board with respect to a cost claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more and the request for hearing is filed within 180 days of the date of the final determination. In this case, the Providers filed their appeal more than three years after the relevant determination, clearly outside of the 180-day appeal period.

Further, the Board lacks jurisdiction over an intermediary's refusal to reopen a cost report because jurisdiction over a reopening rests exclusively with the administrative body that rendered the last determination, in this case the Intermediary. *See* 42 C.F.R. § 405.1885(c) and *Your Home Visiting Nurse Services v. Shalala* 525 U.S. 449 (1999) (a refusal to reopen is not a final determination).

Equitable Tolling

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

Fraud

The Providers also allege that HCFA engaged in fraudulent concealment in Federal Register notices and suppression of a study which they allege demonstrates that the covered days of care adjustment factor was too low. Pursuant to 42 C.F.R. § 1395oo(a)(1)(A)(i), the Board's jurisdiction is limited to matters covered by the cost report. The Board finds that it lacks jurisdiction over the fraud issue because it is not a matter covered by the cost report. The Board previously held in *Morehouse General Hospital v. Louisiana Health Service & Indemnity Company*[2] that with regard to the providers' contentions that the intermediary was guilty of fraud, the Board's authority is limited to adjudicating reimbursement controversies, not to decide whether an entity acted fraudulently or unethically.

[2] PRBB Dec. 81-D58, Medicare & Medicaid Guide (CCH) ¶ 31,405 (March 19, 1981)

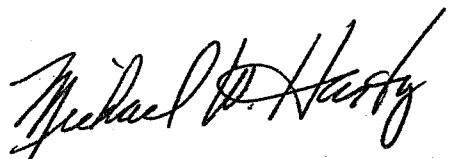
Since the Board has dismissed the case for lack jurisdiction over the appeal because it was not timely filed, the case is hereby closed.

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

Board Members Participating

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

FOR THE BOARD:



Michael W. Harty
Chairman

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

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

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Refer to: 13-1248
Certified Mail

SEP 11 2013

Larry M. Carlton, CPA
Senior Vice President
Lake Granbury Hospital
4000 Meridian Blvd.
Franklin, TN 37067

Re: Lake Granbury Hospital
Provider No.: 45-0596
FYE: 11/30/2008
Case No. 13-1248

Dear Mr. Carlton,

The Provider Reimbursement Review Board (Board) has reviewed the Provider's March 18, 2013 request for hearing which was received (filed)[1] on March 20, 2013. The Board's jurisdictional determination is set forth below.

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

Decision of the Board

The Board received the Provider's request for hearing on March 20, 2013, 209 days after the issuance of the Notice of Program Reimbursement (NPR) dated August 23, 2012. The NPR is presumed to have been received 5 days after the date of issuance by the intermediary. 42 C.F.R. § 405.1801 (a)(1)(iii). In this case, the hearing request was received (filed) 204 days after the presumed date of receipt of the NPR. The Provider did not present evidence that it received the NPR more than 5 days after the NPR date. The request for hearing was not received by the Board within 180 days of the date of the receipt of the NPR as required by 42 C.F.R. §405.1835 and, therefore, it was not timely filed. Consequently, the Board hereby dismisses the appeal.

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

---

[1] See, 42 C.F.R. § 405.1835(a)(3) (a provider has a right to hearing before the Board if, among other things, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the date of receipt by the intermediary's [final] determination.)

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

For the Board:

Michael W. Harty
Chairman

cc: Kevin D. Shanklin, BCBSA

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

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Refer to: 13-2174
Certified Mail

SEP 12 2013

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

Re: F.F. Thompson Hospital
Provider No.: 33-0074
FYE: 12/31/2008
Case No. 13-2174

Dear Mr. Blumberg,

The Provider Reimbursement Review Board (Board) has reviewed the Provider's May 20, 2013 request for hearing which was received (filed)[1] on May 21, 2013. The Board's jurisdictional determination is set forth below.

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

Decision of the Board

The Board received the Provider's request for hearing on May 21, 2013, 186 days after the issuance of the Notice of Program Reimbursement (NPR) dated November 16, 2012. The NPR is presumed to have been received 5 days after the date of issuance by the intermediary. 42 C.F.R. § 405.1801 (a)(1)(iii). In this case, the hearing request was received (filed) 181 days after the presumed date of receipt of the NPR. The Provider did not present evidence that it received the NPR more than 5 days after the NPR date. The request for hearing was not received by the Board within 180 days of the date of the receipt of the NPR as required by 42 C.F.R. §405.1835 and, therefore, it was not timely filed. Consequently, the Board hereby dismisses the appeal.

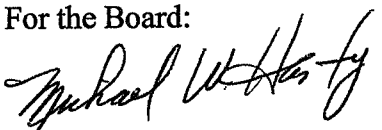
Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

---

[1] See, 42 C.F.R. § 405.1835(a)(3) (a provider has a right to hearing before the Board if, among other things, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the date of receipt by the intermediary's [final] determination.)

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

For the Board:



Michael W. Harty
Chairman

cc: Kevin D. Shanklin, BCBSA

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

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Refer to: 13-2512
Certified Mail

SEP 12 2013

Janice Hoover
CEO
Home Care Home Health Services, Inc.
4001 Cedar Elm Lane
Wichita Falls, TX 76308

Re: Home Care Home Health Services, Inc.
Provider No.: 67-8008
FYE: 12/31/2013
Case No. 13-2512

Dear Ms. Hoover,

The Provider Reimbursement Review Board (Board) has reviewed the Provider's January 2, 2013 request for hearing which was received (filed)[1] on July 18, 2013. The Board's jurisdictional determination is set forth below.

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

Decision of the Board

The Board received the Provider's request for hearing on July 18, 2013, 215 days after the issuance of the Notice of Determination on Two Percent Reduction dated December 15, 2012. The determination notice is presumed to have been received 5 days after the date of issuance by the intermediary. 42 C.F.R. § 405.1801 (a)(1)(iii). In this case, the hearing request was received (filed) 210 days after the presumed date of receipt of the determination notice. The Provider did not present evidence that it received the determination notice more than 5 days after the determination notice date. The request for hearing was not received by the Board within 180 days of the date of the receipt of the determination notice as required by 42 C.F.R. §405.1835 and, therefore, it was not timely filed. Consequently, the Board hereby dismisses the appeal.

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

---

[1] See, 42 C.F.R. § 405.1835(a)(3) (a provider has a right to hearing before the Board if, among other things, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the date of receipt by the intermediary's [final] determination.)

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

For the Board:

Michael W. Harty
Chairman

cc: Kevin D. Shanklin, BCBSA

Cecile Huggins, Supervisor
Palmetto GBA
2300 Springdale Drive – Bldg. ONE
Camden, SC 29020

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Refer to: 09-0061GC

SEP 12 2013

CERTIFIED MAIL

McKay Consulting, Inc.
Michael K. McKay
President
8590 Business Park Drive
Shreveport, LA 71105

National Government Services - NY
Kyle Browning
Appeals Lead
MP: INA102-AF42
P.O. Box 7191
Indianapolis, IN 46207-7191

RE: Request to Reconsider Remand of Labor/Delivery Days Appeal
University of Rochester 2005 Labor and Delivery CIRP Group
Specifically Strong Memorial Hospital
Provider No.: 33-0285
FYE: 12/31/2002
PRRB Case No.: 09-0061GC

Dear Mr. McKay and Mr. Browning,

The Provider Reimbursement Review Board (Board) has reviewed the Providers' Request for Reconsideration case number 09-0061GC. The Board's decision is set forth below.

Background

Strong Memorial Hospital was issued an original Notice of Program Reimbursement (NPR) for fiscal year end 12/31/2002 on March 18, 2006. The Provider filed its individual appeal request from its original NPR on November 9, 2006, to which the Board assigned case number 07-0228. This appeal request did not include the labor and delivery days issue. Unbeknownst to the Board, on August 8, 2006, prior to filing the PRRB appeal, the Provider's representative sent a "Request for Administrative Resolution" to the Intermediary. In this request the Provider said that it self-excluded 421 Medicaid eligible labor days and that it reduced the total discharged days by 1,230 labor days.

On May 30, 2007, the Provider was issued a second revised NPR to correct errors in the first revised NPR that was issued on March 1, 2007. The Provider appealed from the March 1, 2007 NPR on August 22, 2007. This appeal, which included the labor and delivery days issue, was incorporated into the Provider's individual appeal, case number 07-0228.

The subject appeal, case number 09-0061GC, was established on October 10, 2008. Strong Memorial Hospital was added to this appeal on March 9, 2009. On July 24, 2012, the labor and delivery room days issue was remanded to the Intermediary pursuant to CMS Ruling 1498-R and

case number 09-0061GC was closed. In the remand letter, the Board stated that because Strong Memorial appealed from a revised NPR, the remand was limited to those 1,230 days that were actually adjusted in the revised NPR. On November 13, 2012, the Provider's representative requested that the Board reconsider its remand and reopen this case to instruct the MAC to add the labor and delivery days at issue back into both the numerator and the denominator of the Medicaid fraction.

Provider's Contentions

The Provider's representative argues that the Board erred in its determination to remand for the addition of labor/delivery room days to the denominator, but not the numerator, of the DSH Medicaid fraction. The Provider argues that the MAC removed labor/delivery days from both the numerator and the denominator of the Medicaid fraction, and that it appealed the exclusion of those days from both parts of the fraction. In its appeal request, the Provider appealed the MAC's determination to exclude labor/delivery room days from the Medicaid fraction, contending that these days should "be included in both the numerator and the denominator" of the Medicaid fraction. Based on these arguments, the Provider requests that the Board reopen the case and correct its decision to remand only to restore the labor/delivery days to the denominator of the Medicaid fraction.

Board's Decision

The Board hereby grants Strong Memorial Hospital's request to reopen case number 09-0061GC to reconsider its prior decision, however not for the reason the Provider requested. Upon further review of the file and additional documentation submitted to the Board, the Board concludes that the 1,230 days that were adjusted in the revised NPR were removed from *total* days, which is not an issue that is covered by CMS Ruling 1498-R. Case number 09-0061GC is hereby reopened in order to transfer the issue of labor and delivery days in total days to case number 07-0228, which remains an open appeal.

The Board lacks jurisdiction over Strong Memorial Hospital's labor and delivery room day appeal that would be covered by CMS Ruling 1498-R because it appealed from a revised NPR that did not specifically adjust the labor and delivery room days that are subject to the remand. The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 1885 provides in relevant part:

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

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

> (a) If a revision is made in a Secretary or intermediary determination or a decision

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

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

The revised NPR that Strong Memorial Hospital appealed from did not specifically adjust the Medicaid labor and delivery room days that are subject to CMS Ruling 1498-R, only the total labor and delivery room days. Total days and Medicaid days are located in two separate columns of Worksheet S-3. Therefore the Board finds that it does not have jurisdiction over the Medicaid labor and delivery days issue for strong Memorial Hospital.

Conclusion

The Board hereby reopens case number 09-0061GC in order to transfer the total labor and delivery days issue to case number 07-0228. The Board finds that it does not have jurisdiction over the Medicaid labor and delivery room days subject to CMS Ruling 1498-R. Once the total days issue is transferred out of this appeal, case number 09-0061GC will be closed once again.

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

FOR THE BOARD

Michael W. Harty
Chairman

cc: Kevin D. Shanklin
Executive Director
Senior Government Initiatives

Blue Cross and Blue Shield Association
225 N. Michigan Ave.
Chicago, IL 60601-7680

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Refer to: 13-0273
Certified Mail

SEP 12 2013

Shawn Nordby
Mary Lanning Memorial Hospital
715 North Saint Joseph Avenue
Hastings, NE 68901

Re: Mary Lanning Memorial Hospital
Provider No.: 28-0032
FYE: 12/31/2006
Case No. 13-0273

Dear Mr. Nordby,

The Provider Reimbursement Review Board (Board) has reviewed the Provider's December 19, 2012 request for hearing which was received (filed)[1] on December 21, 2012. The Board's jurisdictional determination is set forth below.

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

Decision of the Board

The Board received the Provider's request for hearing on December 21, 2012, 626 days after the issuance of the Notice of Correction of Program Reimbursement (NPR) dated April 5, 2011. The NPR is presumed to have been received 5 days after the date of issuance by the intermediary. 42 C.F.R. § 405.1801 (a)(1)(iii). In this case, the hearing request was received (filed) 621 days after the presumed date of receipt of the NPR. The Provider did not present evidence that it received the NPR more than 5 days after the NPR date. The request for hearing was not received by the Board within 180 days of the date of the receipt of the NPR as required by 42 C.F.R. §405.1835 and, therefore, it was not timely filed. Consequently, the Board hereby dismisses the appeal.

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

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[1] See, 42 C.F.R. § 405.1835(a)(3) (a provider has a right to hearing before the Board if, among other things, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the date of receipt by the intermediary's [final] determination.)

Board Members Participating:
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

For the Board:
Michael W. Harty
Chairman

cc: Kevin D. Shanklin, BCBSA

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Refer to: ~~13-1922GC~~

CERTIFIED MAIL

SEP 12 2013

Stephen P. Nash, Esq.
Patton Boggs LLP
1801 California Street
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Denver, CO 80202

RE: Patton Boggs/Intermountion Health RFBNA Group
Provider Nos. Various
FYE 12/31/2007 (which includes FFY 2007 (the period 1/1/2007-9/30/2007) and FFY 2008 (the period 10/31/2007-12/31/2007))
PRRB Case No. 13-1922GC

Dear Mr. Nash:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' request for expedited judicial review (EJR) dated August 14, 2013 (received August 15, 2013) in the above-referenced group appeal. The issue under dispute involves whether the Centers for Medicare & Medicaid Services (CMS) erred in calculating a budget neutrality adjustment to the PPS standardized amount to account for the effects of the rural floor on the wage index. The Board's jurisdictional decision and decision regarding EJR is set forth below.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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

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

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

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

Standardized Amount

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

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

Budget Neutrality

Budget neutrality is determined by comparing aggregate IPPS payments before and after making changes that are required to be budget neutral (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 adjustments. Id. at 48147.

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

Rural Floor

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

determined for the State's rural area. Since 1998 CMS had implemented the budget neutrality requirement of this provision by adjusting the standardized amounts. 72 Fed. Reg. 24680, 24787 (May 3, 2007). In establishing the PPS standardized amount for FFY 2007, and for prior Federal fiscal years, CMS adjusted the standardized amount to account for the effects of the rural floor. See e.g., 71 Fed. Reg. 48145-48 (August 18, 2006). In FFY 2008 CMS applied the budget neutrality adjustment to the wage index, rather than the standardized amount.[1]

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

> . . . the rural floor budget neutrality adjustment previously was a cumulative adjustment, similar to the adjustments we currently make for updates to the wage index and DRG [diagnostic related groups] reclassification and recalibration. Beginning in 2008, the rural floor budget neutrality adjustment will be noncumulative.
>
> . . .With regard to alleged errors in FY 1999 through 2007, our calculation of the budget neutrality in past fiscal years is not within the scope of this rulemaking Even if errors were made in prior fiscal years, we would not make an adjustment to make up for those errors when setting rates for FY 2008. It is our longstanding policy that finality is critical to a prospective payment system. Although such errors in rate setting are inevitable, we believe the need to establish final prospective rates outweighs the greater accuracy we might gain if we retroactively recomputed rates whenever an error is discovered.

72 Fed. Reg. at 47330.

Wage Index

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

PROCEDURAL HISTORY:

These appeals were timely filed from the issuance of the Providers Notices of Program Reimbursement. The Providers challenged CMS' calculation and application of the budget neutrality adjustment to the PPS standardized amount to account for annual adjustments to the

[1] 72 Fed. Reg. 47130, 47329 (August 22, 2007).

PPS wage index. The Providers contend that CMS has erred in the computation of the annual budget neutrality adjustment factors, including the adjustment factor applied to the standardized amounts and hospital-specific rates for FFY 2007, to account for changes in the wage index and rural floor. The alleged error results in a systematic understatement of the PPS standardized amount and the hospital-specific rates because it overstates the budget neutrality factor for annual updates to the wage index. The Providers believe the error is annual and recurring and so the final rates established in the final PPS rule for FFY 2007 are understated both as a result of the effect of the computational error for FFY 2007 and as a result of the cumulative effect of the same error in prior years' calculations.

Basis for EJR

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

> [W]e used FY 2005 discharge data to simulate payments and compared aggregate payments using the FY 2006 relative weights and wage indexes to aggregate payments using the FY 2007 relative weights and wage indexes. The same methodology was used for the FY 2006 budget neutrality adjustment.
>
> *****
>
> These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2006 budget neutrality adjustments.

71 Fed. Reg. at 48147.

The Providers are challenging an aspect of CMS' calculation of the final PPS rates published in the Federal Register for FFY 2007[2] and 2008.[3] The Providers contend that CMS erred in calculating a budget neutrality adjustment to the PPS standardized amount to account for the effects of the rural floor on the wage index. This alleged error results in a systematic understatement of the PPS rates, and this error has been an annual and recurring one. Each year's error is permanently incorporated into the standardized amount paid under PPS for each successive year. Consequently, the Providers allege, the final rates established in the final FFYs 2007 and 2008 PPS rules are understated, both as the result of the erroneous computation methodology used to calculate the budget neutrality adjustment for the effects of the rural floor

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

[3] The final IPPS rates for this period were published in the Federal Register on August 22, 2007. 72 Fed. Reg. 47130, 47329 (August 22, 2007).

in FFYs 2007 and 2008 itself, and as a result of the cumulative effect of the same error in prior fiscal years.

As a result of the alleged recurring computation methodology error, the Providers contend that CMS has not applied the rural floor in a manner assuring that the aggregate payments are not less than those which would have been made if the rural floor did not apply. The Providers assert that, rather than achieving the budget neutrality required by law, the Secretary has effected PPS payment reductions for FFYs 2007 and 2008 that exceeded the Secretary's statutory authority, are arbitrary and capricious, and are otherwise contrary to law.

Decision of the Board:

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

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

> There shall be no administrative or judicial review under [42 U.S.C. §1395oo] or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount of any adjustment effected pursuant to subsection (e)(1) [budget neutrality] or the determination of the applicable percentage increase under paragraph (12)(A)(ii) . . .

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

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

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

> Neither administrative or judicial review is available for controversies about the following matters:
>
> (a) The determination of the requirement, or the proportional amount, of any *budget neutrality adjustment* in the prospective payment rates. . . . (emphasis added)

CMS stated at the time the rule was adopted that the purpose of the rule is:

> to state that the determinations and decisions described in section 1886(d)(7) of the Act may not receive Board or judicial review. Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
>
> > A determination of the requirement, or the proportional amounts of, any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act . . .

48 Fed. Reg. 39752, 39785 (September 1, 1983).

In addition, section 701(a) of the Administrative Procedure Act (APA) states that the appeal provisions of the APA apply to the administrative actions except where statutes preclude judicial review. *See* 5 U.S.C. § 701(a). The statutes and the regulations both preclude administrative and judicial review of the budget neutrality adjustment.

In *Amgen, Inc. v. Smith*[4] the D.C. Circuit Court considered whether there is jurisdiction over outpatient PPS (OPPS) payments where the statute precludes administrative or judicial review of the "other adjustments" to OPPS (the classification system, establishment of groups and relative payment weights for covered services, of wage adjustment factors). The Court explained that there is a strong presumption that Congress intends judicial review of administrative action which can only be overcome with "clear and convincing evidence" that Congress intended to preclude appeal. The Court concluded that where the statute stipulated that "there should be no administrative or judicial review," that language constituted clear and convincing evidence that appeal was precluded. The Court further noted that payments under PPS are made on a prospective basis and, given the length of time that review of individual appeals could take, the result would be retroactive adjustments to payment rates with the potential of creating havoc with the payment system. The aggregate impact of appeal decisions would undermine the Secretary's ability to ensure budget neutrality.

In an earlier decision, *Universal Health Services of McAllen, Inc. v. Sullivan*,[5] (*UHS*) the D. C. District Court distinguished between an appeal of a Medicare Geographic Classification Review Board (MGCRB) decision (over which judicial review is precluded) and a challenge to the validity of the guidelines utilized by the MGCRB and the Secretary to make reclassification decisions. The Court noted that § 701(a) of the APA precludes judicial review where a statute or regulation denies review. In *UHS*, the Court found that it had jurisdiction over the challenge to the guidelines but would not have had jurisdiction over an appeal of an MGCRB decision which was precluded by law.

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[4] 357 F .3d 103 (D.C. Cir. 2004).
[5] 770 F. Supp. 704 (D.C. Dist. 1991.)

Allegation that Review of Budget Neutrality is Limited to FY 1984 and 1985

The Board is not persuaded that preclusion of review of budget neutrality provisions is limited to the fiscal years 1984 and 1985. When Congress enacted the PPS payment rates for 1984 and 1985, it instructed the Secretary to determine the allowable operating cost from the most recently available cost reporting period for which data are available, updated to 1983 and further updated to 1984 by the market basket plus one percent. The resulting amounts were standardized by excluding specified costs and then an average standardized amount was computed for urban and rural hospitals under TEFRA. The average standardized amounts were reduced to be budget neutral. Congress noted that the method of calculating the PPS rates for 1986 and later were the same, but there was no step in the process for budget neutrality. Instead an independent panel would advise the Secretary regarding the updating factor to be used. The Secretary was required to publish the methodology and the data used to create the PPS rates, including any adjustment to produce budget neutrality, in the Federal Register on or before September 1 of each fiscal year. House Report No. 98-25(I) 1983 U.S.C.C.A.N. 219, 354-355 (1983).

In addressing the appeals process, Congress provided for the same administrative and judicial review of payments made under PPS as was available for cost-based reimbursement. Review was permitted with the exception of determinations necessary to maintain budget neutrality and the establishment of diagnosis related groups (DRGs), the methods for classifying DRGs and the DRG weighting factors. Congress stated that such preclusion of judicial review was necessary to maintain a workable payment system. House Report No. 98-25(I) 1983 U.S.C.C.A.N. 219, 361-362 (1983) and Senate Report No. 98-23 1983 U.S.C.C.A.N. 143, 197-198 (1983). This preclusion of administrative and judicial review was codified in 42 U.S.C. § 1395ww(d)(7).

Subsection (d)(7) states that there shall be no administrative or judicial review under 42 U.S.C. §1395oo of the determination of the requirement or the proportional amount of any adjustment effected pursuant to subsection (e)(1). 42 U.S.C. §1395ww(e)(1) provides that for cost reporting periods of hospitals beginning in fiscal years 1984 or 1985 the Secretary shall provide for a proportional adjustment in the applicable percentage increase (otherwise applicable to the periods under subsection (b)(3)(B)) as may be necessary to assure budget neutrality. Section 1395ww(b)(3)(B) references all cost reporting periods from 1986 through the present as being affected by the budget neutrality adjustment.

In response to the enactment of the above statutes, the Board's governing regulations were modified. In the September 1, 1983 preamble to new regulations, the Secretary explained that 42 U.S.C. § 1395oo(g)(2) was added by Pub. L. 98-21 to state that the determinations and decisions described in § 1395ww(d)(7) precludes administrative and judicial review of, among other things, a determination of the requirement, or proportional amount of any "budget neutrality" adjustment effected under §1395ww(e)(1). The Secretary stated that it was the clear intent of Congress that a hospital would not be permitted to argue that the level of payment that it receives under the prospective payment system is inadequate to cover its costs. The Secretary amended 42 C.F.R. Part 405, Subpart R to implement the changes to 42 U.S.C. § 1395(g)(2) contained in Pub. L. 98-21. The changes to the regulation included the addition of 42 C.F.R. § 405.1804 to

describe matters not reviewable by the Board or the courts as provided in § 1395ww(d)(7).[6] Section 405.1804 states specifically that there is neither administrative nor judicial review of the determination of the requirement or the proportional amount of any budget neutrality adjustment in the prospective payment rate. Therefore, the Secretary clearly interpreted the statutory prohibition on review as not being confined to 1984 and 1985.

When the Secretary "updated, clarified and revised"[7] the Board's governing regulations in 2008, he separately and specifically addressed the limitations on the Board's jurisdiction. The original regulation at 42 C.F.R. § 405.1804, stating that budget neutrality issues are not reviewable, was reissued without change or comment. In addition, the Secretary added 42 C.F.R. § 405.1840 to the regulations specifically dealing with the Board's jurisdiction. Section 405.1840(b) states that certain matters at issue were removed from the jurisdiction of the Board and included "[c]ertain matters affecting payments to hospitals under the prospective payment system, as provided in [42 U.S.C. § 1395ww(d)(7)] and § 405.1804 of this subpart." If the budget neutrality provisions of § 405.1804 were limited to appeals of FY 1984 and 1985, there would be no reason to leave the regulation unchanged during a comprehensive revision of the Board's regulations and certainly no need to add § 405.1840(b)(2) reiterating and emphasizing the Board's lack of jurisdiction over the budget neutrality issue. The Secretary's action demonstrates a twenty five year consistent position that all budget neutrality determinations are off limits to the Board; not just those relating to fiscal years 1984 and 1985. Whether the Secretary's view is consistent with Congress' intent is not for the Board to decide for it is bound by the regulation.

EJR Determination

42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permit providers to bypass the Board's hearing procedure and obtain judicial review of a specific matter at issue involving a question of law or regulation where the Board determines that it is without authority to decide the legal question. Prior to rendering a decision that it lacks the authority to decide the legal question before it, the Board must determine that it has jurisdiction over the matter at issue in the appeal under 42 U.S.C. § 1395oo. 42 C.F.R. § 405.1842(a)(2008). We conclude that both the statute and regulation preclude administrative review of the budget neutrality adjustment; therefore, the Board lacks jurisdiction over the appeal.

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

Application of Cape Cod case on the Request for EJR

Ordinarily our EJR analysis would end with a determination of no jurisdiction. However, in *Cape Cod HC 2007 Wage Index/Rural Floor Group*, PRRB case number 07-0705G et al, (*Cape Cod*), the Secretary has taken a contrary position. In *Cape Cod*, the Board concluded that it lacked jurisdiction over the budget neutrality adjustment based on the authorities set forth above. The Board's decision was not reversed by the CMS Administrator. On appeal to the

[6] 48 Fed. Reg. 39740, 39785 (September 1, 1983).
[7] 73 Fed. Reg. 30190 (May 23, 2008).

Federal district court, however, the Secretary moved for remand on the basis that the Board had jurisdiction over the issue. The provider plaintiffs responded that the remand was unnecessary because the case was properly before the court on EJR. It argued that implicit in the Board's finding it lacked jurisdiction was a determination that it also lacked authority to decide the question, thus, EJR was appropriate. In its remand order, the District Court explained that the two findings are distinct. "Jurisdiction to take any legal action" asks whether the Providers may obtain a hearing at all; "authority to decide the question" asks whether the Board has authority to reach the merits of Providers' claims. The Court concluded that the Secretary's position was correct: the Court lacked subject matter jurisdiction without the Board's first being afforded an opportunity to consider the merits of the Providers' claims, including whether it has authority to decide the question. Neither the D.C. District court remand[8] nor the remand from the Deputy Administrator addresses the Secretary's rationale for his position regarding jurisdiction. Assuming, however, that the Secretary will take the same position in this case with respect to the Board's having jurisdiction over the budget neutrality issue, and in the interest of judicial economy, the Board will also address the question of whether EJR is appropriate.[9]

The Providers in this appeal seek to have the final wage index rates published in the Federal Register modified by applying a different calculation methodology relating to the budget neutrality and rural floor factors. Pursuant to 42 C.F.R. § 412.64, the Secretary calculates the standardized amount on an annual basis. This calculation is published annually in the Federal Register following a complex and lengthy process of data collection and analysis. The methodology for the calculation is described in general terms.

The Board is bound by the Secretary's final rules and has no authority to review the data underlying the rate published unless specifically authorized. Notably the Final Rule only provides for Board review of denials of requests by hospitals for correction of certain wage data that eventually goes into one hospital-specific component of the final rate.[10] If the provider appealing the denial is successful, the remedy is limited to the hospital bringing the successful appeal. There is no provision for the Board to adjust the rate itself (as applied to all hospitals) to account for the effect of the error. The Board concludes that the specific grant of authority and establishment of a detailed process for correcting the rate of only the hospital bringing the appeal, coupled with the failure to include the effect of that correction on other hospitals or to establish a similar correction process for other components of the wage index, are strong indications that the Board does not have authority to change the rate itself.

Even more compelling, however, is the language of the statute and the regulation quoted above that prohibits review of budget neutrality determinations which are at the heart of the question before the Board in this case. Even if the Board interpreted the statutory and regulatory prohibitions on review of budget neutrality determinations too broadly to bar jurisdiction, those

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[8] *Cape Cod Hospital v. Leavitt*, 565 F. Supp.2d (D.D.C. 2008).

[9] After the above remand based on the Secretary's position regarding jurisdiction, the Board found the Provider was entitled to expedited judicial review. In December of 2009, the District Court for the District of Columbia granted the defendant's (government's) motion for summary judgment for the budget neutrality adjustment. *Cape Cod Hospital et al. v. Sebelius*, 677 F. Supp. (D.D.C. 2009).

[10] 64 Fed. Reg. 41490, 41513 (July 30, 1999). This authority has never been codified in the code of Federal Regulations.

prohibitions cannot be ignored altogether. We conclude that the statute and regulation evidence Congress' and the Secretary's intent that budget neutrality determinations are insulated from the Board's authority to affirm, reverse or modify a reimbursement determination. Otherwise, the specific prohibitions articulated there would be rendered meaningless.

Assuming, arguendo, that the Secretary takes the same position in these cases that the Board has jurisdiction, then the Board finds that:

1) based upon the Providers' unopposed assertions regarding the challenges to the rural floor/budget neutrality methodology, there are no findings of fact for resolution by the Board;

2) it is bound by the Final Rule in the Federal Register and the regulation; and

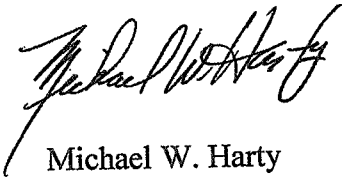
3) it is without authority to decide the legal question of whether the calculation methodology for the budget neutrality/rural floor adjustment is valid.

Accordingly, the Board finds that the budget neutrality/rural floor issue properly falls within the Provisions of 42 U.S.C. § 1395oo(f)(1) and expedited judicial review is appropriate. Because this is the only issue under appeal in this case, the Board hereby closes the case.

Board Members Participating:

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

FOR THE BOARD:



Michael W. Harty
Chairperson

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

cc: James Ward, Noridan Administrative Services (w/Schedule of Providers)
Kevin Shanklin, BCBSA (w/Schedule of Providers)

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Refer to: ~~13-0206G~~

CERTIFIED MAIL

SEP 12 2013

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Denver, CO 80202

RE: Patton Boggs 2007 RFBNA Group
Provider Nos. Various
FYE 12/31/2007 (which includes FFY 2007 (the period 1/1/2007-9/30/2007) and FFY 2008 (the period 10/31/2007-12/31/2007))
PRRB Case No. 13-0206G

Dear Mr. Nash:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' request for expedited judicial review (EJR) dated August 14, 2013 (received August 15, 2013) in the above-referenced group appeal. The issue under dispute involves whether the Centers for Medicare & Medicaid Services (CMS) erred in calculating a budget neutrality adjustment to the PPS standardized amount to account for the effects of the rural floor on the wage index. The Board's jurisdictional decision and decision regarding EJR is set forth below.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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

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

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

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

Standardized Amount

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

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

Budget Neutrality

Budget neutrality is determined by comparing aggregate IPPS payments before and after making changes that are required to be budget neutral (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 adjustments. Id. at 48147.

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

Rural Floor

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

determined for the State's rural area. Since 1998 CMS had implemented the budget neutrality requirement of this provision by adjusting the standardized amounts. 72 Fed. Reg. 24680, 24787 (May 3, 2007). In establishing the PPS standardized amount for FFY 2007, and for prior Federal fiscal years, CMS adjusted the standardized amount to account for the effects of the rural floor. See e.g., 71 Fed. Reg. 48145-48 (August 18, 2006). In FFY 2008 CMS applied the budget neutrality adjustment to the wage index, rather than the standardized amount.[1]

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

> . . . the rural floor budget neutrality adjustment previously was a cumulative adjustment, similar to the adjustments we currently make for updates to the wage index and DRG [diagnostic related groups] reclassification and recalibration. Beginning in 2008, the rural floor budget neutrality adjustment will be noncumulative.
>
> . . .With regard to alleged errors in FY 1999 through 2007, our calculation of the budget neutrality in past fiscal years is not within the scope of this rulemaking Even if errors were made in prior fiscal years, we would not make an adjustment to make up for those errors when setting rates for FY 2008. It is our longstanding policy that finality is critical to a prospective payment system. Although such errors in rate setting are inevitable, we believe the need to establish final prospective rates outweighs the greater accuracy we might gain if we retroactively recomputed rates whenever an error is discovered.

72 Fed. Reg. at 47330.

Wage Index

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

PROCEDURAL HISTORY:

These appeals were timely filed from the issuance of the Providers Notices of Program Reimbursement. The Providers challenged CMS' calculation and application of the budget neutrality adjustment to the PPS standardized amount to account for annual adjustments to the

[1] 72 Fed. Reg. 47130, 47329 (August 22, 2007).

PPS wage index. The Providers contend that CMS has erred in the computation of the annual budget neutrality adjustment factors, including the adjustment factor applied to the standardized amounts and hospital-specific rates for FFY 2007, to account for changes in the wage index and rural floor. The alleged error results in a systematic understatement of the PPS standardized amount and the hospital-specific rates because it overstates the budget neutrality factor for annual updates to the wage index. The Providers believe the error is annual and recurring and so the final rates established in the final PPS rule for FFY 2007 are understated both as a result of the effect of the computational error for FFY 2007 and as a result of the cumulative effect of the same error in prior years' calculations.

Basis for EJR

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

> [W]e used FY 2005 discharge data to simulate payments and compared aggregate payments using the FY 2006 relative weights and wage indexes to aggregate payments using the FY 2007 relative weights and wage indexes. The same methodology was used for the FY 2006 budget neutrality adjustment.
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> *****
>
> These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2006 budget neutrality adjustments.

71 Fed. Reg. at 48147.

The Providers are challenging an aspect of CMS' calculation of the final PPS rates published in the Federal Register for FFY 2007[2] and 2008.[3] The Providers contend that CMS erred in calculating a budget neutrality adjustment to the PPS standardized amount to account for the effects of the rural floor on the wage index. This alleged error results in a systematic understatement of the PPS rates, and this error has been an annual and recurring one. Each year's error is permanently incorporated into the standardized amount paid under PPS for each successive year. Consequently, the Providers allege, the final rates established in the final FFYs 2007 and 2008 PPS rules are understated, both as the result of the erroneous computation methodology used to calculate the budget neutrality adjustment for the effects of the rural floor

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

[3] The final IPPS rates for this period were published in the Federal Register on August 22, 2007. 72 Fed. Reg. 47130, 47329 (August 22, 2007).

in FFYs 2007 and 2008 itself, and as a result of the cumulative effect of the same error in prior fiscal years.

As a result of the alleged recurring computation methodology error, the Providers contend that CMS has not applied the rural floor in a manner assuring that the aggregate payments are not less than those which would have been made if the rural floor did not apply. The Providers assert that, rather than achieving the budget neutrality required by law, the Secretary has effected PPS payment reductions for FFYs 2007 and 2008 that exceeded the Secretary's statutory authority, are arbitrary and capricious, and are otherwise contrary to law.

Decision of the Board:

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

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

> There shall be no administrative or judicial review under [42 U.S.C. §1395oo] or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount of any adjustment effected pursuant to subsection (e)(1) [budget neutrality] or the determination of the applicable percentage increase under paragraph (12)(A)(ii) . . .

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

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

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

> Neither administrative or judicial review is available for controversies about the following matters:
>
> (a) The determination of the requirement, or the proportional amount, of any *budget neutrality adjustment* in the prospective payment rates. . . . (emphasis added)

CMS stated at the time the rule was adopted that the purpose of the rule is:

> to state that the determinations and decisions described in section 1886(d)(7) of the Act may not receive Board or judicial review. Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
>
> > A determination of the requirement, or the proportional amounts of, any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act . . .

48 Fed. Reg. 39752, 39785 (September 1, 1983).

In addition, section 701(a) of the Administrative Procedure Act (APA) states that the appeal provisions of the APA apply to the administrative actions except where statutes preclude judicial review. *See* 5 U.S.C. § 701(a). The statutes and the regulations both preclude administrative and judicial review of the budget neutrality adjustment.

In *Amgen, Inc. v. Smith*[4] the D.C. Circuit Court considered whether there is jurisdiction over outpatient PPS (OPPS) payments where the statute precludes administrative or judicial review of the "other adjustments" to OPPS (the classification system, establishment of groups and relative payment weights for covered services, of wage adjustment factors). The Court explained that there is a strong presumption that Congress intends judicial review of administrative action which can only be overcome with "clear and convincing evidence" that Congress intended to preclude appeal. The Court concluded that where the statute stipulated that "there should be no administrative or judicial review," that language constituted clear and convincing evidence that appeal was precluded. The Court further noted that payments under PPS are made on a prospective basis and, given the length of time that review of individual appeals could take, the result would be retroactive adjustments to payment rates with the potential of creating havoc with the payment system. The aggregate impact of appeal decisions would undermine the Secretary's ability to ensure budget neutrality.

In an earlier decision, *Universal Health Services of McAllen, Inc. v. Sullivan*,[5] (*UHS*) the D. C. District Court distinguished between an appeal of a Medicare Geographic Classification Review Board (MGCRB) decision (over which judicial review is precluded) and a challenge to the validity of the guidelines utilized by the MGCRB and the Secretary to make reclassification decisions. The Court noted that § 701(a) of the APA precludes judicial review where a statute or regulation denies review. In *UHS*, the Court found that it had jurisdiction over the challenge to the guidelines but would not have had jurisdiction over an appeal of an MGCRB decision which was precluded by law.

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[4] 357 F .3d 103 (D.C. Cir. 2004).
[5] 770 F. Supp. 704 (D.C. Dist. 1991.)

Allegation that Review of Budget Neutrality is Limited to FY 1984 and 1985

The Board is not persuaded that preclusion of review of budget neutrality provisions is limited to the fiscal years 1984 and 1985. When Congress enacted the PPS payment rates for 1984 and 1985, it instructed the Secretary to determine the allowable operating cost from the most recently available cost reporting period for which data are available, updated to 1983 and further updated to 1984 by the market basket plus one percent. The resulting amounts were standardized by excluding specified costs and then an average standardized amount was computed for urban and rural hospitals under TEFRA. The average standardized amounts were reduced to be budget neutral. Congress noted that the method of calculating the PPS rates for 1986 and later were the same, but there was no step in the process for budget neutrality. Instead an independent panel would advise the Secretary regarding the updating factor to be used. The Secretary was required to publish the methodology and the data used to create the PPS rates, including any adjustment to produce budget neutrality, in the Federal Register on or before September 1 of each fiscal year. House Report No. 98-25(I) 1983 U.S.C.C.A.N. 219, 354-355 (1983).

In addressing the appeals process, Congress provided for the same administrative and judicial review of payments made under PPS as was available for cost-based reimbursement. Review was permitted with the exception of determinations necessary to maintain budget neutrality and the establishment of diagnosis related groups (DRGs), the methods for classifying DRGs and the DRG weighting factors. Congress stated that such preclusion of judicial review was necessary to maintain a workable payment system. House Report No. 98-25(I) 1983 U.S.C.C.A.N. 219, 361-362 (1983) and Senate Report No. 98-23 1983 U.S.C.C.A.N. 143, 197-198 (1983). This preclusion of administrative and judicial review was codified in 42 U.S.C. § 1395ww(d)(7).

Subsection (d)(7) states that there shall be no administrative or judicial review under 42 U.S.C. §1395oo of the determination of the requirement or the proportional amount of any adjustment effected pursuant to subsection (e)(1). 42 U.S.C. §1395ww(e)(1) provides that for cost reporting periods of hospitals beginning in fiscal years 1984 or 1985 the Secretary shall provide for a proportional adjustment in the applicable percentage increase (otherwise applicable to the periods under subsection (b)(3)(B)) as may be necessary to assure budget neutrality. Section 1395ww(b)(3)(B) references all cost reporting periods from 1986 through the present as being affected by the budget neutrality adjustment.

In response to the enactment of the above statutes, the Board's governing regulations were modified. In the September 1, 1983 preamble to new regulations, the Secretary explained that 42 U.S.C. § 1395oo(g)(2) was added by Pub. L. 98-21 to state that the determinations and decisions described in § 1395ww(d)(7) precludes administrative and judicial review of, among other things, a determination of the requirement, or proportional amount of any "budget neutrality" adjustment effected under §1395ww(e)(1). The Secretary stated that it was the clear intent of Congress that a hospital would not be permitted to argue that the level of payment that it receives under the prospective payment system is inadequate to cover its costs. The Secretary amended 42 C.F.R. Part 405, Subpart R to implement the changes to 42 U.S.C. § 1395(g)(2) contained in Pub. L. 98-21. The changes to the regulation included the addition of 42 C.F.R. § 405.1804 to

describe matters not reviewable by the Board or the courts as provided in § 1395ww(d)(7).[6] Section 405.1804 states specifically that there is neither administrative nor judicial review of the determination of the requirement or the proportional amount of any budget neutrality adjustment in the prospective payment rate. Therefore, the Secretary clearly interpreted the statutory prohibition on review as not being confined to 1984 and 1985.

When the Secretary "updated, clarified and revised"[7] the Board's governing regulations in 2008, he separately and specifically addressed the limitations on the Board's jurisdiction. The original regulation at 42 C.F.R. § 405.1804, stating that budget neutrality issues are not reviewable, was reissued without change or comment. In addition, the Secretary added 42 C.F.R. § 405.1840 to the regulations specifically dealing with the Board's jurisdiction. Section 405.1840(b) states that certain matters at issue were removed from the jurisdiction of the Board and included "[c]ertain matters affecting payments to hospitals under the prospective payment system, as provided in [42 U.S.C. § 1395ww(d)(7)] and § 405.1804 of this subpart." If the budget neutrality provisions of § 405.1804 were limited to appeals of FY 1984 and 1985, there would be no reason to leave the regulation unchanged during a comprehensive revision of the Board's regulations and certainly no need to add § 405.1840(b)(2) reiterating and emphasizing the Board's lack of jurisdiction over the budget neutrality issue. The Secretary's action demonstrates a twenty five year consistent position that all budget neutrality determinations are off limits to the Board; not just those relating to fiscal years 1984 and 1985. Whether the Secretary's view is consistent with Congress' intent is not for the Board to decide for it is bound by the regulation.

EJR Determination

42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permit providers to bypass the Board's hearing procedure and obtain judicial review of a specific matter at issue involving a question of law or regulation where the Board determines that it is without authority to decide the legal question. Prior to rendering a decision that it lacks the authority to decide the legal question before it, the Board must determine that it has jurisdiction over the matter at issue in the appeal under 42 U.S.C. § 1395oo. 42 C.F.R. § 405.1842(a)(2008). We conclude that both the statute and regulation preclude administrative review of the budget neutrality adjustment; therefore, the Board lacks jurisdiction over the appeal.

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

Application of Cape Cod case on the Request for EJR

Ordinarily our EJR analysis would end with a determination of no jurisdiction. However, in *Cape Cod HC 2007 Wage Index/Rural Floor Group*, PRRB case number 07-0705G et al, (*Cape Cod*), the Secretary has taken a contrary position. In *Cape Cod*, the Board concluded that it lacked jurisdiction over the budget neutrality adjustment based on the authorities set forth above. The Board's decision was not reversed by the CMS Administrator. On appeal to the

[6] 48 Fed. Reg. 39740, 39785 (September 1, 1983).
[7] 73 Fed. Reg. 30190 (May 23, 2008).

Federal district court, however, the Secretary moved for remand on the basis that the Board had jurisdiction over the issue. The provider plaintiffs responded that the remand was unnecessary because the case was properly before the court on EJR. It argued that implicit in the Board's finding it lacked jurisdiction was a determination that it also lacked authority to decide the question, thus, EJR was appropriate. In its remand order, the District Court explained that the two findings are distinct. "Jurisdiction to take any legal action" asks whether the Providers may obtain a hearing at all; "authority to decide the question" asks whether the Board has authority to reach the merits of Providers' claims. The Court concluded that the Secretary's position was correct: the Court lacked subject matter jurisdiction without the Board's first being afforded an opportunity to consider the merits of the Providers' claims, including whether it has authority to decide the question. Neither the D.C. District court remand[8] nor the remand from the Deputy Administrator addresses the Secretary's rationale for his position regarding jurisdiction. Assuming, however, that the Secretary will take the same position in this case with respect to the Board's having jurisdiction over the budget neutrality issue, and in the interest of judicial economy, the Board will also address the question of whether EJR is appropriate.[9]

The Providers in this appeal seek to have the final wage index rates published in the Federal Register modified by applying a different calculation methodology relating to the budget neutrality and rural floor factors. Pursuant to 42 C.F.R. § 412.64, the Secretary calculates the standardized amount on an annual basis. This calculation is published annually in the Federal Register following a complex and lengthy process of data collection and analysis. The methodology for the calculation is described in general terms.

The Board is bound by the Secretary's final rules and has no authority to review the data underlying the rate published unless specifically authorized. Notably the Final Rule only provides for Board review of denials of requests by hospitals for correction of certain wage data that eventually goes into one hospital-specific component of the final rate.[10] If the provider appealing the denial is successful, the remedy is limited to the hospital bringing the successful appeal. There is no provision for the Board to adjust the rate itself (as applied to all hospitals) to account for the effect of the error. The Board concludes that the specific grant of authority and establishment of a detailed process for correcting the rate of only the hospital bringing the appeal, coupled with the failure to include the effect of that correction on other hospitals or to establish a similar correction process for other components of the wage index, are strong indications that the Board does not have authority to change the rate itself.

Even more compelling, however, is the language of the statute and the regulation quoted above that prohibits review of budget neutrality determinations which are at the heart of the question before the Board in this case. Even if the Board interpreted the statutory and regulatory prohibitions on review of budget neutrality determinations too broadly to bar jurisdiction, those

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[8] *Cape Cod Hospital v. Leavitt*, 565 F. Supp.2d (D.D.C. 2008).

[9] After the above remand based on the Secretary's position regarding jurisdiction, the Board found the Provider was entitled to expedited judicial review. In December of 2009, the District Court for the District of Columbia granted the defendant's (government's) motion for summary judgment for the budget neutrality adjustment. *Cape Cod Hospital et al. v. Sebelius*, 677 F. Supp. (D.D.C. 2009).

[10] 64 Fed. Reg. 41490, 41513 (July 30, 1999). This authority has never been codified in the code of Federal Regulations.

prohibitions cannot be ignored altogether. We conclude that the statute and regulation evidence Congress' and the Secretary's intent that budget neutrality determinations are insulated from the Board's authority to affirm, reverse or modify a reimbursement determination. Otherwise, the specific prohibitions articulated there would be rendered meaningless.

Assuming, arguendo, that the Secretary takes the same position in these cases that the Board has jurisdiction, then the Board finds that:

1) based upon the Providers' unopposed assertions regarding the challenges to the rural floor/budget neutrality methodology, there are no findings of fact for resolution by the Board;

2) it is bound by the Final Rule in the Federal Register and the regulation; and

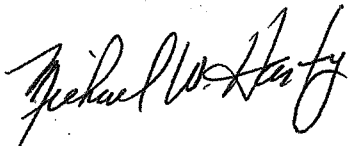
3) it is without authority to decide the legal question of whether the calculation methodology for the budget neutrality/rural floor adjustment is valid.

Accordingly, the Board finds that the budget neutrality/rural floor issue properly falls within the Provisions of 42 U.S.C. § 1395oo(f)(1) and expedited judicial review is appropriate. Because this is the only issue under appeal in this case, the Board hereby closes the case.

Board Members Participating:

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

FOR THE BOARD:



Michael W. Harty
Chairperson

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

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2670

Phone: 410-786-2671
Internet: www.cms.gov/PRRBReview FAX: 410-786-5298

Refer to: 13-0256GC

CERTIFIED MAIL

SEP 12 2013

Stephen P. Nash, Esq.
Patton Boggs LLP
1801 California Street
Suite 4900
Denver, CO 80202

RE: Patton Boggs/Lee Memorial 2007 RFBNA Group
Provider Nos. Various
FFY 2007
PRRB Case No. 13-0256GC

Dear Mr. Nash:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' request for expedited judicial review (EJR) dated August 14, 2013 (received August 15, 2013) in the above-referenced group appeal. The issue under dispute involves whether the Centers for Medicare & Medicaid Services (CMS) erred in calculating a budget neutrality adjustment to the PPS standardized amount to account for the effects of the rural floor on the wage index. The Board's jurisdictional decision and decision regarding EJR is set forth below.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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

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

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

Standardized Amount

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

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

Budget Neutrality

Budget neutrality is determined by comparing aggregate IPPS payments before and after making changes that are required to be budget neutral (e.g., reclassifying and recalibrating the diagnostic related groups (DRGs)). Outlier payments are also included in the simulations. *Id.* at 48147.

Rural Floor

Section 4410 of the Balanced Budget Act of 1997 (BBA of 1997) established the rural floor by requiring that the wage index of a hospital in any urban area cannot be less than the wage index determined for the state's rural area. Since Federal fiscal year (FFY) 1998, CMS has implemented the budget neutrality requirement of this provision by adjusting the standardized amounts. 72 Fed. Reg. 24680, 24787 (May 3, 2007). In establishing the PPS standardized amount for FFY 2007 and for prior Federal fiscal years, CMS adjusted the standardized amount downward to account for the effects of the rural floor. *See e.g.* 71 Fed. Reg. 48145-48 (August 18, 2006).

Wage Index

The statute, 42 U.S.C. § 1395ww(d)(3)(E) and (d)(9)(C)(iv), requires that CMS make an adjustment to the labor-related portion of the national and Puerto Rico PPS rates to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-

related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. *Id.* at 48153. The wage index must be updated annually. *Id.* at 48005.

PROCEDURAL HISTORY:

These appeals were timely filed from the issuance of the Providers Notices of Program Reimbursement. The Providers challenged CMS' calculation and application of the budget neutrality adjustment to the PPS standardized amount to account for annual adjustments to the PPS wage index. The Providers contend that CMS has erred in the computation of the annual budget neutrality adjustment factors, including the adjustment factor applied to the standardized amounts and hospital-specific rates for FFY 2007, to account for changes in the wage index and rural floor. The alleged error results in a systematic understatement of the PPS standardized amount and the hospital-specific rates because it overstates the budget neutrality factor for annual updates to the wage index. The Providers believe the error is annual and recurring and so the final rates established in the final PPS rule for FFY 2007 are understated both as a result of the effect of the computational error for FFY 2007 and as a result of the cumulative effect of the same error in prior years' calculations.

Basis for EJR

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

> [W]e used FY 2005 discharge data to simulate payments and compared aggregate payments using the FY 2006 relative weights and wage indexes to aggregate payments using the FY 2007 relative weights and wage indexes. The same methodology was used for the FY 2006 budget neutrality adjustment.
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The Providers are challenging an aspect of CMS' calculation of the final PPS rates published in the Federal Register for FFY 2007.[1] The Providers contend that CMS erred in calculating a budget neutrality adjustment to the PPS standardized amount to account for the effects of the

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

rural floor on the wage index. This alleged error results in a systematic understatement of the PPS rates, and this error has been an annual and recurring one. Each year's error is permanently incorporated into the standardized amount paid under PPS for each successive year. Consequently, the Providers allege, the final rates established in the final FFY 2007 PPS rule are understated, both as the result of the erroneous computation methodology used to calculate the budget neutrality adjustment for the effects of the rural floor in FFY 2007 itself, and as a result of the cumulative effect of the same error in prior fiscal years.

As a result of the alleged recurring computation methodology error, the Providers contend that CMS has not applied the rural floor in a manner assuring that the aggregate payments are not less than those which would have been made if the rural floor did not apply. The Providers assert that, rather than achieving the budget neutrality required by law, the Secretary has effected PPS payment reductions for FFY 2007 that exceeded the Secretary's statutory authority, are arbitrary and capricious, and are otherwise contrary to law.

Decision of the Board:

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

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

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

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CMS stated at the time the rule was adopted that the purpose of the rule is:

> to state that the determinations and decisions described in section 1886(d)(7) of the Act may not receive Board or judicial review. Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
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48 Fed. Reg. 39752, 39785 (September 1, 1983).

In addition, section 701(a) of the Administrative Procedure Act (APA) states that the appeal provisions of the APA apply to the administrative actions except where statutes preclude judicial review. *See* 5 U.S.C. § 701(a). The statutes and the regulations both preclude administrative and judicial review of the budget neutrality adjustment.

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In an earlier decision, *Universal Health Services of McAllen, Inc. v. Sullivan,*[3] (*UHS*) the D. C. District Court distinguished between an appeal of a Medicare Geographic Classification Review Board (MGCRB) decision (over which judicial review is precluded) and a challenge to the validity of the guidelines utilized by the MGCRB and the Secretary to make reclassification decisions. The Court noted that § 701(a) of the APA precludes judicial review where a statute or regulation denies review. In *UHS*, the Court found that it had jurisdiction over the challenge to

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the guidelines but would not have had jurisdiction over an appeal of an MGCRB decision which was precluded by law.

Allegation that Review of Budget Neutrality is Limited to FY 1984 and 1985

The Board is not persuaded that preclusion of review of budget neutrality provisions is limited to the fiscal years 1984 and 1985. When Congress enacted the PPS payment rates for 1984 and 1985, it instructed the Secretary to determine the allowable operating cost from the most recently available cost reporting period for which data are available, updated to 1983 and further updated to 1984 by the market basket plus one percent. The resulting amounts were standardized by excluding specified costs and then an average standardized amount was computed for urban and rural hospitals under TEFRA. The average standardized amounts were reduced to be budget neutral. Congress noted that the method of calculating the PPS rates for 1986 and later were the same, but there was no step in the process for budget neutrality. Instead an independent panel would advise the Secretary regarding the updating factor to be used. The Secretary was required to publish the methodology and the data used to create the PPS rates, including any adjustment to produce budget neutrality, in the Federal Register on or before September 1 of each fiscal year. House Report No. 98-25(I) 1983 U.S.C.C.A.N. 219, 354-355 (1983).

In addressing the appeals process, Congress provided for the same administrative and judicial review of payments made under PPS as was available for cost-based reimbursement. Review was permitted with the exception of determinations necessary to maintain budget neutrality and the establishment of diagnosis related groups (DRGs), the methods for classifying DRGs and the DRG weighting factors. Congress stated that such preclusion of judicial review was necessary to maintain a workable payment system. House Report No. 98-25(I) 1983 U.S.C.C.A.N. 219, 361-362 (1983) and Senate Report No. 98-23 1983 U.S.C.C.A.N. 143, 197-198 (1983). This preclusion of administrative and judicial review was codified in 42 U.S.C. § 1395ww(d)(7).

Subsection (d)(7) states that there shall be no administrative or judicial review under 42 U.S.C. §1395oo of the determination of the requirement or the proportional amount of any adjustment effected pursuant to subsection (e)(1). 42 U.S.C. §1395ww(e)(1) provides that for cost reporting periods of hospitals beginning in fiscal years 1984 or 1985 the Secretary shall provide for a proportional adjustment in the applicable percentage increase (otherwise applicable to the periods under subsection (b)(3)(B)) as may be necessary to assure budget neutrality. Section 1395ww(b)(3)(B) references all cost reporting periods from 1986 through the present as being affected by the budget neutrality adjustment.

In response to the enactment of the above statutes, the Board's governing regulations were modified. In the September 1, 1983 preamble to new regulations, the Secretary explained that 42 U.S.C. § 1395oo(g)(2) was added by Pub. L. 98-21 to state that the determinations and decisions described in § 1395ww(d)(7) precludes administrative and judicial review of, among other things, a determination of the requirement, or proportional amount of any "budget neutrality" adjustment effected under §1395ww(e)(1). The Secretary stated that it was the clear intent of Congress that a hospital would not be permitted to argue that the level of payment that it receives under the prospective payment system is inadequate to cover its costs. The Secretary amended

42 C.F.R. Part 405, Subpart R to implement the changes to 42 U.S.C. § 1395(g)(2) contained in Pub. L. 98-21. The changes to the regulation included the addition of 42 C.F.R. § 405.1804 to describe matters not reviewable by the Board or the courts as provided in § 1395ww(d)(7).[4] Section 405.1804 states specifically that there is neither administrative nor judicial review of the determination of the requirement or the proportional amount of any budget neutrality adjustment in the prospective payment rate. Therefore, the Secretary clearly interpreted the statutory prohibition on review as not being confined to 1984 and 1985.

When the Secretary "updated, clarified and revised"[5] the Board's governing regulations in 2008, he separately and specifically addressed the limitations on the Board's jurisdiction. The original regulation at 42 C.F.R. § 405.1804, stating that budget neutrality issues are not reviewable, was reissued without change or comment. In addition, the Secretary added 42 C.F.R. § 405.1840 to the regulations specifically dealing with the Board's jurisdiction. Section 405.1840(b) states that certain matters at issue were removed from the jurisdiction of the Board and included "[c]ertain matters affecting payments to hospitals under the prospective payment system, as provided in [42 U.S.C. § 1395ww(d)(7)] and § 405.1804 of this subpart." If the budget neutrality provisions of § 405.1804 were limited to appeals of FY 1984 and 1985, there would be no reason to leave the regulation unchanged during a comprehensive revision of the Board's regulations and certainly no need to add § 405.1840(b)(2) reiterating and emphasizing the Board's lack of jurisdiction over the budget neutrality issue. The Secretary's action demonstrates a twenty five year consistent position that all budget neutrality determinations are off limits to the Board; not just those relating to fiscal years 1984 and 1985. Whether the Secretary's view is consistent with Congress' intent is not for the Board to decide for it is bound by the regulation.

EJR Determination

42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permit providers to bypass the Board's hearing procedure and obtain judicial review of a specific matter at issue involving a question of law or regulation where the Board determines that it is without authority to decide the legal question. Prior to rendering a decision that it lacks the authority to decide the legal question before it, the Board must determine that it has jurisdiction over the matter at issue in the appeal under 42 U.S.C. § 1395oo. 42 C.F.R. § 405.1842(a)(2008). We conclude that both the statute and regulation preclude administrative review of the budget neutrality adjustment; therefore, the Board lacks jurisdiction over the appeal.

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

Application of Cape Cod case on the Request for EJR

Ordinarily our EJR analysis would end with a determination of no jurisdiction. However, in *Cape Cod HC 2007 Wage Index/Rural Floor Group*, PRRB case number 07-0705G et al, (*Cape Cod*), the Secretary has taken a contrary position. In *Cape Cod*, the Board concluded that it

[4] 48 Fed. Reg. 39740, 39785 (September 1, 1983).
[5] 73 Fed. Reg. 30190 (May 23, 2008).

lacked jurisdiction over the budget neutrality adjustment based on the authorities set forth above. The Board's decision was not reversed by the CMS Administrator. On appeal to the Federal district court, however, the Secretary moved for remand on the basis that the Board had jurisdiction over the issue. The provider plaintiffs responded that the remand was unnecessary because the case was properly before the court on EJR. It argued that implicit in the Board's finding it lacked jurisdiction was a determination that it also lacked authority to decide the question, thus, EJR was appropriate. In its remand order, the District Court explained that the two findings are distinct. "Jurisdiction to take any legal action" asks whether the Providers may obtain a hearing at all; "authority to decide the question" asks whether the Board has authority to reach the merits of Providers' claims. The Court concluded that the Secretary's position was correct: the Court lacked subject matter jurisdiction without the Board's first being afforded an opportunity to consider the merits of the Providers' claims, including whether it has authority to decide the question. Neither the D.C. District court remand[6] nor the remand from the Deputy Administrator addresses the Secretary's rationale for his position regarding jurisdiction. Assuming, however, that the Secretary will take the same position in this case with respect to the Board's having jurisdiction over the budget neutrality issue, and in the interest of judicial economy, the Board will also address the question of whether EJR is appropriate.[7]

The Providers in this appeal seek to have the final wage index rates published in the Federal Register modified by applying a different calculation methodology relating to the budget neutrality and rural floor factors. Pursuant to 42 C.F.R. § 412.64, the Secretary calculates the standardized amount on an annual basis. This calculation is published annually in the Federal Register following a complex and lengthy process of data collection and analysis. The methodology for the calculation is described in general terms.

The Board is bound by the Secretary's final rules and has no authority to review the data underlying the rate published unless specifically authorized. Notably the Final Rule only provides for Board review of denials of requests by hospitals for correction of certain wage data that eventually goes into one hospital-specific component of the final rate.[8] If the provider appealing the denial is successful, the remedy is limited to the hospital bringing the successful appeal. There is no provision for the Board to adjust the rate itself (as applied to all hospitals) to account for the effect of the error. The Board concludes that the specific grant of authority and establishment of a detailed process for correcting the rate of only the hospital bringing the appeal, coupled with the failure to include the effect of that correction on other hospitals or to establish a similar correction process for other components of the wage index, are strong indications that the Board does not have authority to change the rate itself.

Even more compelling, however, is the language of the statute and the regulation quoted above that prohibits review of budget neutrality determinations which are at the heart of the question

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[6] *Cape Cod Hospital v. Leavitt*, 565 F. Supp.2d (D.D.C. 2008).

[7] After the above remand based on the Secretary's position regarding jurisdiction, the Board found the Provider was entitled to expedited judicial review. In December of 2009, the District Court for the District of Columbia granted the defendant's (government's) motion for summary judgment for the budget neutrality adjustment. *Cape Cod Hospital et al. v. Sebelius*, 677 F. Supp. (D.D.C. 2009).

[8] 64 Fed. Reg. 41490, 41513 (July 30, 1999). This authority has never been codified in the code of Federal Regulations.

before the Board in this case. Even if the Board interpreted the statutory and regulatory prohibitions on review of budget neutrality determinations too broadly to bar jurisdiction, those prohibitions cannot be ignored altogether. We conclude that the statute and regulation evidence Congress' and the Secretary's intent that budget neutrality determinations are insulated from the Board's authority to affirm, reverse or modify a reimbursement determination. Otherwise, the specific prohibitions articulated there would be rendered meaningless.

Assuming, arguendo, that the Secretary takes the same position in these cases that the Board has jurisdiction, then the Board finds that:

1) based upon the Providers' unopposed assertions regarding the challenges to the rural floor/budget neutrality methodology, there are no findings of fact for resolution by the Board;

2) it is bound by the Final Rule in the Federal Register and the regulation; and

3) it is without authority to decide the legal question of whether the calculation methodology for the budget neutrality/rural floor adjustment is valid.

Accordingly, the Board finds that the budget neutrality/rural floor issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and expedited judicial review is appropriate. Because this is the only issue under appeal in this case, the Board hereby closes the case.

Board Members Participating:

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

FOR THE BOARD:

Michael W. Harty
Chairperson

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

cc: Geoff Pike, First Coast Services Options (FL) (w/Schedule of Providers)
Kevin Shanklin, BCBSA (w/Schedule of Providers)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2670

Phone: 410-786-2671
Internet: www.cms.gov/PRRBReview FAX: 410-786-5298

Refer to: 13-2622GC

CERTIFIED MAIL

SEP 12 2013

Stephen P. Nash, Esq.
Patton Boggs LLP
1801 California Street
Suite 4900
Denver, CO 80202

RE: Patton Boggs/Lee Memorial 2008 RFBNA Group
Provider Nos. Various
FFY 2008
PRRB Case No. 13-2622GC

Dear Mr. Nash:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' request for expedited judicial review (EJR) dated August 14, 2013 (received August 15, 2013) in the above-referenced group appeal. The issue under dispute involves whether the Centers for Medicare & Medicaid Services (CMS) erred in calculating a budget neutrality adjustment to the PPS standardized amount to account for the effects of the rural floor on the wage index. The Board's jurisdictional decision and decision regarding EJR is set forth below.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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

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

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

Standardized Amount

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

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

Budget Neutrality

Budget neutrality is determined by comparing aggregate IPPS payments before and after making changes that are required to be budget neutral (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 adjustments. Id. at 48147.

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

Rural Floor

Section 4410 of the Balanced Budget Act of 1997 (BBA of 1997) established the rural floor by requiring that the wage index of a hospital in any urban area cannot be less than the wage index determined for the State's rural area. Since 1998 CMS had implemented the budget neutrality requirement of this provision by adjusting the standardized amounts. 72 Fed. Reg. 24680, 24787 (May 3, 2007). In establishing the PPS standardized amount for FFY 2007, and for prior

Federal fiscal years, CMS adjusted the standardized amount to account for the effects of the rural floor. See e.g., 71 Fed. Reg. 48145-48 (August 18, 2006). In FFY 2008 CMS applied the budget neutrality adjustment to the wage index, rather than the standardized amount.[1]

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

> . . . the rural floor budget neutrality adjustment previously was a cumulative adjustment, similar to the adjustments we currently make for updates to the wage index and DRG [diagnostic related groups] reclassification and recalibration. Beginning in 2008, the rural floor budget neutrality adjustment will be noncumulative.
>
> . . .With regard to alleged errors in FY 1999 through 2007, our calculation of the budget neutrality in past fiscal years is not within the scope of this rulemaking Even if errors were made in prior fiscal years, we would not make an adjustment to make up for those errors when setting rates for FY 2008. It is our longstanding policy that finality is critical to a prospective payment system. Although such errors in rate setting are inevitable, we believe the need to establish final prospective rates outweighs the greater accuracy we might gain if we retroactively recomputed rates whenever an error is discovered.

72 Fed. Reg. at 47330.

Wage Index

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

PROCEDURAL HISTORY:

These appeals were timely filed from the issuance of the Providers Notices of Program Reimbursement. The Providers challenge an aspect of the Secretary's calculation of the PPS rates published in the Federal Register for FFY 2008.[2] The Providers contend that

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[1] 72 Fed. Reg. 47130, 47329 (August 22, 2007).

[2] On August 1, 2007, CMS posted on its website the final inpatient hospital PPS rule for FFY 2008. *See* Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates, *available* at http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1533-FC.pdf. The rule was published in the Federal Register on August 22, 2007. 72 Fed. Reg. 47130. On October 10, 2007, a correction to the August

CMS committed an error in calculating the budget neutrality adjustment to the PPS standardized amount to account for the effects of the rural floor on the wage index. This error results in a systematic understatement of the PPS rates, and this error has been an annual recurring one. Each year's error is permanently built into the standardized amount paid under PPS for each successive year. Thus, the Providers assert the PPS rates established in the FFY 2008 PPS rules are understated both as a result of errors in the calculation of the budget neutrality adjustment for the effects of the rural floor in 2008 and as a result of the cumulative effect of the same error in prior calculations of the budget neutrality adjustments for the effect of the rural floor in prior Federal fiscal years.

Basis for EJR

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

> [W]e used FY 2005 discharge data to simulate payments and compared aggregate payments using the FY 2006 relative weights and wage indexes to aggregate payments using the FY 2007 relative weights and wage indexes. The same methodology was used for the FY 2006 budget neutrality adjustment.
>
> *****
>
> These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2006 budget neutrality adjustments.

71 Fed. Reg. at 48147.

The Providers are challenging an aspect of CMS' calculation of the final PPS rates published in the Federal Register for and 2008.[3] The Providers contend that CMS erred in calculating a budget neutrality adjustment to the PPS standardized amount to account for the effects of the rural floor on the wage index. This alleged error results in a systematic understatement of the PPS rates, and this error has been an annual and recurring one. Each year's error is permanently incorporated into the standardized amount paid under PPS for each successive year. Consequently, the Providers allege, the final rates established in the final FFY 2008 PPS rules are understated, both as the result of the erroneous computation methodology used to calculate the budget neutrality adjustment for the effects of the rural floor in FFY 2008 itself, and as a result of the cumulative effect of the same error in prior fiscal years.

2007 final IPPS rule for FFY 2008 was published in the Federal Register to rectify prior errors in calculating the hospital specific rates for sole community hospitals and Medicare-dependent hospitals. 72 Fed. Reg. 57634. These cases are from the rural floor budget neutrality adjustment. *Id* at 57734.

[3] The final IPPS rates for this period were published in the Federal Register on August 22, 2007. 72 Fed. Reg. 47130, 47329 (August 22, 2007).

As a result of the alleged recurring computation methodology error, the Providers contend that CMS has not applied the rural floor in a manner assuring that the aggregate payments are not less than those which would have been made if the rural floor did not apply. The Providers assert that, rather than achieving the budget neutrality required by law, the Secretary has effected PPS payment reductions for FFY 2008 that exceeded the Secretary's statutory authority, are arbitrary and capricious, and are otherwise contrary to law.

Decision of the Board:

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

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

> There shall be no administrative or judicial review under [42 U.S.C. §1395oo] or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount of any adjustment effected pursuant to subsection (e)(1) [budget neutrality] or the determination of the applicable percentage increase under paragraph (12)(A)(ii) . . .

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

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

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

> Neither administrative or judicial review is available for controversies about the following matters:
>
> (a) The determination of the requirement, or the proportional amount, of any *budget neutrality adjustment* in the prospective payment rates. . . . (emphasis added)

CMS stated at the time the rule was adopted that the purpose of the rule is:

> to state that the determinations and decisions described in section 1886(d)(7) of the Act may not receive Board or judicial review. Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
>
> > A determination of the requirement, or the proportional amounts of, any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act . . .

48 Fed. Reg. 39752, 39785 (September 1, 1983).

In addition, section 701(a) of the Administrative Procedure Act (APA) states that the appeal provisions of the APA apply to the administrative actions except where statutes preclude judicial review. *See* 5 U.S.C. § 701(a). The statutes and the regulations both preclude administrative and judicial review of the budget neutrality adjustment.

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In response to the enactment of the above statutes, the Board's governing regulations were modified. In the September 1, 1983 preamble to new regulations, the Secretary explained that 42 U.S.C. § 1395oo(g)(2) was added by Pub. L. 98-21 to state that the determinations and decisions described in § 1395ww(d)(7) precludes administrative and judicial review of, among other things, a determination of the requirement, or proportional amount of any "budget neutrality" adjustment effected under §1395ww(e)(1). The Secretary stated that it was the clear intent of Congress that a hospital would not be permitted to argue that the level of payment that it receives under the prospective payment system is inadequate to cover its costs. The Secretary amended 42 C.F.R. Part 405, Subpart R to implement the changes to 42 U.S.C. § 1395(g)(2) contained in Pub. L. 98-21. The changes to the regulation included the addition of 42 C.F.R. § 405.1804 to

describe matters not reviewable by the Board or the courts as provided in § 1395ww(d)(7).[6] Section 405.1804 states specifically that there is neither administrative nor judicial review of the determination of the requirement or the proportional amount of any budget neutrality adjustment in the prospective payment rate. Therefore, the Secretary clearly interpreted the statutory prohibition on review as not being confined to 1984 and 1985.

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EJR Determination

42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permit providers to bypass the Board's hearing procedure and obtain judicial review of a specific matter at issue involving a question of law or regulation where the Board determines that it is without authority to decide the legal question. Prior to rendering a decision that it lacks the authority to decide the legal question before it, the Board must determine that it has jurisdiction over the matter at issue in the appeal under 42 U.S.C. § 1395oo. 42 C.F.R. § 405.1842(a)(2008). We conclude that both the statute and regulation preclude administrative review of the budget neutrality adjustment; therefore, the Board lacks jurisdiction over the appeal.

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

Application of Cape Cod case on the Request for EJR

Ordinarily our EJR analysis would end with a determination of no jurisdiction. However, in *Cape Cod HC 2007 Wage Index/Rural Floor Group*, PRRB case number 07-0705G et al, (*Cape Cod*), the Secretary has taken a contrary position. In *Cape Cod*, the Board concluded that it lacked jurisdiction over the budget neutrality adjustment based on the authorities set forth above. The Board's decision was not reversed by the CMS Administrator. On appeal to the

[6] 48 Fed. Reg. 39740, 39785 (September 1, 1983).
[7] 73 Fed. Reg. 30190 (May 23, 2008).

Federal district court, however, the Secretary moved for remand on the basis that the Board had jurisdiction over the issue. The provider plaintiffs responded that the remand was unnecessary because the case was properly before the court on EJR. It argued that implicit in the Board's finding it lacked jurisdiction was a determination that it also lacked authority to decide the question, thus, EJR was appropriate. In its remand order, the District Court explained that the two findings are distinct. "Jurisdiction to take any legal action" asks whether the Providers may obtain a hearing at all; "authority to decide the question" asks whether the Board has authority to reach the merits of Providers' claims. The Court concluded that the Secretary's position was correct: the Court lacked subject matter jurisdiction without the Board's first being afforded an opportunity to consider the merits of the Providers' claims, including whether it has authority to decide the question. Neither the D.C. District court remand[8] nor the remand from the Deputy Administrator addresses the Secretary's rationale for his position regarding jurisdiction. Assuming, however, that the Secretary will take the same position in this case with respect to the Board's having jurisdiction over the budget neutrality issue, and in the interest of judicial economy, the Board will also address the question of whether EJR is appropriate.[9]

The Providers in this appeal seek to have the final wage index rates published in the Federal Register modified by applying a different calculation methodology relating to the budget neutrality and rural floor factors. Pursuant to 42 C.F.R. § 412.64, the Secretary calculates the standardized amount on an annual basis. This calculation is published annually in the Federal Register following a complex and lengthy process of data collection and analysis. The methodology for the calculation is described in general terms.

The Board is bound by the Secretary's final rules and has no authority to review the data underlying the rate published unless specifically authorized. Notably the Final Rule only provides for Board review of denials of requests by hospitals for correction of certain wage data that eventually goes into one hospital-specific component of the final rate.[10] If the provider appealing the denial is successful, the remedy is limited to the hospital bringing the successful appeal. There is no provision for the Board to adjust the rate itself (as applied to all hospitals) to account for the effect of the error. The Board concludes that the specific grant of authority and establishment of a detailed process for correcting the rate of only the hospital bringing the appeal, coupled with the failure to include the effect of that correction on other hospitals or to establish a similar correction process for other components of the wage index, are strong indications that the Board does not have authority to change the rate itself.

Even more compelling, however, is the language of the statute and the regulation quoted above that prohibits review of budget neutrality determinations which are at the heart of the question before the Board in this case. Even if the Board interpreted the statutory and regulatory prohibitions on review of budget neutrality determinations too broadly to bar jurisdiction, those

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[8] *Cape Cod Hospital v. Leavitt*, 565 F. Supp.2d (D.D.C. 2008).

[9] After the above remand based on the Secretary's position regarding jurisdiction, the Board found the Provider was entitled to expedited judicial review. In December of 2009, the District Court for the District of Columbia granted the defendant's (government's) motion for summary judgment for the budget neutrality adjustment. *Cape Cod Hospital et al. v. Sebelius*, 677 F. Supp. (D.D.C. 2009).

[10] 64 Fed. Reg. 41490, 41513 (July 30, 1999). This authority has never been codified in the code of Federal Regulations.

prohibitions cannot be ignored altogether. We conclude that the statute and regulation evidence Congress' and the Secretary's intent that budget neutrality determinations are insulated from the Board's authority to affirm, reverse or modify a reimbursement determination. Otherwise, the specific prohibitions articulated there would be rendered meaningless.

Assuming, arguendo, that the Secretary takes the same position in these cases that the Board has jurisdiction, then the Board finds that:

1) based upon the Providers' unopposed assertions regarding the challenges to the rural floor/budget neutrality methodology, there are no findings of fact for resolution by the Board;

2) it is bound by the Final Rule in the Federal Register and the regulation; and

3) it is without authority to decide the legal question of whether the calculation methodology for the budget neutrality/rural floor adjustment is valid.

Accordingly, the Board finds that the budget neutrality/rural floor issue properly falls within the Provisions of 42 U.S.C. § 1395oo(f)(1) and expedited judicial review is appropriate. Because this is the only issue under appeal in this case, the Board hereby closes the case.

Board Members Participating:

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

FOR THE BOARD:

Michael W. Harty
Chairperson

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

cc: Geoff Pike, First Coast Service Options (FL) (w/Schedule of Providers)
Kevin Shanklin, BCBSA (w/Schedule of Providers)

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Refer to:
07-1255, 08-2853
CERTIFIED MAIL

SEP 18 2013

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Akin, Gump, Strauss, Hauer & Feld, LLP
1333 New Hampshire Avenue, NW
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Arthur E. Peabody, Jr., Esq.
Blue Cross Blue Shield Association
1310 G Street, NW
Washington, D.C. 20005-3004

RE: Health Alliance Hospital
Provider No. 22-0001
PRRB Case Nos. 07-1255 FYE 9/30/04
08-2853 FYE 9/30/06

Dear Messrs. Keough and Peabody:

The Provider Reimbursement Review Board (Board) conducted a hearing in the above referenced cases on August 29, 2012, which involved the issue of whether observation beds should be included in the computation of the disproportionate share hospital (DSH) adjustment. During the hearing the Board and the parties discussed the possibility of the Board finding that expedited judicial review (EJR) was appropriate for the issue and fiscal years under appeal in the above-referenced cases. As required by 42 C.F.R. § 405.1842(c) (2008), the Board sent the parties a letter on November 7, 2012, advising that it was considering EJR on its own motion and seeking the comments with respect to that proposed action. Both parties have responded,[1] agreeing that EJR is appropriate.

The Issue under Appeal

The issue under appeal in these cases is whether observation bed days should be included in the computation of the disproportionate share adjustment. In both cases, the Intermediary excluded observation bed days from the computation of the Provider's bed count used to determine the DSH adjustment factor.[2] This resulted in the Provider's DSH adjustment factor being capped under the provision of 42 U.S.C. § 1395ww(d)(5)(F)(xiii)-(xiv) and 42 C.F.R. § 412.106(c)-(d).[3]

[1] The Intermediary responded through correspondence dated December 3, 2012. The Provider responded in correspondence of December 6, 2012.
[2] There is no dispute that the Provider is an urban hospital and that the DSH adjustment for both fiscal years was capped. *See, e.g.,* Provider's Position Paper, PRRB case number 08-2853 at 8 n.1.
[3] *See* Provider's Position Paper in case number 07-1255 at 6. In fiscal year September 30, 2004 the Provider's DSH adjustment factor was limited to 5.25 percent for the period between October 1, 2003 and March 31, 2004, and 12 percent for the period between April 1, 2004 and September 30, 2004. The reimbursement impact was $480,963. For fiscal year September 30, 2006; *See* Provider's Position Paper in case number 08-2853 at 8. The Provider DSH adjustment factor was capped at 12 percent. The Provider's September 16, 2008 hearing request at Tab 3 states that the reimbursement effect is $403,358.

Statutory and Regulatory Background

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).[4] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5]

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[6] This case 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.[7]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage (DPP).[8] 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.

The DPP is defined as the sum of two fractions expressed as percentages.[9] 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 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 . . . .

42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Medicare/SSI fraction is computed annually by CMS, and the Medicare fiscal intermediaries use CMS' calculation to compute a hospital's DSH payment adjustment.[10]

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[4] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[5] *Id.*
[6] *See* 42 U.S.C. § 1395ww(d)(5).
[7] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[10] 42 C.F.R. § 412.l06(b)(2)-(3).

The statute 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.

42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). The fiscal intermediary 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.

Qualifying for a DSH Adjustment

A provider's DSH adjustment factor depends upon whether the hospital is rural or urban and the number of beds is 100 or more.[11] For those urban hospitals with 100 beds or more, the DSH adjustment factor is determined under a formula based on the disproportionate share percentage and is not capped.[12] For urban hospitals with less than 100 beds, the DSH adjustment factor was capped at a lesser reimbursement amount. In FY 2004, the Intermediary removed 1,814 observation beds from the Provider's bed count resulting in a bed count of 98.04;[13] in FY 2006, 2,167 observation bed days were removed resulting in a bed count of 97.06.[14]

Without the removal of the observation bed days, the Provider's DSH adjustment factor for the FY 2004 would have been 13.09 percent.[15] For the periods between October 1, 2003 and March 31, 2004, the Provider's DSH adjustment was capped at 5.25 percent and for the period between April 1, 2004 and September 30, 2004 the DSH adjustment factor was capped at 12 percent.[16] If the regulation had not limited the cap in fiscal year 2006, the Provider's DSH adjustment would have been 15.40 percent.[17] In fiscal year 2006 the Provider's DSH adjustment was capped at 12 percent.[18]

Background on Bed Count and Available Beds

The statute requires a cap is to be applied to the DSH adjustment factor where the hospital has less than 100 beds,[19] but it does not specify how beds are to be counted to determine whether a provider qualifies for a DSH adjustment. The DSH regulation, however, states that the bed count

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[11] 42 U.S.C. § 1395ww(d)(5)(F)(iv), (vii)-(xiv); 42 C.F.R. § 412.106(d).
[12] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vii)(I)(d); 42 C.F.R. § 406(d)(2)(i)(A)(4).
[13] Provider's Position Paper, case number 07-1255 at 5.
[14] Provider's Position paper, case number 08-2853 at 8.
[15] Provider's Position Paper, PRRB case number 07-1255 at 6.
[16] *Id.*
[17] Provider's Position Paper, PRRB case number 08-2853 at 9.
[18] *See* 42 U.S.C. § 1395ww(d)(5)(F)(xii)-(xiv); 42 C.F.R. § 412.106(d)(2)(iii)(B)-(C) and Provider's Position Paper, PRRB case number 08-2853 at 5.
[19] *See, e.g.,* 42 U.S.C. § 1395ww(d)(5)(F)(xiv) (setting the cap for the DSH adjustment for urban hospitals with less than 100 beds).

for DSH is determined by using the indirect medical education methodology described in 42 C.F.R. § 412.105(b).[20] Prior to October 1, 2003, observation beds were not specifically excluded from the bed count calculation in the IME regulation.[21] In the August 1, 2003 Federal Register,[22] the Secretary[23] amended the regulation to state that beds otherwise countable under this section used for outpatient observation services are excluded from the bed count.[24] In 2004, the Secretary added an exception to the rule for instances where a "patient treated in an observation bed is ultimately admitted for acute inpatient care, in which case the beds and days would be included in those counts."[25] In 2009, after the periods at issue here, the Secretary removed the exception for observation beds days for patients subsequently admitted to the hospital as inpatients.[26]

Stipulations of the Parties[27]

On July 29, 2013, parties stipulated to the following matters:

1. For the cost reporting periods ending September 30, 2004 and September 30, 2006, the Provider reported 103 licensed beds located in areas of the hospital subject to the inpatient hospital prospective payment system ("IPPS"). Provider Exhibit 9 at p.7 (FY 2004); Provider Exhibit 5 (FY 2006). These licensed beds were reported on cost report worksheet S-3, column 1. For each fiscal year, the Provider also reported the equivalent number of available bed days in IPPS areas of hospital as available bed days on cost report worksheet S-3, col. 2. The numbers of available bed days reported was 37,595 available bed days for 2006 (103 beds x 365-day year) and 37,698 available bed days for 2004 (103 beds x 366-day year). Provider Exhibit 9 at p.7 (FY 2004); Provider Exhibit 5 (FY 2006); *see also* Tr. at 101, 104. These available bed days included any times when inpatient routine beds were used to provide observation services. Tr. at 95. The Provider did not have a discrete outpatient observation area or unit. *See* Tr. at 119; Provider Exhibit 9 at 14 (FY 2004); Provider Exhibit 8 at p.11 (FY 2006). As is customary, the Provider used available and unoccupied inpatient routine beds for observation. For both cost reporting

[20] *See also* 42 C.F.R. § 412.106(a)(1)(i).
[21] 42 C.F.R. § 412.105(b) (2002) states that ". . . the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period, including beds or bassinets in the healthy newborn nursery, custodial care beds, or beds in excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period."
[22] 68 Fed. Reg. 45346, 45318-45319 (Aug. 1, 2003).
[23] of the Department of Health and Human Services.
[24] *See* 42 C.F.R. § 412.105(b)(3) (2003).
[25] *See* 42 C.F.R. § 412.105(b)(4) (2004); *See, also,* 42 C.F.R. § 412.106(a)(2)(B) (2004).
[26] *See* 74 Fed. Reg. 43754, 43906(Aug, 27, 2009).
[27] The Provider's December 6, 2012 response to the Board's letter advising that it was considering issuing a decision on its own motion finding that EJR was appropriate for the issue under appeal contained proposed findings of fact which did not appear to have been agreed to by the Intermediary On July 15, 2013, the Board asked the parties to confer and, if possible, jointly agree to findings. The findings set forth above are those agreed to by the parties.

periods, the Provider had an occupancy rate of about 70% or less - *i.e.* more than 1 out of 4 inpatient routine beds were unoccupied. Provider Exhibit 9 at p.7 (FY 2004); Provider Exhibit 5 (FY 2006).

2. In its final payment determinations for the fiscal years ending September 30, 2004 and September 30, 2006, the Intermediary subtracted observation services from the number of available bed days reported on worksheet S-3, column 2, and then capped the Medicare disproportionate share hospital (DSH) adjustment percentage on the ground that the Provider had less than 100 beds. *See* Settled Worksheet E part A, lines 3 and 4.03, Provider Exhibit 10 at p.2 (FY 2004); Provider Exhibit 3 (FY 2006); *see also* Tr. at 101-03, 104-05. In making these determinations, the Intermediary converted the time spent furnishing observation services to an equivalent number of bed days and then subtracted those bed days from the total number of available bed days, as reported on Worksheet S-3 col. 2, to calculate the number of available beds used to determine IME and DSH payments on worksheet E, Part A of the cost report. *See* Provider Exhibits 9 at p.7 and 10 at p.2 (FY 2004); Provider Exhibits 3 and 5 (FY 2006); *see also* Tr. at 101-03, 104-05.

3. For fiscal year 2004, the DSH adjustment percentage was capped at 12% for one part of the year and 5.25% for the other part of that fiscal year, based on the determination that the Provider had less than 100 beds. Provider Exhibit 10 at p.2 (FY 2004); Tr. at 102. If observation services were not subtracted from available bed days, the Provider's number of available beds would have been greater than 100, and its DSH adjustment percentage would have been 13.09%. Provider Exhibit 3 (FY 2004).

4. For fiscal year 2006, the DSH adjustment percentage was capped at 12% based on the determination that the Provider had less than 100 beds. Provider Exhibit 3 (FY 2006); Tr. at 104-05. If observation services were not subtracted from available bed days, the Provider's number of available beds would be greater than 100, and its DSH adjustment percentage would be 15.4%. Provider Exhibit 4 (FY 2006).

5. The Secretary amended the DSH and IME regulations governing the bed count in 2003, 2004 and 2009. As amended, the regulations in effect for discharges on and after October 1, 2003 through September 2004 exclude all observation services. *See* Fed. Reg. at 45418-19. The regulations in effect for cost reporting periods beginning on and after October 1, 2004 through September 30, 2009 excluded only the observation services furnished to patients who were not subsequently admitted as inpatients. *See* 69 Fed. Reg. at 49096-98. But, effective for cost reporting periods beginning on and

after October 1, 2009, all observation services are excluded from the bed count. 74 Fed. Reg. at 43095-98.

6. Other related changes to the DSH and IME regulations governing the bed count include the following: 1) for discharges on and after October 1, 2004, if any IPPS level care is provided in an area or unit in the prior 3 months, then the whole area or unit is considered available for the current month (69 Fed. Reg. at 49094); 2) for discharges on and after October 1, 2004, an individual bed in an open unit is counted unless it is unavailable for use within a 24-hour period for the prior 30 consecutive days (69 Fed. Reg. at 49095-96); and 3) effective October 1, 2012, unlicensed labor/delivery beds in an ancillary area of a hospital are included in the bed count. 77 Fed. Reg. 53258, 53411-13 (Aug. 31, 2012).

Basis for EJR

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. § 405.1835 (2007 and 2008), 405.1840 (2008) and 405.1841(2007) the Board finds that the appeals were timely filed and meet the $10,000 threshold for Board jurisdiction. However, the record reveals that the regulatory requirements for counting bed days for the DSH adjustment requires that observation bed days be omitted from the calculation. *See* 42 C.F.R. §§ 412.105(b) (2004) and 412.106(a)(1)(i) (2006) . Pursuant to 42 C.F.R. § 405.1867 (2008), the Board must comply with the provisions of Title XVIII of the Social Security Act and the regulations issued thereunder. Consequently, in its November 7, 2012 letter, the Board proposed it did not have the authority to grant the relief sought by the Provider: inclusion of observation bed days in the bed count used to calculate the DSH adjustment and that EJR may be appropriate by invalidating the regulations in effect October 1, 2003. In light of this, the Board requested that the parties file their comments on whether EJR is appropriate. *See* 42 C.F.R. § 405.1842(c). The Provider responded that the regulations conflict with the plain language and intent of the disproportionate share statute which measures the size of a facility by its number of "beds" and not by its number of patient days or other measure of utilization of hospital services. Further, the Provider argues, the regulations adopted 2003 are arbitrary and capricious on their face and as applied to the bed count in the fiscal years under appeal.[28] The Intermediary agreed that EJR was appropriate.[29]

Decision of the Board

The Board has reviewed the submissions of the Provider pertaining to the request for hearing and expedited judicial review. The Intermediary has agreed that EJR is appropriate. The documentation shows that the estimated amount in controversy exceeds $10,000 in each case and the appeals were timely filed.

The Board concludes that it is required to adhere to the regulations regarding the bed count and the DSH payment formula. *See* 42 C.F.R. § 405.1867. Accordingly, the Board finds, on its own

[28] *See* Provider's December 6, 2012 letter.
[29] *See* Intermediary's December 3, 2012 letter.

motion, that EJR is appropriate because it has no authority to grant the relief sought by including observation bed days in the calculation of the DSH adjustment by invalidating the regulations in effect during fiscal years 2004 and 2006. *See* 42 C.F.R. § 405.1842(a).

The Board finds that:

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

2) based upon the Provider's assertions regarding the observation bed count issue, there are no findings of fact for resolution by the Board;

3) it is bound by the regulations; and

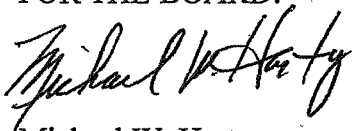
4) it is without the authority to decide the legal question of whether the regulations, 42 C.F.R. §§ 412.105(b)(4) (2004) and 412.106(a)(1)(i) (2004), are valid.

Accordingly, the Board finds that the observation bed issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and own its own motion hereby finds that expedited judicial review is appropriate 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 case.

Board Members Participating

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

FOR THE BOARD:



Michael W. Harty
Chairman

Enclosure: 42 U.S.C. § 1395oo(f)(1)

cc: Danene Harty, NGS
Kevin Shanklin, BCBSA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to:

CERTIFIED MAIL

SEP 23 2013

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

RE: Millcreek Community Hospital, Provider No. 39-0198, FYE 6/30/2002
As a participant in the Blumberg Ribner 2002 SSI Percentage Group, Case No.: 08-1711G

Dear Mr. Blumberg:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeal which is subject to a remand pursuant to CMS Ruling 1498-R. The Board notes an impediment to jurisdiction for one of the participants in the group. The pertinent facts and the Board's jurisdictional determination are set forth below.

Pertinent Facts:

The subject group appeal was filed on March 31, 2008.

Millcreek Community Hospital filed an appeal dated September 10, 2007 from a April 2, 2007 revised NPR to which the Board assigned case number 07-2798. The Provider's appeal request indicates that it ". . . was precluded from utilizing its own internally generated SSI percentage and maintains that it validly *self-disallowed* such an internally generated Percentage in favor of that promulgated by CMS." The audit adjustment page submitted shows adjustments to Hospital Adults & Peds and Allowable disproportionate share percentage due to the addition of Title IX Days.

By letter dated April 23, 2009 the Provider requested the transfer of the SSI Percentage issue from the individual appeal to the subject group appeal.

Board Determination:

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

The Board finds that it does not have jurisdiction over Millcreek Community Hospital (participant # 28) because the Provider is appealing from a revised NPR which did not specifically adjust the SSI Percentage issue.
The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 provides in relevant part:

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

> determinations), by the intermediary (with respect to intermediary determinations) or by the reviewing entity that made the decision (as described in § 405.1885(c) of this subpart).

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

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

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

As there is not evidence of an adjustment to the SSI Percentage in the revised NPR and because self-disallowance is not applicable to appeals of revised NPRs, the Board lacks jurisdiction over Millcreek Community Hospital and dismisses it from the group appeal. Review of this determination is available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Enclosed, please find a Standard Remand of the SSI Percentage for the remaining participants in the group appeal.

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

FOR THE BOARD
Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, Executive Director, BCBSA

National Government Services
Kyle Browning, Appeals Lead
MP: INA102 - AF42
P. O. Box 6474
Indianapolis, IN 46206 6474

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Refer to: 09-0377G

CERTIFIED MAIL

SEP 23 2013

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

National Government Services, Inc.
Kyle Browning
Appeals Lead
MP: INA102 - AF42
Indianapolis, IN 46207-7191

RE: QRS 1995-2004 DSH/Exhausted Medicare Benefits Medicaid Dual Eligible Days
PRRB Case No. 09-0377G
Specifically: Participant 6 (Monongahela Valley Hospital (Provider No. 39-0147), FYE 06/30/1999); Participant 51 (University Medical Center (Provider No. 45-0686), FYE 12/31/2003); Participant 71 (Bethesda Memorial Hospital (Provider No. 10-0002), FYE 09/30/2003) and Participant 74 (Bethesda Memorial Hospital (Provider No. 10-0002), FYE 09/30/2004)

Dear Mr. Ravindran and Mr. Browning:

The Provider Reimbursement Review Board (Board) has reviewed the above-captioned appeal and has noted a jurisdictional matter with regard to participants 6, 51, 71 and 74. The pertinent facts of the case with regard to these participants and the Board's jurisdictional determination are set forth below.

PERTINENT FACTS:

On November 26, 2008, the Providers' Representative filed the original group appeal request with 10 participants. On April 29, 2010, the Intermediary filed jurisdictional challenges to many of the Providers in the group. The Providers' Representative responded to these challenges on May 28, 2010. Based on these challenges, the Board dismissed, on August 24, 2010, the original participants 1, 2, 3, 4 and 10 from the case. In the updated Final Schedule of Providers filed on February 4, 2013, these participants were no longer listed as part of the group.

On November 1, 2011, the Board mailed correspondence advising the Providers' Representative that the group was deemed closed as of that date. The Board requested that the Representative no longer add participants to the group and gave the Providers 60 days to file a final Schedule of Providers with associated jurisdictional documents. The Board advised that the Providers' Representative that it had inappropriately transferred numerous additional providers to the group and asked the Representative to remove any Providers added after November 1, 2011, and those dismissed on August 24, 2010. On February 4, 2013, the Providers' Representative filed correspondence informing the Board that it had inadvertently omitted from the revised final Schedule of Providers 6 participants. These 6 participants were added or transferred to the group prior to November 1, 2011 and were validly part of the group. The Schedule of Providers submitted on February 4, 2013, contains 74 participants and is the basis of the jurisdictional review. Supplemental supporting documentation for the 6 omitted participants was also

supplied. 70 participants appeal from original Notices of Program Reimbursement (NPRs), while participants 6, 51, 71 and 74 appeal from revised NPRs.

Board Determination:

After reviewing the facts in the case, the Board finds that it lacks jurisdiction over participants 6, 51, 71 and 74 in the group.

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

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

In this case, participants 6, 51, 71 and 74 filed timely requests for hearing within 180 days of the revised NPRs. The adjustments from the revised NPRs, do not adjust Dual Eligible days.

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

Because the specific issue of Dual Eligible days was not adjusted on participants 6, 51, 71 and 74 revised NPRs, the Board finds that it lacks jurisdiction over the issue for these participants. Therefore, participants 6, 51, 71 and 74 on the Schedule of Providers are hereby dismissed from the group.

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

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

For the Board:

Michael W. Harty
Chairman

cc: Kevin D. Shanklin, Executive Director, BCBSA

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2520 Lord Baltimore Drive, Suite L
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Phone: 410-786-2671
Internet: www.cms.gov/PRRBReview **FAX: 410-786-5298**

Refer to: 09-0377G

CERTIFIED MAIL SEP 23 2013

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

National Government Services, Inc.
Kyle Browning
Appeals Lead
MP: INA102 - AF42
Indianapolis, IN 46207-7191

RE: QRS 1995-2004 DSH/Exhausted Medicare Benefits Medicaid Dual Eligible Days
PRRB Case No. 09-0377G
Specifically: Participant 35 (Stormont-Vail Regional Medical Center (Provider No. 17-0086), FYE 09/30/2002); Participant 41 (Bellflower Medical Center (Provider No. 05-0531), FYE 08/31/2003); Participant 43 (Saint Francis Hospital and Medical Center (Provider No. 07-0002), FYE 09/30/2003; Participant 53 (Bellflower Medical Center (Provider No. 05-0531), FYE 08/31/2004); and Participant 58 Hartford Hospital (Provider No. 07-0025), FYE 09/30/2004)

Dear Mr. Ravindran and Mr. Browning:

The Provider Reimbursement Review Board (Board) has reviewed the above-captioned appeal and has noted a jurisdictional matter with regard to participants 35, 41, 43, 53 and 58. The pertinent facts of the case with regard to these participants and the Board's jurisdictional determination are set forth below.

PERTINENT FACTS:

On November 26, 2008, the Providers' Representative filed the original group appeal request with 10 participants. On April 29, 2010, the Intermediary filed jurisdictional challenges to many of the Providers in the group. The Providers' Representative responded to these challenges on May 28, 2010. Based on these challenges, the Board dismissed, on August 24, 2010, the original participants 1, 2, 3, 4 and 10 from the case. In the updated Final Schedule of Providers filed on February 4, 2013, these participants were no longer listed as part of the group.

On November 1, 2011, the Board mailed correspondence advising the Providers' Representative that the group was deemed closed as of that date. The Board requested that the Representative no longer add participants to the group and gave the Providers 60 days to file a final Schedule of Providers with associated jurisdictional documents. The Board advised that the Providers' Representative that it had inappropriately transferred numerous additional providers to the group and asked the Representative to remove any Providers added after November 1, 2011, and those dismissed on August 24, 2010. On February 4, 2013, the Providers' Representative filed correspondence informing the Board that it had inadvertently omitted from the revised final Schedule of Providers 6 participants. These 6 participants were added or transferred to the group prior to November 1, 2011, and were validly part of the group. The Schedule of Providers submitted on February 4, 2013, contains 74 participants and is the basis of the jurisdictional review. Supplemental supporting documentation for the 6 omitted participants was also supplied.

The supporting documentation for participants 35, 41, 43, 53 and 58, reveals that these participants did not include the Dual Eligible days issue in their original appeal requests. Additionally, there is not documentation to support that these participants added the Dual Eligible days issue to their individual appeals on or before October 20, 2008, or prior to requesting to transfer the issue to the group appeal.

BOARD DETERMINATION:

Participants 35, 41, 43, 53 and 58, did not include the Dual Eligible days issue in their individual appeal requests and did not separately add the issue to their individual appeals prior to their individual requests to be transferred to the subject group appeal. Effective August 21, 2008, new Board regulations went into effect that limited the addition of issues to appeals. 42 C.F.R. § 405.1835 provides in relevant part:

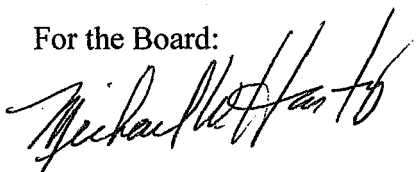
> (c) Adding issues to the hearing request. After filing a hearing request in accordance with paragraphs (a) and (b) of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if the following requirements are met:
>
> ***
>
> (3) The Board receives the request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) of this section.

For appeals already pending when this regulation was promulgated, Providers were given 60 days from the date that the new regulations took effect, August 21, 2008, to add issues to their appeals. In practice this means that issues had to be added to pending appeals by October 20, 2008. *See* 73 Fed. Reg. 30,234 (May 23, 2008). Since there is no evidence in the record demonstrating that the Dual Eligible days issue was a part of the individual appeals for participants 35, 41, 43, 53 and 58, prior to the requests to transfer to the current group appeal which all occurred after the date to add issues, the Board denies the request to include these participants in the group.

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

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

For the Board:



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and .1877

cc: Kevin D. Shanklin, Executive Director, BCBSA

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Refer to: 06-0372

SEP 25 2013

CERTIFIED MAIL

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

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

RE: Hospital Dr. Susoni, Inc.
PN: 40-0117
FYE: 12/31/2001
PRRB Case No.: 06-0372

Dear Mr. Roth and Mr. Pike,

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

Background

The Provider was issued a revised Notice of Program Reimbursement (NPR) for fiscal year 12/31/2001 on June 22, 2005. On December 14, 2005, the Provider filed a hearing request with the Board appealing the SSI% issue. Subsequently, the Provider added the Medicare + Choice Days issue to its individual appeal on December 21, 2007. In order to establish the Board's jurisdiction, the Provider submitted "Documents Confirming Board Jurisdiction Over RNPR Appeal" on May 20, 2008.

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

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

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

Provider's Position

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

Board's Decision

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

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

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

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

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

> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (b)(2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

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

The Board finds that it does not have jurisdiction over the SSI% issue because it was not adjusted when the cost report was reopened. The audit adjustment accompanying the revised NPR shows that DSH was adjusted, as the Provider argued, however there is not a specific adjustment to the SSI%. In addition, the Provider submitted a copy of the Worksheet E, Part A with its May 20, 2008 jurisdictional submission. Line 4 shows that the percentage of SSI recipient days to Medicare Part A patient days remained at .14 when the cost report was reopened. These two documents support the Board's conclusion that it does not have jurisdiction over the SSI% issue because it was not adjusted in the revised NPR.

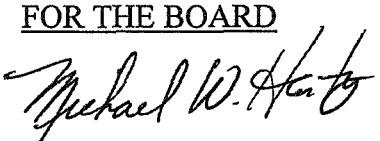
In addition, the Board also finds that it does not have jurisdiction over the Medicare + Choice issue that was added to the appeal. The Provider did not submit any documentation showing that Medicare + Choice days were adjusted in the reopening of the cost report, therefore the Board finds that it does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

The Board finds that it does not have jurisdiction over the two issues in this individual appeal because they were not specifically adjusted in the revised NPR. Therefore, the Board hereby dismisses the two issues and closes case number 06-0372.

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

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

FOR THE BOARD



Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, BCBSA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to: 12-0166GC

SEP 27 2013

Certified Mail

Corinna Goron
Healthcare Reimbursement Services, Inc.
17101 Preston Road
Suite 220
Dallas, TX 75248

RE: QRS/FMOLHS FFYs 1998-2012 RFBNA Equitable Tolling Group
Provider Nos. Various
FFYs 1998-2012
PRRB Case No. 12-0166GC

Dear Ms. Goron:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' September 4, 2013 request for expedited judicial review (EJR) (received September 5, 2013), as well as the hearing request, Schedule of Providers and jurisdictional documents submitted in the above referenced appeal. The Board's determination with respect to jurisdiction and EJR are set forth below.

Background

The Providers in the above case have requested equitable tolling because they assert that they had no "reasonable means" to identify errors in the Secretary's computation of the rural floor budget neutrality adjustment (RFBNA). Beginning in Federal fiscal year (FFY) 2008, the RFBNA was applied to the wage index rather than the standardized amount. However, the Secretary did not indicate that errors had been made in its prior implementation of the budget neutrality provision or the purpose of the change. Consequently, the Providers were unable to discern any error(s) and could not duplicate the Secretary's calculations. They seek a correction of all annual budget neutrality adjustments from FFYs 1999-2012 to allow full and complete relief.[1]

Jurisdiction Over Appeals filed for Federal Fiscal Year 2012

Two Providers, # 20 Our Lady of the Lourdes Regional Medical Center (provider number 19-0102, fiscal year end June 30, 2012) and # 30 St Francis Medical Center (provider number 19-0125, fiscal year end June 30, 2012), timely appealed the period October 1, 2011 through June 30, 2012 from the August 18, 2011 Federal Register[2] that gave rise to the dispute for FFY 2012.

[1] Providers' January 27, 2012 Hearing Request, Tab 2.
[2] 78 Fed. Reg. 51476 (August 18, 2011).

Since these Providers have timely appeals of the RFBNA issue, the Board has established a new group appeal for the Providers for the period October 1, 2011 through June 30, 2012, which has been assigned case number 13-3440GC.[3] The decision set forth below regarding EJR will not be applicable to that case since the Board cannot determine if the group is complete and cannot make a jurisdictional determination with respect to the group. *See* 42 C.F.R. §§ 405.1837(e)(2) and 405.1842(a). A Group Acknowledgement (Common Issue Relate Party (CIRP/Mandatory Group)) letter for case number 13-3440GC is enclosed with this decision.

Board Determination:

The Board finds that the appeal was not timely filed within 180 days of the issuance of the final inpatient prospective payment rules in the relevant Federal Register notice for each Federal fiscal year under appeal as required by 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1837 (2008). Consequently, the Board lacks jurisdiction over the appeal and hereby dismisses the case. Since jurisdiction over an appeal is prerequisite to granting EJR, the Providers' request for EJR is hereby denied. *See* 42 C.F.R. § 405.1842(a). Since there is no further action for the Board to take in this case, the case is closed.

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

In this case, the Providers filed their appeal based on the publication of the final inpatient prospective payment rules in the Federal Register for the FFYs under dispute. Pursuant to 42 C.F.R. § 405.1836, a provider may request good cause for late filing if it can demonstrate that there are extraordinary circumstances beyond its control that prevented timely filing of an appeal and the request for hearing was made within three years of date of receipt of the final determination.[4] The Board notes that the Providers did not request or demonstrate good cause for late filing for those appeals that were filed within three years of the publication of the Federal Register notices. Even if the Providers had made such a request, there would not be any basis for finding good cause for late filing because knowledge of the issues surrounding the RFBNA can be imputed to them as early as 2009 when the district court issued a decision in *Cape Cod Hospital v. Sebelius*, 677 F. Supp. 2d 18 (D.D.C. 2009).

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[3] The group name is "QRS FMOLHS 10/1/2011-6/30/2012 RBNA CIRP."

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

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

Board Members Participating

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

FOR THE BOARD:

Michael W. Harty
Chairman

Enclosures: Schedule of Providers
Group Acknowledgement Letter for case no. 13-3440GC
42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

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

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Refer to: 13-3085
CERTIFIED MAIL

SEP 30 2013

Corinna Goron
President
Healthcare Reimbursement Services
17101 Preston Road, Suite 220
Dallas, TX 75248

Re: Baton Rouge General Medical Center
Provider No. 19-0065
FYE 09/30/07
PRRB Case No. 13-3085

Dear Ms. Goron:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's request for expedited judicial review (EJR) dated September 12, 2013 (received September 13, 2013). The request is unopposed. The issue under dispute involves whether the Centers for Medicare & Medicaid Services (CMS) erred in calculating a budget neutrality adjustment to the PPS standardized amount to account for the effects of the rural floor on the wage index. The Board's jurisdictional determination over the rural floor budget neutrality issue and determination with respect to the request for EJR are set forth below.

Medicare Statutory and Regulatory Background

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

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

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

Standardized Amount

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

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

Budget Neutrality

Budget neutrality is determined by comparing aggregate IPPS payments before and after making changes that are required to be budget neutral (e.g., reclassifying and recalibrating the diagnostic related groups (DRGs)). Outlier payments are also included in the simulations. *Id.* at 48147.

Rural Floor

Section 4410 of the Balanced Budget Act of 1997 (BBA of 1997) established the rural floor by requiring that the wage index of a hospital in any urban area cannot be less than the wage index determined for the state's rural area. Since Federal fiscal year (FFY) 1998, CMS has implemented the budget neutrality requirement of this provision by adjusting the standardized amounts. 72 Fed. Reg. 24680, 24787 (May 3, 2007). In establishing the PPS standardized amount for FFY 2007 and for prior Federal fiscal years, CMS adjusted the standardized amount downward to account for the effects of the rural floor. *See e.g.* 71 Fed. Reg. 48145-48 (August 18, 2006).

Wage Index

The statute, 42 U.S.C. § 1395ww(d)(3)(E) and (d)(9)(C)(iv), requires that CMS make an adjustment to the labor-related portion of the national and Puerto Rico PPS rates to account for

area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. *Id.* at 48153. The wage index must be updated annually. *Id.* at 48005.

Procedural History

This appeal was timely filed on August 29, 2013, from an original NPR. The Provider contends that the rural floor budget neutrality adjustments as implemented by CMS violate the law's requirement of budget neutrality. The Provider challenges CMS' calculation and application of the budget neutrality adjustment to the PPS standardized amount to account for annual adjustments to the PPS wage index. The Provider asserts that CMS implemented the "rural floor" provisions on a budget "negative" basis as opposed to a budget "neutral" basis as required. The budget neutrality adjustments made by CMS have been compounding over the years rather than having been applied and removed on a yearly basis. The Provider maintains there have been errors in the application of these factors over the years that have resulted in understated PPS payments.

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

Basis for EJR

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

> [W]e used FY 2005 discharge data to simulate payments and compared aggregate payments using the FY 2006 relative weights and wage indexes to aggregate payments using the FY 2007 relative weights and wage indexes. The same methodology was used for the FY 2006 budget neutrality adjustment.
>
> . . . These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2006 budget neutrality adjustments.

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

The Provider is challenging an aspect of CMS' calculation of the final PPS rates published in the Federal Register for FFY 2007.[1] The Provider contends that CMS erred in calculating a budget neutrality adjustment to the PPS standardized amount to account for the effects of the rural floor on the wage index. This alleged error results in a systematic understatement of the PPS rates, and this error has been an annual and recurring one. Each year's error is permanently incorporated into the standardized amount paid under PPS for each successive year.

Jurisdiction over the Issue

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

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

Decision of the Board

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

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

> There shall be no administrative or judicial review under [42 U.S.C. §1395oo] or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount of any adjustment effected pursuant to subsection (e)(1) [budget

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

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

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

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

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

> Neither administrative or judicial review is available for controversies about the following matters:
>
> (a) The determination of the requirement, or the proportional amount, of any budget neutrality adjustment in the prospective payment rates. . . . (emphasis added)

CMS stated at the time the rule was adopted that the purpose of the rule is:

> to state that the determinations and decisions described in section 1886(d)(7) of the Act may not receive Board or judicial review. Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
>
> > A determination of the requirement, or the proportional amounts of, any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act . . .

48 Fed. Reg. 39752, 39785 (September 1, 1983).

In addition, section 701(a) of the Administrative Procedure Act (APA) states that the appeal provisions of the APA apply to the administrative actions except where statutes preclude judicial review. *See* 5 U.S.C. § 701(a). The statutes and the regulations both preclude administrative and judicial review of the budget neutrality adjustment.

In *Amgen, Inc. v. Smith*[2] the D.C. Circuit Court considered whether there is jurisdiction over outpatient PPS (OPPS) payments where the statute precludes administrative or judicial review of the "other adjustments" to OPPS (the classification system, establishment of groups and relative payment weights for covered services, of wage adjustment factors). The Court explained that there is a strong presumption that Congress intends judicial review of administrative action which can only be overcome with "clear and convincing evidence" that Congress intended to

[2] 357 F .3d 103 (D.C. Cir. 2004).

preclude appeal. The Court concluded that where the statute stipulated that "there should be no administrative or judicial review," that language constituted clear and convincing evidence that the appeal was precluded. The Court further noted that payments under PPS are made on a prospective basis and, given the length of time that review of individual appeals could take, the result would be retroactive adjustments to payment rates with the potential of creating havoc with the payment system. The aggregate impact of appeal decisions would undermine the Secretary's ability to ensure budget neutrality.

In an earlier decision, *Universal Health Services of McAllen, Inc. v. Sullivan*,[3] (*UHS*) the D. C. District Court distinguished between an appeal of a Medicare Geographic Classification Review Board (MGCRB) decision (over which judicial review is precluded) and a challenge to the validity of the guidelines utilized by the MGCRB and the Secretary to make reclassification decisions. The Court noted that § 701(a) of the APA precludes judicial review where a statute or regulation denies review. In *UHS*, the Court found that it had jurisdiction over the challenge to the guidelines but would not have had jurisdiction over an appeal of an MGCRB decision which was precluded by law.

Allegation that Review of Budget Neutrality is Limited to FY 1984 and 1985

The Board is not persuaded by the Providers' argument that preclusion of review of budget neutrality provisions is limited to the fiscal years 1984 and 1985. When Congress enacted the PPS payment rates for 1984 and 1985, it instructed the Secretary to determine the allowable operating cost from the most recently available cost reporting period for which data are available, updated to 1983 and further updated to 1984 by the market basket plus one percent. The resulting amounts were standardized by excluding specified costs and then an average standardized amount was computed for urban and rural hospitals under TEFRA. The average standardized amounts were reduced to be budget neutral. Congress noted that the method of calculating the PPS rates for 1986 and later were the same, but there was no step in the process for budget neutrality. Instead an independent panel would advise the Secretary regarding the updating factor to be used. The Secretary was required to publish the methodology and the data used to create the PPS rates, including any adjustment to produce budget neutrality, in the Federal Register on or before September 1 of each fiscal year. House Report No. 98-25(I) 1983 U.S.C.C.A.N. 219, 354-355 (1983).

In addressing the appeals process, Congress provided for the same administrative and judicial review of payments made under PPS as was available for cost-based reimbursement. Review was permitted with the exception of determinations necessary to maintain budget neutrality and the establishment of diagnosis related groups (DRGs), the methods for classifying DRGs and the DRG weighting factors. Congress stated that such preclusion of judicial review was necessary to maintain a workable payment system. House Report No. 98-25(I) 1983 U.S.C.C.A.N. 219, 361-362 (1983) and Senate Report No. 98-23 1983 U.S.C.C.A.N. 143, 197-198 (1983). This preclusion of administrative and judicial review was codified in 42 U.S.C. § 1395ww(d)(7).

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[3] 770 F. Supp. 704 (D.C. Dist. 1991.)

Subsection (d)(7) states that there shall be no administrative or judicial review under 42 U.S.C. §1395oo of the determination of the requirement or the proportional amount of any adjustment effected pursuant to subsection (e)(1). 42 U.S.C. §1395ww(e)(1) provides that for cost reporting periods of hospitals beginning in fiscal years 1984 or 1985 the Secretary shall provide for a proportional adjustment in the applicable percentage increase (otherwise applicable to the periods under subsection (b)(3)(B)) as may be necessary to assure budget neutrality. Section 1395ww(b)(3)(B) references all cost reporting periods from 1986 through the present as being affected by the budget neutrality adjustment.

In response to the enactment of the above statutes, the Board's governing regulations were modified. In the September 1, 1983 preamble to new regulations, the Secretary explained that 42 U.S.C. § 1395oo(g)(2) was added by Pub. L. 98-21 to state that the determinations and decisions described in § 1395ww(d)(7) precludes administrative and judicial review of, among other things, a determination of the requirement, or proportional amount of any "budget neutrality" adjustment effected under §1395ww(e)(1). The Secretary stated that it was the clear intent of Congress that a hospital would not be permitted to argue that the level of payment that it receives under the prospective payment system is inadequate to cover its costs. The Secretary amended 42 C.F.R. Part 405, Subpart R to implement the changes to 42 U.S.C. § 1395(g)(2) contained in Pub. L. 98-21. The changes to the regulation included the addition of 42 C.F.R. § 405.1804 to describe matters not reviewable by the Board or the courts as provided in § 1395ww(d)(7).[4] Section 405.1804 states specifically that there is neither administrative nor judicial review of the determination of the requirement or the proportional amount of any budget neutrality adjustment in the prospective payment rate. Therefore, the Secretary clearly interpreted the statutory prohibition on review as not being confined to 1984 and 1985.

When the Secretary "updated, clarified and revised"[5] the Board's governing regulations in 2008, he separately and specifically addressed the limitations on the Board's jurisdiction. The original regulation at 42 C.F.R. § 405.1804, stating that budget neutrality issues are not reviewable, was reissued without change or comment. In addition, the Secretary added 42 C.F.R. § 405.1840 to the regulations specifically dealing with the Board's jurisdiction. Section 405.1840(b) states that certain matters at issue were removed from the jurisdiction of the Board and included "[c]ertain matters affecting payments to hospitals under the prospective payment system, as provided in [42 U.S.C. § 1395ww(d)(7)] and § 405.1804 of this subpart." If the budget neutrality provisions of § 405.1804 were limited to appeals of FY 1984 and 1985, there would be no reason to leave the regulation unchanged during a comprehensive revision of the Board's regulations and certainly no need to add § 405.1840(b)(2) reiterating and emphasizing the Board's lack of jurisdiction over the budget neutrality issue. The Secretary's action demonstrates a twenty five year consistent position that all budget neutrality determinations are off limits to the Board; not just those relating to fiscal years 1984 and 1985. Whether the Secretary's view is consistent with Congress' intent is not for the Board to decide for it is bound by the regulation.

EJR Determination

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[4] 48 Fed. Reg. 39740, 39785 (September 1, 1983).
[5] 73 Fed. Reg. 30190 (May 23, 2008).

42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permit providers to bypass the Board's hearing procedure and obtain judicial review of a specific matter at issue involving a question of law or regulation where the Board determines that it is without authority to decide the legal question. Prior to rendering a decision that it lacks the authority to decide the legal question before it, the Board must determine that it has jurisdiction over the matter at issue in the appeal under 42 U.S.C. § 1395oo. 42 C.F.R. § 405.1842(a)(2008). We conclude that both the statute and regulation preclude administrative review of the budget neutrality adjustment; therefore, the Board lacks jurisdiction over the issue.

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

Application of *Cape Cod* case on the Request for EJR

Ordinarily our EJR analysis would end with a determination of no jurisdiction. However, in *Cape Cod HC 2007 Wage Index/Rural Floor Group*, PRRB case number 07-0705G et al, (*Cape Cod*), the Secretary has taken a contrary position. In *Cape Cod*, the Board concluded that it lacked jurisdiction over the budget neutrality adjustment based on the authorities set forth above. The Board's decision was not reversed by the CMS Administrator. On appeal to the Federal district court, however, the Secretary moved for remand on the basis that the Board had jurisdiction over the issue. The provider plaintiffs responded that the remand was unnecessary because the case was properly before the court on EJR. It argued that implicit in the Board's finding it lacked jurisdiction was a determination that it also lacked authority to decide the question, thus, EJR was appropriate. In its remand order, the District Court explained that the two findings are distinct. "Jurisdiction to take any legal action" asks whether the Providers may obtain a hearing at all; "authority to decide the question" asks whether the Board has authority to reach the merits of Providers' claims. The Court concluded that the Secretary's position was correct: the Court lacked subject matter jurisdiction without the Board's first being afforded an opportunity to consider the merits of the Providers' claims, including whether it has authority to decide the question. Neither the D.C. District court remand[6] nor the remand from the Deputy Administrator addresses the Secretary's rationale for his position regarding jurisdiction. Assuming, however, that the Secretary will take the same position in this case with respect to the Board's having jurisdiction over the budget neutrality issue, and in the interest of judicial economy, the Board will also address the question of whether EJR is appropriate.[7]

The Provider in this appeal seeks to have its final wage index rate modified by applying a different calculation methodology relating to the budget neutrality and rural floor factors. Pursuant to 42 C.F.R. § 412.64, the Secretary calculates the standardized amount on an annual basis. This calculation is published annually in the Federal Register following a complex and lengthy process of data collection and analysis. The methodology for the calculation is described

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[6] *Cape Cod Hospital v. Leavitt*, (D.D.C. July 21, 2008) (2008 WL 2791683).

[7] After the above remand based on the Secretary's position regarding jurisdiction, the Board found the Provider was entitled to expedited judicial review. In December of 2009, the District Court for the District of Columbia granted the defendant's (government's) motion for summary judgment for the budget neutrality adjustment. *Cape Cod Hospital et al. v. Sebelius*, 2009 WL 4981330 (D.D.C. December 22, 2009) at pp. 9-16.

in general terms.

The Board is bound by the Secretary's final rules and has no authority to review the data underlying the rate published unless specifically authorized. Notably the Final Rule only provides for Board review of denials of requests by hospitals for correction of certain wage data that eventually goes into one hospital-specific component of the final rate.[8] If the provider appealing the denial is successful, the remedy is limited to the hospital bringing the successful appeal. There is no provision for the Board to adjust the rate itself (as applied to all hospitals) to account for the effect of the error. The Board concludes that the specific grant of authority and establishment of a detailed process for correcting the rate of only the hospital bringing the appeal, coupled with the failure to include the effect of that correction on other hospitals or to establish a similar correction process for other components of the wage index, are strong indications that the Board does not have authority to change the rate itself.

Even more compelling, however, is the language of the statute and the regulation quoted above that prohibits review of budget neutrality determinations which are at the heart of the question before the Board in this case. Even if the Board interpreted the statutory and regulatory prohibitions on review of budget neutrality determinations too broadly to bar jurisdiction, those prohibitions cannot be ignored altogether. We conclude that the statute and regulation evidence Congress' and the Secretary's intent that budget neutrality determinations are insulated from the Board's authority to affirm, reverse or modify a reimbursement determination. Otherwise, the specific prohibitions articulated there would be rendered meaningless.

Assuming, arguendo, that the Secretary takes the same position in these cases that the Board has jurisdiction, then the Board finds that:

1) based upon the Provider's unopposed assertions regarding the challenges to the rural floor/budget neutrality methodology, there are no findings of fact for resolution by the Board;

2) it is bound by the Final Rule in the Federal Register and the regulation; and

3) it is without authority to decide the legal question of whether the calculation methodology for the budget neutrality/rural floor adjustment is valid.

Accordingly, the Board finds that the budget neutrality/rural floor issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and expedited judicial review is appropriate. Since this is the only issue under dispute, the Board closes the case.

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[8] 64 Fed. Reg. 41490, 41513 (July 30, 1999). This authority has never been codified in the code of Federal Regulations.

BOARD MEMBERS PARTICIPATING:
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Clayton J. Nix, Esq.

For the Board:

Michael W. Harty
Chairman

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

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FYE: 12/31/1999
PRRB Case No.: 04-2209

Dear Mr. Roth and Mr. Pike,

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

Background

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

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

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

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

Provider's Position

The Provider argues in its May 20, 2008 jurisdictional submission that the Board has jurisdiction over the revised NPR appeal. The Provider argues that the Board has jurisdiction because the Worksheet E, Part A adjustments show that the revised NPR included an adjustment to the Hospital's DSH-SSI percentage.

Board's Decision

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

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

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

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

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.

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

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

The Board finds that it does not have jurisdiction over the SSI% issue because it was not adjusted when the cost report was reopened. The Provider submitted Worksheet E, Part A in support of its stance that the Board has jurisdiction over the SSI% issue. However, Line 4 shows that the DSH percentage of SSI recipient patient days to Medicare Part A patient days remained at .10 upon reopening. In fact, Line 4.04 shows that the DSH adjustment in general was not adjusted. Therefore the Board finds that it does not have jurisdiction over the SSI% issue for this Provider.

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

The Board finds that it does not have jurisdiction over the two issues in this individual appeal because they were not specifically adjusted in the revised NPR. Therefore, the Board hereby dismisses the two issues and closes case number 04-2209.

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:
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John Gary Bowers, CPA
Clayton J. Nix, Esq.

FOR THE BOARD

Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, BCBSA