DEPARTMENT OF HEALTH AND HUMAN SERVICES
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CERTIFIED MAIL

JAN 02 2014

James Cummings
Quality Reimbursement Services
150 N. Santa Anita Avenue
Suite 570A
Arcadia, CA 91006

RE: Jurisdictional Challenge
Provider: Anaheim General Hospital
Provider No: 05-0173
FYE: 08/31/2000
PRRB Case Nos.: 09-1531

Dear Mr. Cummings:

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

Background

On September 13, 2006, the Provider requested a reopening of their cost report for fiscal year end (FYE) August 31, 2000, to correct the following errors: 1) Medicare disproportionate share hospital (DSH) SSI percentage, 2.) Medicaid proxy (to include Medicare/Medicaid dual eligible patient days where Medicare benefits are exhausted and Medicaid eligible days previously excluded) and 3.) Capital Payments. On December 4, 2006, the Intermediary issued a Notice of Reopening to the Provider advising that it intended to review the appropriate amount of disproportionate share reimbursement per the Provider's new information.

On December 17, 2008, the Intermediary prepared its work paper showing adjustments to the Provider's Medicaid eligible days to be included in the DSH calculation. On January 2, 2009, the Intermediary issued a revised Notice of Program Reimbursement (RNPR). On April 10, 2009, the Provider filed an appeal of the RNPR challenging DSH SSI percentage (Provider specific), DSH SSI percentage (systemic errors), DSH Medicaid eligible days (Provider specific) and DSH Medicaid eligible labor room days.

On November 30, 2009, the Provider submitted the first page of its Preliminary Position Paper to the Board. On January 25, 2010, the Intermediary filed a jurisdictional challenge regarding the DSH SSI percentage (Provider specific), DSH Medicaid eligible days (Provider specific) and DSH Medicaid eligible labor room days contending that the Provider abandoned its claim on these issues. The Intermediary also challenged the DSH SSI percentage (systemic errors) issue as not being specifically revised in the RNPR. The Intermediary submitted the first page of its Preliminary Position Paper to the Board.

Intermediary's position

The Intermediary contends the Provider did not submit its Preliminary Position Paper regarding the DSH SSI percentage (Provider specific), DSH Medicaid eligible days (Provider specific) and DSH Medicaid eligible labor room days issue. Since the Provider did not brief these issues in its Preliminary Position paper, the Provider abandoned its claim. The Intermediary requests the Board dismiss these issues from the case.

Regarding the DSH SSI percentage (systemic errors) issue, the Intermediary maintains that the SSI fraction was not reopened and therefore remained finalized from the NPR issued in 2000 [sic]. The Intermediary did not take affirmative action that would demonstrate that it reopened the SSI fraction. The Intermediary took the affirmative step of sending a reopening notice regarding the Medicaid fraction, but did not take any sort of similar affirmative action regarding the SSI fraction.

The Intermediary argues that it followed the proper procedure when dealing with the reopening request. First, the Intermediary considered which, if any, issues should be reopened. Upon making that decision, the Intermediary issued a Notice of Reopening specifically informing the Provider that it would review the appropriate amount of disproportionate share reimbursement per the Provider's new information.

The Intermediary contends that the only new information submitted by the Provider was the Medicaid eligible days, which was adjusted by the Intermediary, thus resulting in a RNPR issued on January 2, 2009.[1] The Intermediary argues that per the regulation at 42 C.F.R. § 405.1889 (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. The Intermediary maintains that in its RNPR dated January 2, 2009, it did not address the issue under this appeal (SSI fraction).

Furthermore, the regulation at 42 C.F.R. § 405.1889(b)(2) states, any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision. The Intermediary cites to the case of *Little Company of Mary Hospital v. Sebelius*, 7th Cir., No. 09-1665, November 24, 2009, in support of its position wherein the court found the following:

> The Intermediary in this case followed the proper procedure when dealing with Little Company's reopening request . . . by not informing Little Company that they intended to reopen the SSI fraction, the Intermediary effectively denied that reopening request.

The Intermediary maintains that the proper NPR that addresses the issue under appeal (SSI fraction) is dated September 15, 2003. This is the date of the initial NPR issued by the Intermediary just after the filed cost report was audited. Obviously, this date does not adhere to

[1] Intermediary Jurisdictional Challenge at 6.

the law or regulation applicable to the 180 day time limit, therefore the Provider is not entitled to a Board hearing. The Intermediary requests the Board dismiss the appeal in its entirety.[2]

Decision of the Board

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 ($50,000 for a group) and the request for a hearing is filed within 180 days of the NPR.[3]

Jurisdiction for reopening a determination rests exclusively with the administrative body that rendered the last determination.[4] A determination or decision to reopen or not to reopen a determination is not a final determination within the meaning of Subpart R of Title 42 and is not subject to further administrative or judicial review.[5] A revised NPR is considered a separate and distinct determination from which the provider may appeal.[6] A Provider's appeal of a revised NPR is limited to the specific issues revised on reopening and does not extend further to all determinations underlying the original NPR.[7]

PRRB rule 41.2 (effective August 21, 2008) provides that the Board may dismiss a case on its own motion if it has a reasonable basis to believe that the issues have been fully settled or abandoned. PRRB Rule 25 (effective August 21, 2008) provides that preliminary position papers are expected to present the fully developed positions of the parties. Rule 25.1 A. states that that the text of the Preliminary Position Paper must include for each issue, the material facts supporting the claim, the controlling authority and a conclusion applying the material facts to the controlling authorities.

In the instant case, the Provider did not brief the following issues in its Preliminary Position Paper: the DSH SSI percentage (systemic errors), DSH Medicaid eligible days (Provider specific) and DSH Medicaid eligible labor room days issue. The Provider briefed the following issue "[w]hether the correct SSI percentage was used in the DSH calculation" (DSH SSI percentage (Provider specific issue)). [8] Specifically, the Provider contended that its' SSI percentage published by CMS was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's fiscal year end.[9]

PRRB rule 25 makes it clear that Preliminary Position Papers are expected to present the fully developed positions of the parties. Rule 25.1 A. states that the text of the Preliminary Position

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[2] *Id.* at 8-9.
[3] 42 U.S.C. § 1395oo(a)(2009) and 42 C.F.R. §§ 405.1835-1841(2009).
[4] 42 C.F.R. §405.1885(c) (2009).
[5] *See, Your Home Visiting Nurse Services, Inc. v. Shalala*, 525 U.S. 449 (1999).
[6] 42 C.F.R. §405.1889 (2009).
[7] *See, HCA Health Services of Oklahoma, Inc. v. Shalala*, 27 F.3d 614 (D.C. Cir 1994).
[8] Intermediary's Jurisdictional Challenge Tab 1-10 at 3.
[9] *Id.* at 7.

Paper must include for each issue (indicating that each issue must be included in the Preliminary Position Paper) the facts that support the claim, the controlling authority and a conclusion. In the instant appeal, the Provider did not present positions for the above referenced issues. The Provider did not include these issues in its Preliminary Position Paper. As such, the Board finds that the Provider abandoned its claim on the DSH SSI percentage (systemic errors), DSH Medicaid eligible days (Provider specific), and DSH Medicaid eligible labor room days issues and dismisses the issues from the appeal.

Regarding the DSH SSI percentage (Provider specific) issue, the Provider requested a reopening of its cost report to correct the DSH SSI percentage, Medicaid proxy (to include Medicare/Medicaid dual eligible patient days where Medicare benefits are exhausted and Medicaid eligible days previously excluded) and Capital Payments. The Intermediary reopened the cost report to include additional eligible Medicaid days in the DSH calculation. No adjustment was made by the Intermediary to the SSI percentage. The SSI percentage was not reopened by the Intermediary. As the Provider appealed from a RNPR and there was no specific adjustment to the SSI percentage, the Board finds that it lacks jurisdiction over the SSI percentage (Provider specific) issue. As no outstanding issues remain in the appeal, the Board hereby closes the case.

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

Board Members Participating
Michael W. Harty
John Gary Bowers, CPA
L. Sue Anderson, 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, Blue Cross and Blue Shield Association
Darwin San Luis, Noridian Healthcare Solutions, LLC

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RE: Clarian West Medical Center
Provider No. 15-0158
FYE 12/31/2007
PRRB Case No. 12-0629

Dear Messrs. Keough and Lamprecht:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's December 5, 2013 request for expedited judicial review (EJR) (received December 6, 2013). The Board's decision with respect to EJR and jurisdiction is set forth below.

Background

Procedural History

The Provider's September 25, 2012 hearing request, appealing its March 30, 2012 Notice of Program Reimbursement (NPR) was received[1] by the Board on September 26, 2012, 180 days after the issuance of the NPR. The issue identified in the hearing request as the subject of the appeal was:

> The Intermediary[2] disallowed outlier payments previously made to the hospital based on a recalculation of the Provider's cost-to-charge ratio for the cost reporting period ending December

[1] Pursuant to 42 C.F.R. §§ 405.1835-405.1840 (2011) 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 appeal), and the request for hearing is filed within 180days of the date of receipt of the final determination.

[2] The Provider refers to the entity that issued its NPR interchangeably as the Intermediary or MAC [Medicare Administrative Contractor] in its submissions to the Board. The Intermediary/MAC is contracted to handle the Centers for Medicare & Medicaid Services' (CMS') payment and audit functions used to determine payments due providers. *See* 42 U.S.C. § 1395kk-1. The Intermediary/MAC hereinafter will be referred to as the "Intermediary."

31, 2007. The Provider contends that this adjustment is incorrect, and should be reversed.[3]

The amount in controversy for this issue is $2,202,240. The Provider also appealed the intermediary's assessment of interest on the amount it determined the Provider had been paid on outliers in the amount of $207,252, asserting that this action was inconsistent with the outlier statute, 42 U.S.C. § 1395ww(d)(5)(A), and the statute governing the payment of interest, 42 U.S.C. §1395g(d).[4]

Outlier Payment Background

The Medicare program pays most general acute care hospitals under a prospective payment system (PPS) for operating and capital related costs of covered services. 42 U.S.C. §§ 1395ww(d), 1395ww(g); 42 C.F.R. Part 412. Under PPS, Medicare pays hospitals a prospectively-determined standardized amount per discharge. *See generally County of Los Angeles v. Shalala*, 192 F.3d 1005, 1008 (D.C. Cir. 1999).[5]

The base payment rate per discharge under PPS is further adjusted to reflect relative differences in the resources required for patients assigned to various diagnosis-related groups (DRGs), relative differences in area labor costs (as represented by area wage indexes), the costs incurred by hospitals that treat a disproportionate share of low-income patients (DSH), indirect medical education (IME) costs and costs of new technologies. *See* 42 C.F.R. §§ 412.2.[6]

For cases that are extraordinarily costly relative to other cases in the same DRG, referred to as outlier cases, the prospective payment per discharge is increased.[7] The outlier payment is designed to protect a Medicare-participating hospital from large financial losses due to unusually expensive cases.[8] Outlier payments are made on claim-by-claim basis from information from the bill that is processed through the intermediary's claim processing system[9] and payments are made for both operating and capital expenses. To qualify for outlier payments, a case must have cost above a fixed-loss cost threshold (a dollar amount by which the cost of a case must exceed payments in order to qualify for outlier payments). Outlier payments are added to a hospital's adjusted base payment rate.[10] Hospital specific cost-to-charge ratios are applied to the covered charges for a case to determine whether the costs of the case exceed the fixed-loss outlier threshold.[11]

In the June 9, 2003 Federal Register the Secretary explained that proposed rules had been published that would change the methodology for establishing how extraordinary high cost cases (outliers) would qualify for an outlier payment. This change was made to correct situations in which rapid increases in charges by certain hospitals maximized their outlier reimbursement based on two vulnerabilities. The first vulnerability occurs as the result of a time lag between the current charges on a submitted bill and the cost-to-charge ratio taken from the most recent settled cost report. The second vulnerability results when some hospitals increase their charges so far

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[3] Provider's September 26, 2012 Hearing Request, Tab 3, Issue 1.
[4] Provider's September 26, 2012 Hearing Request, Tab 3, Issue 2.
[5] Provider's Preliminary Position Paper at 5.
[6] *Id. at 6.*
[7] *See* 42 U.S.C. § 1395ww(d)(5)(A); 42 C.F.R. §§ 412.84, 412.312(c).
[8] *See County of Los Angeles v. Shalala* 192 Fed.3d at 1017.
[9] 68 Fed. Reg. 34494, 34500 (June 9, 2003).
[10] *Id.*
[11] *Id.* at 34495.

above costs so that their cost-to-charge ratios fall below 3 standard deviations from the geometric mean of cost-to-charge ratios; in that situation a higher statewide average cost-to-charge ratio is applied to determine payment.[12]

In that same Federal Register, the Secretary announced that a final rule was being implemented that would change the methodology for calculating how high-cost cases qualify for outlier payments. The changes addressed both situations in which rapid increases in charges by certain hospitals result in their cost-to-charge ratio being set too high.[13] The Secretary explained that currently, intermediaries use the most recent settled cost report when determining cost-to-charge ratios for PPS hospitals. For example, the covered charges on bills submitted for payment during fiscal year (FY) 2003 are converted to costs by applying a cost-to-charge ratio from cost reports that began in 2000 or earlier. The covered charges from 2003 reflected all of the charge increases to date, but were not reflected in the FY 2000 cost-to-charge ratio. If a hospital's rate-of-charge increases since FY 2000 exceeded the rate of a hospital's cost increases during that time, a hospital's charge ratio based on its FY 2000 cost report would be too high, and applying current charges would overestimate the hospital's costs per case during FY 2003. This could result in some cases receiving outlier payments for cases which are not actually high-cost cases.[14]

Because a hospital has the ability to increase its outlier payments during the time lag between the current charges and the cost-to-charge ratio from the settled cost report, through dramatic charge increases, a new regulation, 42 C.F.R. § 412.84(i)(1), was enacted to allow intermediaries to use more up-to-date data when determining the cost-to-charge ratio for each hospital. As a result of the change, intermediaries are to use either the most recent settled cost report or the most recent tentative settled cost report, which is from the later cost reporting period.[15]

Under PPS, hospitals must submit a bill for each Medicare patient stay for which they expect payment. The information from the bill is processed through the intermediary's claims processing system to determine a payment amount for each case. Payments are made based on the actual amount determined for each bill or a bi-weekly periodic interim payment (1/26 of the total estimated amount of payment for the year). However, outlier payments are not made on an interim payment, but are made on a claim-by-claim basis, even for hospitals that receive interim payments.[16]

As a result of hospital taking advantage of the vulnerabilities described above, in which some providers increase their charges at extremely high rates, knowing that there would be a time lag before their cost-to-charge ratios would be adjusted to reflect higher charges, the Secretary stated changes were being implemented to reduce the opportunity for hospitals to manipulate the system to maximize outlier payments.[17] A new provision was added to the regulations[18] which required that outlier payments would become subject to reconciliation when hospitals cost reports were settled. Under this policy, payments would be processed throughout the year using operating and capital cost-to-charge ratios based on the best information at the time. When a cost report was settled, any reconciliation of outlier payments by the intermediaries would be

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[12] *Id.* at 34496.
[13] *Id.*
[14] *Id.* at 34497.
[15] *Id.*
[16] *Id.* at 34500.
[17] Id. at 34501.
[18] *See* 412.84(h) (effective August 8, 2003). (68 Fed. Reg. at 34515 and 34494 (respectively)).

based on operating and capital cost-to-charge ratios calculated based on a ratio of costs to charges computed from cost report and charge data determined at the time the cost report coinciding with the discharge is settled.[19]

The Secretary noted that there would still be the opportunity for a hospital to manipulate its outlier payments by dramatically increasing its charges during the year in which the discharges occur. In this case, a hospital would receive excess outlier payments, which although the hospital would incur an overpayment and be required to refund money when the cost report was settled, would allow the hospital to obtain excess payments on a short-term basis. As a result, the Secretary concluded, it may be necessary to adjust the amount of final outlier payment to reflect the time value of money during the time the overpayment is held by the provider. Consequently, the Secretary enacted 42 C.F.R. § 412.84(m) to provide that when a cost report is settled, outlier payments would be subject to an adjustment to account for the value of the money during the time period it was inappropriately held by the hospital or the hospital was underpaid.[20]

In its EJR request, the Provider notes that the Centers for Medicare & Medicaid Services (CMS) adopted numeric criteria for recalculation of outlier payments based on a reconciliation of the cost-to-charge ratio.[21] The Program instruction provides for retrospective revisions when the current period cost report and charge data would change the cost-to-charge ratio by at least 10 percentage points and total outlier payments exceed $500,000 for the applicable cost reporting period.[22] When CMS reconciles the cost-to-charge ratio, the Provider points out that claims submitted for the discharges are recalculated in a process that the Provider states is separate and apart from the claims processing system established under the Medicare program regulations.[23] The Provider also points out that CMS is required by statute[24] to provide beneficiary's notice regarding action on each claim for benefits in a Summary Notice giving the amount Medicare payment made. The Provider does not believe this was done when CMS retroactively recalculates outlier reimbursement through reconciliation of the cost to charge ratio. After an initial claims determination is made, it may be reopened and revised by the intermediary within one year for any reason.[25] After one year, the claims can be reopened by the intermediary only where good cause is established.[26] After four years, absent fraud, a claim cannot be reopened.[27]

Provider's Request for EJR

In its EJR request, the Provider explained that it was a new facility, with its first 13-month cost report period ending December 31, 2005. When the FY 2005 cost report was settled it was assigned the statewide average cost-to-charge ratio for use in calculating outlier reimbursement because it was a new facility. Because the Provider's utilization was relatively low in 2005, the hospital's actual ratios of costs to charges, as reflected on the final settled cost report, were much greater than the state average ratios that were used to make outlier payments through the normal cost reporting process. The Provider's ratio exceeded the statewide average ratios that were

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[19] 68 Fed. Reg. at 34501.
[20] *Id.*
[21] Provider's December 5, 2013 EJR request at 6 citing to the Provider's Preliminary Position Paper, Ex. P-12, the Medicare Claims Processing Manual, Chapter 3, § 20.
[22] *Id. at* § 20.1.2.5.
[23] *Id.* § 20.
[24] 42 U.S.C. § 1395b-7.
[25] 42 C.F.R. § 405.980(b)(1).
[26] 42 C.F.R. § 405.980(b)(2).
[27] 42 C.F.R § 405.980(b)(3).

used to calculate outlier payments by more than 10 percentage points and the actual ratios were later increased even further in 2010 when the Provider's cost report was reopened to include several hundreds of thousands of dollars of additional costs for 2005. However, the Intermediary did not recalculate outlier payments for 2005 based on the actual cost and charge data in the 2005 cost report because the outlier payments previously made through the claims processing system did not total more than $500,000 for the discharges in FY 2005.[28]

In fiscal years 2006 and 2007, its second and third years of operation, the Provider's utilization more than doubled and, as a result, its cost-to-charge ratios decreased dramatically from 2005 to 2007.[29] In March of 2008, the Intermediary had calculated the outlier payments on all outlier claims submitted in 2008. However, the NPR for FY 2007 was not issued until March 30, 2012, one day prior to the four-year reopening period for claims determinations. However, in that cost report determination the intermediary, retroactively recalculated and reduced the outlier payments previously made on claims made for services rendered in 2007, as a result of an alleged *post hoc* reconciliation of the cost-to-charge ratios based on the costs and charges reflected in the final settled cost report for 2007. As a result, the Provider was required to repay more than $1.8 million of outlier payments for operating costs and $386,000 of outlier payments for capital costs. In addition, the Provider was charged $207,252 for the time value of money.[30]

The Provider contends that CMS's allegedly "confidential' and "offline" process for retroactive recalculation of outlier claims payments and the Intermediary's outlier adjustments based on that process must be reversed. The Provider asks that Board to decide whether it has the authority to decide the following questions:

1. Whether the reconciliation process established under the outlier regulation 42 C.F.R. § 412.84(h), in invalid because it is inconsistent with the plain language and manifest intent of the Medicare PPS statute.

2. Whether the reconciliation process established under the outlier regulation, 42 C.F.R. § 412.84(h), is procedurally and substantively invalid because the regulation establishes no standards governing the exceptions process and related program instructions were not adopted in accordance with the notice and comment rulemaking requirements mandated by the Administrative Procedure Act and Medicare Act.

3. Whether the reconciliation process established under the outlier regulation, 42 C.F.R. § 412.84(h), is invalid because it violates the statutes and regulations governing claims payment determinations, including the four-year reopening period applicable to claims payment determinations, and statutory provisions expressly requiring CMS to notify beneficiaries of final action taken on such claims.

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[28] Provider's December 5, 2013 EJR Request at 10-11.
[29] *Id.* at 11.
[30] *Id.* at 12.

4. Whether the reconciliation process established under the outlier regulation, 42 C.F.R. § 412.84(h), is invalid because the process, as applied, has a discriminatory application and effect of hospitals generally, and new hospitals in particular, and is, therefore, arbitrary and capricious.

5. Whether the reconciliation process applied under the outlier regulations, 42 C.F.R. § 412.84(h), is invalid because it violates the statutory prescription against the imposition of retroactive liabilities against providers and beneficiaries who are "without fault" with respect to overpayments on claims payment determinations rendered more than three years earlier.

6. Whether the assessment of interest against the Provider with respect to the retroactive recalculation of outlier payments for 2007 is invalid because it is contrary to controlling statutory provisions on interest and nearly 50 years of agency precedent construing those authorizes.[31]

Decision of the Board

The Board hereby grants the Provider's request for EJR over questions 1, 2, and 4, above, because the Board concludes it lacks the authority to grant the relief sought by the Provider with respect to those issues involving the validity of 42 C.F.R. § 412.84(h). The Board hereby dismisses questions 3, 5 and 6 because it concludes that it lacks jurisdiction over those issues for the reasons set forth below. The Board hereby dismisses questions 3, 5, and 6 from this appeal

Jurisdiction over Questions 3, 5 and 6, above

The Board concludes that it lacks jurisdiction over question 3, above, dealing with reconciliation of beneficiary claims. The Board's jurisdiction is limited to matters covered by a provider's cost report where a provider is dissatisfied with the total amount of program reimbursement calculated pursuant to 42 U.S.C. § 1395ww(d) (the inpatient prospective payment system). *See* 42 U.S.C. § 1305oo(a). Reconsideration and appeals for individual beneficiaries' claims are set forth in Subpart G of Part 405 of Title 42 of the Code of Federal Regulations and are not reviewable by the Board.

Further, the Board finds that it lacks jurisdiction over question 5, the imposition of retroactive liabilities against providers and beneficiaries who are "without fault" for overpayments. Without fault is defined in 42 U.S.C. § 1395gg(b)(4). This statutory provision allows the Secretary to find that a provider or beneficiary is without fault if the request for repayment of an overpayment is made subsequent to the fifth year following the year in which notice was sent to an individual that such amount had been paid. Pursuant to 42 C.F.R. § 405.1801(a)(4), a final determination does not include action with respect to compromise of a Medicare overpayment claim, or termination or suspension of an overpayment claim. The regulation, 42 C.F.R. § 376(j) states that "[a]ny action taken by CMS under this section regarding the compromise of an overpayment claims, or termination or suspension of a collection on an overpayment is not an initial

[31] *Id.* at 14-15.

determination under Subpart . . . R." Finding a provider is "without fault" for a liability owed to the government would constitute a compromise of an overpayment, and is not within the Board's jurisdiction.

The Board concludes that it lacks jurisdiction over question 6, the validity of the assessment of interest. Interest is not a matter covered by the cost report because it is not part of the total amount of program reimbursement due a provider for items and services furnished to Medicare beneficiaries for which payment may be made for the period covered by the cost report. *See 42 U.S.C. § 1395oo(a)(1)(A)(i).*

EJR

Background

42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permits expedited administrative review where the Board determines that it does not have the authority to decide a question of law, regulation or CMS ruling. In this case, the Provider is challenging the validity of 42 C.F.R. § 412.84(h) through questions 1, 2, and 4 of the Provider's request for EJR.[32]

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 agreed that EJR was appropriate.[33] The documentation shows that the estimated amount in controversy exceeds $10,000 and the appeal was timely filed.

The Board finds that:

1) it has jurisdiction over questions 1, 2, and 4 for the subject year and the Provider is entitled to a hearing before the Board;

2) based upon the Provider's assertions regarding the validity of 42 C.F.R. § 412.84(h), there are no findings of fact for resolution by the Board;

3) it is bound by the regulation; and

4) it is without the authority to decide the legal question of whether the regulation, 42 C.F.R. § 412.84(h), is valid.

Accordingly, the Board finds that the questions 1, 2 and 4, regarding the validity of 42 C.F.R. § 412.84(h) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provider's request for expedited judicial review with respect to those matter for the subject year. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since the Board lacks jurisdiction over questions 3, 5, and 6 and the Board has granted the Provider's request for EJR over the remaining questions, the Board hereby,

[32] *See* Provider's December 5, 2013 EJR request at 13-15.
[33] *See* Intermediary's September 23, 2013 Preliminary Position Paper at 6.

closes the case. Review of the jurisdictional 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 Anderson, 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 Shanklin, BCBSA

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Brook McClurg
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RE: Port Huron Hospital
Provider No. 23-0216
FYE 6/30/2007
PRRB Case No. 13-2517

Dear Mr. Liston and Ms. McClurg:

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

Background

Through correspondence dated July 22, 2013 (received July 24, 2013), the Provider filed an appeal of it February 15, 2013 Notice of Correction of Program Reimbursement (revised NPR).[1] The Provider appealed the following issues:

1. Whether the Medicare Administrative Contractor (the "MAC") improperly denied the Provider's request for the Provider's fiscal year to be used instead of the Federal fiscal year for purposes of the computation of the SSI% [Supplemental Security Income] fraction of the disproportionate share hospital ("DSH") Adjustment?

2. [The Provider] appeals the determination and application of the Budget Neutrality Adjustment for the calculation of the Rural Floor ("RFBN Adjustment") pertaining to the Wage Index as applied to Medicare IPPS [inpatient prospective payment system] for the captioned cost reporting period.[2]

[1] Provider's Hearing Request, Tab 1A
[2] *Id.* at Tab 3.

Adjustment 5 from audit adjustment report accompanying the revised NPR demonstrated that the SSI percentage was revised.[3] The RFBN adjustment was not revised by the February 13, 2013 revised NPR.

MAC's Position

SSI Realignment Issue

The MAC objects to the Board's jurisdiction over the SSI realignment issue because it believes the issue is suitable for reopening but is not an appealable issue. Until the recalculation is received, the appeal of the SSI issue is premature. The regulation, 42 C.F.R. § 412.106(b)(3), permits a provider that wishes to use its cost reporting period instead of the Federal fiscal year when its SSI percentage is calculated to make a written request to its intermediary. This is known as an SSI realignment and is a voluntary election by a provider.

The MAC notes that the Provider did make a realignment request which the MAC has forwarded to the Centers for Medicare & Medicaid Services (CMS). Further, the MAC has issued a Notice of Reopening on August 23, 2013, which will permit it to recalculate the disproportionate share adjustment upon receipt of the necessary information from CMS.

RFBN Adjustment Issue

With respect to the RFBN adjustment issue, the MAC believes that the Board lacks jurisdiction over the issue because there was no adjustment to the issue in the revised NPR. Since there was no determination made with respect to the issue in the revised NPR, the MAC asks that the issue be dismissed.

Provider's Position

SSI Realignment Issue

The Provider asserts that the Board should find that it is entitled to receive a realignment pursuant to 42 C.F.R. § 412.101(b)(3) [sic]. Further, the Provider points out that the SSI realignment is not something the MAC can grant through reopening, the realignment is a matter of right.

The Provider asks that the Board find that it requested a realignment from the MAC. In addition, the MAC's June 24, 2013 e-mail denying the Provider's request for realignment should be noted as being part of the record since the MAC did not address this document in its jurisdictional brief. The Provider argues that it timely filed an appeal of the MAC's refusal to grant a request for realignment of the SSI percentage, since that is the only remedy available to it.
RFBN Adjustment

[3] Provider's July 22, 2013 Hearing Request, Tab 1E.

RFBN Adjustment Issue

The Provider points out that following the decision in *Cape Cod Hospital v. Sebelius,*[4] CMS has acknowledged an error in the calculation of the RFBN adjustment. Since CMS has acknowledged this error in its computation, the Provider believes the MAC is obligated to make an audit adjustment when it issued the revised NPR. The Provider asserts it was necessary for CMS to have instructed the MAC to grant the relief to which the Provider asserts it is entitled.

Decision of the Board

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 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. The Board concludes that it lacks jurisdiction over the SSI percentage realignment and the RFBN adjustment issues and hereby dismisses them from the appeal. Since these are the only two issues in this appeal, the Board hereby closes the case.

SSI Percentage Realignment Issue

The Board notes that the Provider's jurisdictional brief included the June 24, 2013 e-mail correspondence between the Provider and MAC in which the MAC refused to consider the Provider's request for realignment. However, the Intermediary's jurisdictional brief contained correspondence dated August 23, 2013 in which it advised the Provider that it had forwarded the request a recalculation of the hospital's SSI/Medicare Part A percentage to comport with the Provider's fiscal year to CMS. Since CMS has not responded to the Provider's request for recalculation and there is no final determination with respect to that issue as required by 42 C.F.R. §§ 405.1835-405.1840 for Board jurisdiction. Consequently, the Provider's appeal is premature and the Board hereby dismisses the issue from the case.

RFBN Adjustment Issue

In this case, the Provider filed a timely request for a hearing within 180 days of the revised NPR, but more than 180 days after the issuance of the original NPR. The revised NPR did not adjust the RFBN adjustment issue. The effect of a revised NPR on a provider's right to a Board hearing is addressed in 42 C.F.R. § 405.1889. This regulation provides that an appeal of a revision to a final determination is a separate and distinct determination to which the provisions of 42 C.F.R. § 405.1835 apply and "only those matters that are specifically revised in a revised determination . . . are within the scope of any appeal of the revised determination." A revised NPR does not reopen the entire cost report to appeal nor does it extend the 180 day appeal period for any earlier NPR(s). It merely reopens those parts of the cost report adjusted by the revised NPR and only those adjustments may be appealed. Because the RFBN adjustment issue was not

[4] 630 F.3d 202 (D.C. Cir. 2011).

adjusted by the revised NPR the Board finds that it lacks jurisdiction over this issue and hereby dismisses the issue.

Review of this decision is available under the provisions of 42 U.S.C. § 1395oo(f)(1) 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 Anderson, Esq.

FOR THE BOARD:

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Byron Lamprecht, WPS
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Refer to: 12-0492
Certified Mail

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Provider Audit-Mail Code AG-380
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RE: Alpha Omega Hospice, LP
Provider No. 45-1778
Cap Year Ending 10/31/2010
PRRB Case No. 12-0492

Dear Ms. Vemula and Ms. Huggins:

The Provider Reimbursement Review Board (Board) has reviewed the record in this case incident to the submission of the Provider's Proposed Joint Scheduling Order (PJSO) dated March 28, 2013. The jurisdictional decision of the Board is set forth below.

Procedural Background

This appeal was filed with the Board through correspondence dated August 6, 2012 (received August 13, 2012) from a Notice of Effect of Inpatient Day Limitation and Hospice Cap Amount (hospice cap notice) dated July 5, 2012. The Provider exceeded the cap amount by $362,655 when paid under the streamline methodology.[1] In its September 11, 2012 correspondence the Provider noted that by electing reimbursement under the patient-by-patient proportional methodology[2] (proportional method) its liability to the Medicare program would be reduced by $206,024.36.[3]

On March 28, 2013, the Provider submitted a PJSO (received April 1, 2013) identifying the issue as "[w]hether the Intermediary properly calculated the cap determination that resulted in a $362,655.00 overpayment for the Petitioner?" The Provider challenged the validity of the cap regulation governing the cap calculation, 42 C.F.R. § 418.309, contending that it was contrary to 42 U.S.C. § 1395f(i)(2)(C)[4] and results in unlawful taking of private property in violation of the

[1] Provider's August 6, 2012 hearing request. The regulations regarding payment under the streamlined methodology are found at 42 C.F.R. § 418.309(b).
[2] *See* 42 C.F.R. § 418.309(c).
[3] Provider's September 12, 2012 letter, Ex. P-3.
[4] 42 U.S.C. § 1395f(i)(2)(C) states that "[f]or purposes of subparagraph (A), the "number of medicare beneficiaries" in a hospice program in an accounting year is equal to the number of individuals who have made an election under subsection (d) with respect to a hospice program and have been provided hospice care by . . . the hospice program

Fifth Amendment of the Constitution. The Provider argued that the Intermediary failed to allocate the cap allowances across years of service and based on geographic location which resulted in the overpayment.[5]

Statutory and Regulatory Background

Hospice Reimbursement under Medicare: Cap Reimbursement

Coverage for hospice care was provided through the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Pub. L. No. 97-248. It was designed to provide terminally ill patients with palliative care rather than curative care with individuals waiving all rights to Medicare payments for treatment underlying their terminal illnesses. 42 U.S.C. § 1395d(d)(2)(A).

Pursuant to 42 U.S.C. § 1395f(i), Medicare pays hospice providers on a per diem basis. *See* 42 C.F.R. § 418.302. The total payment to a hospice in an accounting year known as a cap year runs from November 1 through October 31 and is limited by a statutory cap. *See* 42 U.S.C. § 1395f(i)(2)(A). Payments in excess of the statutory cap are considered overpayments and must be refunded to the Medicare program by the hospice. *See* 42 C.F.R. § 418.308.

In 1983, the Secretary adopted a rule that allocates hospice care on an aggregate basis by allocating each beneficiary entirely to the cap year in which he or she would be likely to receive the preponderance of his or her care. 48 Fed. Reg. 56,0008, 56,022 (December 16, 1983). Once a beneficiary is counted for a given hospice, the beneficiary is not counted in the cap in subsequent years if services continue into more than one cap year.[6]

Hospice Payment Litigation and CMS Ruling CMS-1355-R (Ruling 1355-R)

In 2006, Providers began filing appeals objecting to the current counting methodology used in calculating hospice reimbursement, seeking to have the overpayment determination calculated under the methodology described above invalidated. The Federal district courts and courts of appeals that ruled on the question have issued decisions concluding that the methodology is in consistent with the plain language of the Medicare statute and set aside the overpayment determinations.[7]

As a result of the outcome of the litigation, the Centers for Medicare & Medicaid Services (CMS) issued Ruling 1355-R which allowed certain providers to have their reimbursement determined using a patient-by-patient proportional methodology and, subsequently, issued a revised regulation implementing this elective methodology in future years. Under the ruling, hospice providers which had timely appeals pending under 42 U.S.C. § 1395oo could request that their reimbursement be

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under this part in the accounting year, such number reduced to reflect the portion of hospice care that each such individual was provided in a previous or subsequent accounting year . . . ."

[5] March 28, 2013 PJSO, Tab 3.

[6] Ruling 1355-R at 3-5.

[7] *See e.g. Lion Head Health Services v. Sebelius*, 689 F. Supp. 2d 849 (N.D. Tex. 2010); Los Angeles Haven Hospice, 2009 WL 5868513 (C.D. Cal.); *Hospice of New Mexico v. Sebelius*, 691 F. Supp. 2d 1275 (D.N.M. 2010); *IHG Healthcare, Inc. v. Sebelius, 717 F. Supp. 2d 696 (S.D. Tex. 2010).*

recalculated using the proportional methodology. Under this methodology each Medicare beneficiary who received hospice care in a cap year is allocated to that hospice provider's cap year on the basis of a fraction. The numerator of the fraction is the number of patient days for that beneficiary in that hospice for that cap year and the denominator will be the total number of patient days for that beneficiary in all cap years in which the beneficiary received hospice services. The individual beneficiary counts for a given cap year will then be summed to compute the hospice's total aggregate beneficiary count (number of Medicare beneficiaries) for that cap year. A new payment cap would be calculated and a notice of overpayment determination would be issued.

CMS recognized that, at the time of recalculation using the patient-by-patient proportional methodology, a hospice beneficiary could still be receiving services resulting in an overstatement of a fractional allocation. Consequently, these providers' cap determinations would be subject to reopening under the reopening regulations and the reimbursement adjusted. Some portion of the hospice beneficiary's patient days will be counted toward the hospice cap in each cap year in which services were received.

Under the Ruling intermediaries and Medicare Administrative Contractors (MACs) were to identify properly pending appeals and recalculate the aggregate cap using the patient-by-patient methodology using the best available data. For hospices which had not filed appeals challenging the cap, the intermediaries and MACs were to use the reimbursement methodology that appeared in the regulation at 42 C.F.R. § 418.309(b)(1) for any cap year ending on or before October 31, 2011, unless CMS adopted a rule providing otherwise.[8]

Changes to the Aggregate Cap Calculation Methodology Effective October 1, 2011

In the August 4, 2011 Federal Register[9] the Secretary announced changes to calculations of hospice cap calculation for cap years before October 31, 2011 and on or after October 31, 2012. This notice included a change in the hospice payment regulation, 42 C.F.R. § 418.309, allowing providers reimbursement to be calculated under either the new patient-by-patient proportional methodology or the streamlined methodology (the existing methodology). These changes were made as a result of the litigation resulting in Ruling 1355-R, described above, and the Secretary's requests for comments on potential modernization of the hospice cap calculation.[10]

The Secretary noted that there were hospices that had not filed appeals of overpayments determinations challenging the validity of 42 C.F.R. § 418.309 and which were awaiting cap determinations for cap years ending on or before October 31, 2011. As of October 1, 2011, those hospices could elect to have their final cap determination for those cap year(s), and all subsequent years calculated using the patient-by-patient methodology. A hospice that did not challenge the methodology used for determining the number of beneficiaries used in the cap calculation could continue to have the streamlined methodology used to calculate their reimbursement. Those hospices not seeking a change were not required to take any action.

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[8] Ruling at 9-11.
[9] 76 Fed. Reg. 47302, 47308 (August 4, 2011).
[10] *See* note7.

With respect to changing hospice reimbursement methodologies, the Secretary noted in relevant part that:

> (4) Hospices which elected to have their cap determination calculated using the streamlined methodology could later elect to have their cap determinations calculated pursuant to the patient-by-patient proportional methodology by either:
>
> a. Electing to change to the patient-by-patient proportional methodology; or
> b. Appealing a cap determination calculation using the streamlined methodology to determine the number of Medicare beneficiaries.

76 Fed. Reg. 47302, 47310 (August 4, 2011).

Hospice Payment: Geographical Location

When Congress first authorized Medicare payment for hospice care under the TEFRA the benefit period was two 90-day benefit periods and a 30 day extension of benefits. 42 U.S.C. § 1395(dd)(3)(A) (1984). In 1997, Congress amended the statute to extend the benefit period providing beneficiaries with unlimited 60 day extensions for care. 42 U.S.C. § 1395d(d)(1).

TEFRA directed the Secretary to make payments to hospices for the reasonable cost of providing services under 42 U.S.C. § 1395(d)(i)(1) (1982). Pursuant to this statutory authority, the Health Care Financing Administration (HCFA, now CMS) instituted a prospective payment system for paying rates based on the level of care. 48 Fed. Reg. 56008 (December 16, 1983). Rather than apply an adjustment based on regional Medicare expenditures as provided for under 42 U.S.C. § 1395f(i)(2)(B), HCFA based its adjustment on 1981 data furnished by the Bureau of Labor Statistics (BLS) that was also used in the initial Metropolitan Statistical Area (MSA) index for inpatient hospital prospective payment. *See* 48 Fed. Reg. at 56021-22.

The prospectively determined hospice rates were also subject to a cap on payments that hospices can receive for treatment of Medicare beneficiaries. *See,* 42 U.S.C. § 1395f(i)(2)(B). The Provider asserts that TEFRA instructed the Secretary to devise the cap so that it would represent 40 percent of the average cost of providing hospice care to a patient during the last six months of the beneficiary's life. The Secretary was then to "compute a regional average Medicare per capita expenditure amount for each region, by adjusting the national average Medicare per capita expenditure" to reflect the relative difference between that regions average cost of delivering health care and the national average cost . . ." 42 U.S.C. § 1395(i)(2)(B)(iii) (1982).

Less than a year after TEFRA became law, and before the proposed regulations implementing the hospice benefit were issued, Congress passed a "technical amendment" to the hospice cap requirement in Pub. Law 98-90. Congress replaced the 40 percent target with a flat cap of

$6,500 to be adjusted annually for inflation according to the Consumer Price Index's health care expenditure figure. *See* H.R. Rep. 98-333, 98th Cong. (1983) (*reprinted in* 1983 U.S.C.C.A.N. 1043).

In 1997, HCFA altered the way it calculates the hospice wage index used to adjust the prospective payment rates for hospice care. Initially, the hospice wage index was tied to the 1981 BLS data used for the inpatient hospital prospective payment system. In 1997, after undertaking negotiated rulemaking on the issue, HCFA adopted a new wage index methodology for hospice rates based on 1993 hospital cost data. *See* 62 Fed. Reg. 42860 (August 8, 1997).

CMS has never adjusted the hospice cap for regional differences in the cost of furnishing hospice care. Congress amended the hospice cap provision of the Medicare statute in 1997 to require that hospices "shall submit claims for payment for hospice care furnished in an individual's home under this title only on the basis of geographic location at which the service is furnished, as determined by the Secretary." 42 U.S.C. § 1395f(i)(2)(D) (1997). This provision is located in the part of the statute establishing the hospice cap. In 2005, CMS began setting the per diem rate paid to hospices based on the location where the service is furnished. 42 C.F.R. § 418.306(c)(2007). However, the wage indices applied to these hospice payment rates are published in the Federal Register. *See e.g.* 71 Fed. Reg. 52080 (September 1, 2006).[11] However, the published wage indices for hospice payments do not apply to the hospice cap. As a result, a hospice in a higher per diem payment area will receive higher payment than those in a lower per diem payment area.

Decision of the Board

Addition of the Geographic Location Issue

The Board finds that the issue of proper allocation of cap payments based on the geographic location of the hospice contained in the PJSO is a new issue and was not timely filed from the issuance of the Notice of Inpatient Limitation and Hospice Cap Amount on July 5, 2012. Consequently, the Board dismisses the geographic location issue from the appeal. The regulation, 42 C.F.R. § 405.1835(c) (2008) permits providers to add an issue to an existing appeal if the Board receives the request to add issues no later than 60 days after the expiration of the 180-day appeal period described in 42 C.F.R. § 405.1835 (240 days after the deemed receipt of the final determination). In this case, the Provider's original cap determination was issued on July 5, 2012, and the geographic location issue was not received[12] in the Board's offices until April 1, 2013, 265 days after the Provider is deemed to have received its cap notice. *See* 42 C.F.R. § 405.1801(a)(1)(iii) (the date of receipt is presumed to be 5 days after the date of issuance of an intermediary notice).

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[11] *Id.* at 3.

[12] Pursuant to 42 C.F.R. § 405.1801(a)(2)(i) (2008) the determination of the date of receipt by the Board is the date delivered by a nationally recognized overnight carrier or the date received where a nationally recognized next day carrier is not employed. In this case, the letter was identified as being sent by priority mail through the United States Postal Service which is not overnight mail service.

Remand[13] as the Result of the Requirements of 42 C.F.R. § 418.309(d)(1)

The Provider in this case filed an appeal regarding payment that was made under 42 C.F.R. § 418.309(b), the streamlined methodology for cap period ending October 31, 2010. The Provider challenged the validity of 42 C.F.R. § 418.309(b) alleging that it did not comport with the requirements of 42 U.S.C. § 1395f(i)(2)(C). The Board concludes that it is required to order the MAC to calculate reimbursement under 42 C.F.R. § 418.309(c), the patient-by-patient, proportional methodology because the regulation, 42 C.F.R. § 418.309(d)(1) (2011), mandates that:

> For cap years ending October 31, 2011 and for prior cap years, a hospice's aggregated cap is calculated using the streamlined methodology described in paragraph (b) of this section subject to the following:
>
> (i) A hospice that has not received a cap determination for a cap year ending on or before October 31, 2011 as of October 1, 2011, may elect to have its final cap determination for such cap years calculated using the patient-by-patient methodology described in paragraph (c) of this section; or
>
> (ii) *A hospice that has filed a timely appeal regarding the methodology used for determining the number of Medicare beneficiaries in it cap calculation for any cap year is deemed to have elected that its cap determination for the challenged year, and all subsequent cap years be calculated using the patient-by-patient proportional methodology* described in paragraph (c) of this section. (emphasis added)

The Board is bound by the regulations issued under Title XVIII of the Social Security Act and the hospice cap regulations, found in Subpart G of Part 418 of Title 42 of the Code of Federal Regulations, were issued under that authority. *See* 42 C.F.R. § 405.1867. Pursuant to the regulation, 42 C.F.R. § 418.309(d)(ii), a timely appeal of the methodology used for determining the number of Medicare beneficiaries a cap calculation, is deemed to be an election requiring the provider's cap determination be calculated using the patient-by-patient proportional methodology described in 42 C.F.R. § 418.309(c). Since the Board is bound by this regulation, it finds that it must remand the appeal of this issue to the MAC for determination of reimbursement under the patient-by-patient proportional methodology described in 42 C.F.R. § 418.309(c). Since there is no other action for the Board to take in this case, the Board hereby closes the case.

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[13] The Board's remand authority is found in 42 C.F.R. § 405.1845(b).

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.
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 Shanklin, BCBSA

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RE: Patton Boggs 2010 Outlier Group
Provider Nos. Various
FYE 2010
PRRB Case No. 12-0439G

Dear Mr. Nash:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' August 8 2013 request for expedited judicial review (EJR) (received August 12, 2013) and the Schedules of Providers and associated jurisdictional documents. In addition, on September 11, 2013, the Board sent the parties a letter seeking additional information with respect to this case; the Medicare Administrative Contractor (MAC) responded through two letters dated October 8 and 9, 2013, and the Providers responded on November 8, 2013. On November 27, 2013, the Board sent the Providers a second request for information and the Providers responded on December 27, 2013 (received December 30, 2013). The Board decision with respect to the request for EJR and jurisdiction is set forth below.

Background

The Providers are all subsection (d) hospitals and receive reimbursement for inpatient services under the inpatient prospective payment system for inpatient operating and capital costs (IPPS). The Providers allege that the calculation of the outlier payments under IPPS is incorrect because the Secretary[1] improperly established the "fixed loss thresholds" (FLT) used to calculate the number of cases qualify for and the amount of outlier payments. In Federal fiscal year 2003, the regulations establishing the method of calculating were amended to correct what the Secretary described a number of vulnerabilities in the payment system that made is susceptible to manipulation. Analysis revealed that hospitals had taken advantage of the two vulnerabilities to maximize their outlier payments.[2] The Providers contend that the FFY 2010 FLT used MEDPAR data that was from the period in which certain hospitals had manipulated their data to increase outlier reimbursement resulting in inaccurate, inflated and overstated charge data being using in the compilation of the FLT. This resulted in outlier payments being less than the 5-6% of the actual DRG payments as required by 42 U.S.C. § 1395ww(d)(5)(A)(i)-(iv).

[1] of the Department of Health and Human Services.
[2] 68 Fed. Reg. 34494, 34496 (June 9, 2003).

Decision of the Board

The Board concludes that it lacks jurisdiction over the appeal and hereby dismisses the case. Since jurisdiction is a prerequisite to granting a request for EJR, the Board hereby denies the request for EJR. *See* 42 C.F.R. § 405.1842(a).

These appeals were filed based on the provisions of 42 U.S.C. §§ 1395oo(a) and 42 C.F.R. § 405.1835(a) which permit a provider to file an appeal within 180 days of the expiration of the 12-month period for issuing an intermediary determination where the Medicare Administrative Contractor (MAC) has received a perfected cost report. In this regard, 42 U.S.C. § 1395oo(a) states in relevant part:

> (a) . . . any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1886 and which has submitted such reports within such time as the Secretary may require in order to make payment under such section *may obtain a hearing* with respect to such payment by the Board, if—
>
> (1) such provider . . .
>
> (B) has not received such final determination from such intermediary on a timely basis after filing such report *where such report complied with the rules and regulations of the Secretary relating to such report* . . .
>
> (2) the amount in controversy is $10,000 or more, and
>
> (3) such provider files a request for hearing . . . with respect to appeals pursuant to paragraph (1)(B) . . . within 180 days after notice of such determination would have been received if such determination had been made.[3]

Similarly, 42 C.F.R. § 405.1835(a) (2008) states in pertinent part:

> (a) **Criteria.** A provider . . . has a *right to a Board hearing*, as a single provider appeal, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination, *only if*—
>
> (1) *The provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for specific item(s) at issue, by* either—

[3] (Emphasis added.)

> (i) Including a claim for specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or
>
> (ii) Effective with cost reporting periods that end on or after December 31, 2008, *self-disallowing the specific item(s) by following the applicable procedures for filing a cost report under protest*, where the provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy (for example, if the intermediary lacks discretion to award the reimbursement the provider seeks for the item(s)).
>
> (2) The amount in controversy . . . is $10,000 or more; and
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836 of this subpart, the date of receipt by the Board of the Provider's hearing request is . . .
>
> (ii) If the intermediary determination is not issued (through no fault of the provider) within 12 months of the date of receipt by the intermediary of the provider's perfected cost report or amended cost report . . . no later than 180 days after the expiration of the 12 month period for issuance of the intermediary determination.[4]

The cost reporting period under appeal involves fiscal year 2010.

At the outset, the Board notes that providers subject to IPPS ("IPPS providers") are required to file cost reports on an annual basis pursuant to 42 C.F.R. §§ 412.40 and 412.52. Further, in defining "determination" for purposes of appeal rights under 42 U.S.C. § 1395oo(a), CMS has specified in 42 C.F.R. § 405.1803 that the appeal rights of an IPPS provider flow from the intermediary's issuance of the NPR that is based upon the cost report filed by that provider. Thus, the Board concludes that the "report" discussed in § 1395oo(a)(1)(B) is the cost report.

As previously noted, in order to exercise appeal rights under § 1395oo(a)(1)(B) for the nonissuance of a "final determination" on a cost report, the cost report must have "complied with the rules and regulations of the Secretary relating to such [cost] report." The rules governing cost reports *for purposes of IPPS providers* are located in multiple places including:

1. 42 U.S.C. § 1395g(a);
2. 42 C.F.R. Part 405, Subpart R;
3. 42 C.F.R. Part 412;
4. 42 C.F.R. Part 413; and

[4] (Italics emphasis added.)

5. The Provider Reimbursement Manual (PRM), Parts 1 and 2 (CMS Pubs. 15-1 and 15-2, respectively).[5]

The Board notes that the cost report (including the procedures for filing a cost report under protest) are based on the provider's obligation to provide information that the Secretary requires to determine payment. In this regard, 42 U.S.C. § 1395g(a) specifies in pertinent part:

> (a) The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it . . . except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.

CMS has historically set forth the rules governing items filed under protest in PRM 15-2 § 115 *et seq.* and specified what information providers are required to furnish for items under protest in PRM 15-2 §§ 115.1 and 115.2:

> 115.1 **Provider Disclosure of Protest** --When you file a cost report under protest, the disputed item and amount *for each issue* must be specifically identified in footnotes to the settlement worksheet and the fact that the cost report is filed under protest must be disclosed.
>
> 115.2 **Method for Establishing Protested Amounts** --The effect of *each nonallowable cost report item is estimated* by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. In addition, *you must submit*, with the cost report, *copies of the working papers used to develop the estimated adjustments* in order for the contractor/contractor to evaluate the reasonableness of the methodology for purposes of establishing whether the cost report is acceptable. The cumulative effect on reimbursement for all disputed issues is shown as an adjustment to balance due to the program (provider) in the reimbursement settlement computation. The actual effect on reimbursable cost(s) is determined after final adjudication of the issue(s).[6]

Effective with cost report periods that end on or after December 31, 2008, CMS amended the regulations governing cost report appeals to incorporate PRM 15-2 § 115 *et seq.* into the regulations at 42 C.F.R. § 405.1835(a)(1)(ii) (2008) by specifying that, where a provider seeks payments that it believes may not be allowable or may not be in accordance with Medicare

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[5] The Agency's paper based manual can be found on the internet at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html?redirect=/Manuals/PBM/list.asp.

[6] (Italics emphasis added.)

policy, the provider must claim the items as self-disallowed costs "by following the applicable procedures for filing a cost report under protest." In promulgating this regulation, CMS included the following discussion in the preamble to the final rule published on May 23, 2008 ("2008 Final Rule")[7] to confirm that this regulation codified the PRM rules governing cost reports filed under protest:

> **Comment**: One commenter recommended that the text of section 115 *et seq.* of the PRM, Part II, be placed in the regulations. The commenter noted that these sections of the PRM have not changed since 1980. . . .
>
> **Response**: We are adopting the proposal, which is essentially a codification of the protested amount line procedures set forth in section 115 *et seq.* of the PRM, Part II.[8]

For purposes of IPPS providers, filing a cost report under protest is achieved by entering such costs on Worksheet E, Part A, Line 30 of the cost report. In this regard, PRM 15-2 § 3630.1 requires that IPPS providers:

> Enter the program reimbursement effect of the protested items. Estimate the reimbursement effect of the nonallowable cost items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process (See § 115.2). Attach a schedule showing the details and the computation for this line.

The Board notes that 42 C.F.R. § 405.1804(d) (2008) provides further evidence that the "rules and regulations governing [cost] reports" are, in part, located in 42 C.F.R. Part 405, Subpart R. This regulation governs implementation of decisions to award, part or in full, self-disallowed items filed under protest:

> (d) **Effect of certain final agency decisions and final court judgments: audits of self-disallowed and other items. . . .**
>
> (2) CMS may require the intermediary to audit any item, including any self-disallowed item, at issue in an appeal or a civil action, before any revised intermediary determination or additional Medicare payment, recoupment, or offset may be determined for an item under paragraph (d)(2) of this section.

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[7] 73 Fed. Reg. 30190 (May 23, 2008).

[8] *Id.* at 30195. Similarly, the preamble to the 2008 Final Rule states the following regarding the documentation requirements for filing a cost report under protest: "We are attempting to strike a balance between, on the one hand, having provider present enough information so as to put the intermediaries on notice as to the actual or potential reimbursement disputes, and, on the other hand, not making it unduly burdensome for providers to file cost reports." *Id.* The preamble further states: "We believe it reasonable to require provider to notify their intermediaries, via their cost report submission, of all items for which they potentially may be claiming reimbursement." *Id.* at 30198.

In the preamble to the 2008 Final Rule, CMS stated the following regarding the purpose of this regulatory provision:

> The final decision awarding reimbursement for a self-disallowed item may come from the Board, the Administrator, or a court. Although we believe that, in most instances, the administrative or judicial body that issues a decision would not specify a dollar figure for reimbursement, the proposal was intended to ensure that intermediaries, in fact, have the opportunity to determine the correct amount of reimbursement after an award is made. We believe that it would be inappropriate for the administrative or judicial body to award a specific amount for reimbursement without the benefit of an audit by the intermediary.[9]

Thus, the procedures and documentation required for filing an item under protest and the audit of such items when they are awarded (in part or in full) following a successful appeal as codified at 42 C.F.R. §§ 405.1835(a)(1)(ii) and 405.1804(d) respectively is an integral part of the cost reporting process to establish under 42 U.S.C. § 1395g(a) that the provider has "furnished such information as the Secretary may request in order to determine the amounts due such provider."

In the instant case, there is no amount claimed on Worksheet E, Part A, Line 30 of the cost reports at issue as required to protest the amount of outlier reimbursement pursuant to § 405.1835(a)(1)(ii).[10] As these cost reports involve a fiscal year that ends on or after December 31, 2008, self-disallowed items such as the outlier reimbursement at issue must have been filed under protest in order to have "complied with the rules and regulations of the Secretary relating to such [cost] report" and, thereby, established one of the elements for Board jurisdiction under 42 U.S.C. § 1395oo(a)(1)(B). Thus, as the Providers failed to protest the outlier reimbursement at issue and that is the sole issue involved in these appeals, the Board lacks jurisdiction over the appeal and hereby dismisses the case. Since there is no jurisdiction over the Providers participating in this case as required for the Board to grant a request for EJR, the Providers' request for EJR is hereby denied. *See* 42 C.F.R. § 405.1842(a). This action closes the case.

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[9] 73 Fed. Reg. at 30199.

[10] Billings Clinic (provider number 27-0004), Parkview Medical Center (provider number 06-0020), Good Samaritan Hospital (provider number 05-0471), Sarasota Memorial Hospital (provider number 10-0087), West Virginia University Hospital (provider number 51-0001) and Memorial Hospital of Colorado Springs (provider number 06-0022) furnished a statement (found under Tab A for each Provider) stating that they did not protest outlier reimbursement on their as-filed cost reports. The following Providers did not claim any protested amount on Worksheet E, Part A, Line 30: Boulder Community Hospital (provider number 06-0027) and Denver Hospital (provider number 06-0011). Halifax Medical Center (provider number 10-0017) claimed $4,160,079 as a protested amount on its cost report; however, the listed of protested items did not included outlier payments. Charleston Area Medical Center (provider number 51-0022) claimed $1,901,163 as a protested amount, this amount involved only self-pay bad debts, not outlier payments.

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, Schedule of Providers

cc: Geoff Pike, First Coast Services Options
Kevin Shanklin, BCBSA