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

CERTIFIED MAIL JUN 03 2014

Novitas Solutions, Inc.
Timothy LeJeune
JH Provider Audit & Reimbursement
Union Trust Building
501 Grant Street, Suite 600
Pittsburgh, PA 15219

Covenant Medical Center - Lakeside
Daniel A. Olvera
Finance Dept. Box 148
3615 19th Street
Lubbock, TX 79410

RE: Request for Alternative Remand under CMS Ruling CMS-1498-R
Provider Name: Covenant Medical Center - Lakeside
Provider No.: 45-0040
Issue: Labor/Delivery Room Inpatient Days
FYE: 06/30/2008
PRRB Case No.: 13-1202

Dear Timothy LeJeune and Daniel A. Olvera:

This appeal includes a challenge to the exclusion of labor/delivery room (LDR) inpatient days from the calculation of the disproportionate share (DSH) percentage during a cost reporting period beginning before October 1, 2009. The Provider has requested this issue be remanded under CMS Ruling-1498-R.[1]

CMS published the Ruling on April 28, 2010 to address jurisdictionally proper pending appeals and open cost reports that included one or more of the three DSH issues covered by the Ruling. One of the DSH issues covered by the Ruling is LDR inpatient days. The Ruling requires that the applicable appeals tribunal, in this case the PRRB, remand back to the Intermediary all challenges to the exclusion of LDR inpatient days under the terms of the Centers for Medicare & Medicaid Services (CMS) Ruling CMS-1498-R for recalculation of the disproportionate share hospital (DSH) payment adjustment.

The Notice of Program Review (NPR) under appeal in this case was issued on September 21, 2012, more than two years after the Ruling instructed the Intermediary that LDR inpatient days are subject to the Ruling:

> CMS and the Medicare contractors will apply the foregoing provisions of this Section 5 of this Ruling, regarding each of the three DSH issues for the above-described patient discharge dates and cost reporting periods (as set forth in Sections 1, 2, and 3 of this Ruling), in calculating the DSH payment adjustment for each qualifying open cost reporting period where the contractor has not yet settled finally the provider's Medicare cost report through the issuance of an initial NPR. . . . The initial NPR will be subject to administrative and

[1] *See* Provider's *Request Alternative Remand* letter dated March 7, 2014.

judicial review in accordance with the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines.[2]

The Ruling specifically addressed pre-October 1, 2009 cost reporting periods that were not yet finally settled, and therefore not appealed, providing:

> [I]n order to avoid, or at least minimize, the filing of new DSH administrative appeals on the LDR inpatient day issue, CMS and the Medicare contractors will ensure that a hospital's LDR inpatient days are included in the Medicaid fraction or the SSI fraction (whichever proves to be applicable), in calculating the DSH payment adjustment for each open cost report for a pre-October 1, 2009 cost reporting period where the contractor has not yet settled finally the provider's Medicare cost report through the issuance of an initial NPR...[3]

The Board finds the LDR inpatient days issue appealed in this case is not covered by CMS Ruling CMS-1498-R and therefore cannot be remanded back to the contractor for payment pursuant to the Ruling. The NPR under appeal in this case was issued more than two years after the Intermediary was instructed by CMS Ruling CMS-1498-R to ensure LDR inpatient days were properly included in the DSH payment. Therefore, the relief the Provider would receive under CMS-1498-R, should have already been received in the NPR from which it appealed. If the Provider did not receive the relief required in CMS Ruling CMS-1498-R for its open cost report, the Provider must pursue its appeal on the merits of the issue.

The Board denies the Provider's request for remand of the LDR inpatient days issue.

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

FOR THE BOARD:

Board Member

Enclosure: Copy of Remand Request

cc: Kevin D. Shanklin, Executive Director, BCBSA

[2] CMS Ruling CMS-1498-R at 31.
[3] CMS Ruling CMS-1498-R at 16.

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Refer to: 13-3738G

Certified Mail

JUN 13 2014

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

RE: Parkview Medical Center, Provider No. 06-0020, FYE 6/30/2011 as a participant in Patton Boggs 2011 Outlier Group, PRRB Case No. 13-3738G

Dear Mr. Nash:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' May 19, 2014 request for expedited judicial review (EJR) (received May 20, 2014) and the accompanying Schedule of Providers and associated jurisdictional documentation. The Board's determination with respect to request for EJR and jurisdiction over the Provider is set forth below.

Background

The Provider's appeal in this case was based on the regulatory provisions of 42 C.F.R. § 405.1835(a)(3)(ii). This regulation permits a provider to file an appeal with the Board

> [i]f the intermediary[1] determination is not issued . . . within 12 months of the date of receipt by the intermediary of the provider's perfected cost report . . . *no later than 180 days after the expiration of the 12 month period for issuance of the intermediary determination.*[2] The date of receipt by the intermediary of the provider's perfected cost report . . . is presumed to be the date the intermediary stamped "Received" unless it is shown by a preponderance of the evidence that the intermediary received the cost report on an earlier date.

In this case, the Provider's cost report was received by the Intermediary on January 25, 2012.[3] The Intermediary's acceptance of the cost report on February 14, 2012[4] demonstrates that the cost report was considered "perfected". One year after the receipt of the Provider's cost report was January 25, 2013 which opened the 180-day appeal window. The Provider's appeal was received (filed) in the Board's offices on July 25, 2013.

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[1] Intermediaries are now also referred to as Medicare Administrative Contractors (MACs).
[2] (Emphasis added).
[3] *See* May 24, 2014 Schedule of Providers and associated jurisdictional documents, Tab 2.B. FedEx Express Customer Support Trace.
[4] *Id.* at Tab 2.B. April 15, 2014 e-mail from Joseph Bandola of Novitas Solutions (Intermediary) to Mimi Hu (Provider Representative) regarding acceptance of the Provider's cost report.

Decision of the Board

The Board concludes that it lacks jurisdiction over Parkview Medical Center, provider number 06-0020, fiscal year end June 30, 2011 because the Provider's appeal was not timely filed. The appeal was received[5] in the Board's offices 181 days after the expiration of the 12 month period for issuance of the intermediary determination.[6] As noted above, 42 C.F.R. § 405.1835(a)(3)(ii) permits a provider to file an appeal with the Board "no later than 180 days after the expiration of the 12 month period for issuance of the intermediary determination."

The Board notes that the STAR system indicates that the Provider's Notice of Program Reimbursement for fiscal year end June 30, 2011, was issued on April 1, 2014. *See STAR* report enclosed. As of the date of this letter, the Provider is within the 180-day appeal period for filing an appeal of this determination, if it so chooses.

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, Esq.
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, STAR Report for Parkview Medical Center

cc: Timothy LeJeune, Novitas Government Solutions
Kevin Shanklin, BCBSA

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[5] *See* 42 C.F.R. § 405.1835(a)(3) (a provider has a right to hearing 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 of the intermediary's [final] determination.), 42 C.F.R. § 405.1801(a)(2) (2008) (the date of receipt means the date stamped "Received" by the reviewing entity).

[6] 42 C.F.R. § 405.1801(a)(3)(iii) states that the date of receipt by a party of documents involved before a reviewing entity is presumed to be 5 days after the date of issuance of an intermediary notice or reviewing entity document. In the case of the failure to issue and NP there is no document for which the Provider is awaiting delivery. The one year anniversary of the submission of the cost report is a specific date on the calendar, calculated from the dated the intermediary received the cost report. Consequently, there is no document transmission involved in this process and no need to allow the 5 days for mailing something that has not been issued.

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CERTIFIED MAIL

JUN 13 2014

Hooper, Lundy & Bookman, P.C.
Jordan B. Keville
1875 Century Park East
Suite 1600
Los Angeles, CA 90067-2799

RE: **Orange Coast Memorial Medical Center**
Provider Number: 05-0678
FYE: 06/30/2007
Case Number: 13-0980

Dear Mr. Keville:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeal on its own motion. The pertinent facts of the case and the Board's jurisdictional determination are set forth below.

Pertinent Facts:

The appeal was dated March 4, 2013, and filed from a Revised Notice of Program Reimbursement (RNPR) dated September 18, 2012. The Provider appealed the following issues:

1. SSI Ratio - Realignment Based on Provider's FY
2. SSI Ratio - Accuracy of Underlying Data
3. SSI Ratio - Inclusion of Medicare Part C Days

On November 1, 2013, the Provider submitted two separate letters requesting to transfer the SSI Ratio – Part C Days issue to CIRP Group Case No. 13-3945GC and the SSI Ratio – Accuracy of Underlying Data issue to CIRP Group Case No. 13-3946GC.

On February 18, 2014, the Intermediary filed a jurisdictional challenge regarding the SSI Realignment issue. The Intermediary stated since it did not make a determination in terms of the SSI Realignment issue, the Board does not have jurisdiction over this issue pursuant to 42 C.F.R. §405.1803. The Intermediary requested that the Board dismiss the SSI Realignment from this appeal. The Provider did not submit a rebuttal brief.

Board Determination:

SSI Realignment Issue:

In its description, of the SSI Realignment issue, the Provider stated:

> The Provider disputes the accuracy of the SSI ratio utilized by the MAC in the calculation of the operating and capital DSH adjustment.... Based on the SSI data received from CMS in support of the ratios published in March 2012, *the Provider has not requested realignment of the Medicare faction*.... The Provider cannot make a final decision regarding realignment of the Medicare fraction until this variance is understood and the accuracy of the SSI data has been verified. (Emphasis added.)

The Board finds that it does not have jurisdiction over the SSI Realignment issue in this appeal, as this issue is premature. 42 C.F.R. §405.1835 states:

> The provider ... has a right to a hearing before the Board about any matter designated in §405.1801(a)(1), if ... [a]n intermediary determination has been made with respect to the provider.

In this case, there was no final determination made by the Intermediary and the Provider has not yet decided whether it will request realignment. Realignment is a remedy the Provider may pursue if it is dissatisfied with MEDPAR SSI data. The Board hereby denies jurisdiction over the SSI Realignment issue. Since there are no remaining issues in this appeal, the Board hereby closes this appeal and removes it from the Board's docket.

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

FOR THE BOARD:

Michael W. Harty
Chairman

cc: Noridian Healthcare Solutions, LLC
Donna Kalafut
JE Part A Appeals Coordinator
P.O. Box 6782
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Refer to: 06-0064

CERTIFIED MAIL

JUN 13 2014

Blumberg Ribner, Inc.
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Chief Operating Officer
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CGS Administrators
Judith E. Cummings
Accounting Manager
CGS Audit & Reimbursement
P.O. Box 20020
Nashville, TN 37202

RE: Jurisdictional Review - St. Rita's Medical Center
Provider No.: 36-0066
FYE: 12/31/2002
PRRB Case No.: 06-0064

Dear Mr. Blumberg and Ms. Cummings:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal in response to the Intermediary's challenge to the Board's jurisdiction. The pertinent facts of the case and the Board's jurisdictional determination are set forth below.

Pertinent Facts:

October 17, 2005	Provider representative, Campbell Wilson, filed a request to appeal and transfer from an original Notice of Program Reimbursement (NPR) dated April 20, 2005. The appeal request identified two issues – SSI and Bad Debts. The SSI issue was transferred simultaneously to the Campbell Wilson SSI Group Appeal, Case. No. 03-1254G.[1]
August 27, 2007	The Provider added DSH – Hospital Care Assurance Program (HCAP) days to the subject appeal.
December 14, 2007	The Intermediary filed its final position paper. The issues briefed were the Bad Debts and HCAP days.
December 26, 2007	The Provider filed its final position paper. The issue briefed was the HCAP days.
October 17, 2008	The new Provider representative, Blumberg Ribner, Inc., filed a request to add the SSI%, SSI% Realignment, Medicaid Eligible Days, Dual Eligible Days, and HCAP days issues to the subject appeal.
July 29, 2009	Blumberg Ribner, Inc. withdrew the Medicaid Eligible Days issue.
October 11, 2013	The Provider filed a supplemental position paper in accordance with Board policy. The SSI% and Dual Eligible days issues were briefed.

[1] Case No. 03-1254G was closed August 13, 2013 after a standard remand was issued.

February 7, 2014	The Provider filed a request for standard remand on the SSI% and Dual Eligible days issues.
February 7, 2014	The Intermediary filed jurisdictional challenges on the Bad Debts, SSI% and SSI Realignment issues as well as a challenge to the expansion of the Dual Eligible Days issue within the Provider's position paper.
February 10, 2014	The Provider filed a request to withdraw the subject appeal once the requested remands for SSI% and Dual Eligible days were processed.
April 16, 2014	The Board issued the remand for the Dual Eligible Days issue.

Board's decision:

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 of the date of receipt of the final determination.

The original appeal was filed with two issues – DSH SSI and Bad Debts. Issues were transferred, added and withdrawn per timeline above.

The SSI% issue was transferred to Case No. 03-1254G therefore it no longer resides in the subject appeal. The Board has already remanded the Dual Eligible Days issue under CMS Ruling 1498-R, thus will not address the jurisdictional challenge regarding the expansion of the issue.

The Board has determined, per PRRB rule 27, that the Bad Debts and SSI% realignment issues were abandoned since they were not briefed in the final or supplemental position papers filed by the Provider. Therefore, the Board hereby dismisses these issues from the appeal. The only remaining issue in the subject appeal is the HCAP Days issue. However, the Provider submitted a withdrawal request on February 10, 2014, and the Board hereby closes the subject appeal pursuant to the Provider's request.

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:
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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Refer to: 13-3738GC
Certified Mail

JUN 13 2014

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

RE: Patton Boggs 2011 Medicare Outlier Group
Provider Nos. Various
FYE 2011
PRRB Case No. 13-3738GC

Dear Mr. Nash:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' May 19, 2014 request for expedited judicial review (EJR) (received May 20, 2014). The Board decision with respect to the request for EJR and jurisdiction for the Providers on the enclosed Schedule of Providers is set forth below.

Background

The Providers are all subsection (d)[1] 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[2] improperly established the "fixed loss thresholds" (FLT) used to calculate the number of cases that 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.[3] Analysis revealed that hospitals had taken advantage of the three vulnerabilities to maximize their outlier payments.[4] The Providers contend that the FFY 2004 FLT used 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 be being using in the compilation of the FLT. This resulted in outlier payments being less than the 5-6 percent of the actual DRG payments as required by 42 U.S.C. § 1395ww(d)(5)(A)(i)-(iv).

The Providers on the enclosed Schedule of Providers all filed appeals under the provisions of 42 C.F.R. § 405.1835(a)(3)(ii). This regulation permits providers that have submitted perfected cost

[1] 42 U.S.C. § 1395ww(d).
[2] of the Department of Health and Human Services.
[3] *See* 68 Fed. Reg. 10,420, 10,423 (March 5, 2003) and 68 Fed. Reg. 34,494, 34,501 (June 9, 2003).
[4] 68 Fed. Reg. 34494, 34496 (June 9, 2003).

reports to their respective Medicare Administrative Contractors (MACs)[5] to file appeals with the Board where the MAC has not issued a final determination "no later than 180 days after the expiration of the 12 month period for issuance of the intermediary determination." The Providers, with the exception of #5 Denver Health Medical Center (provider number 06-0011), admit that they did not claim outlier reimbursement as a protested amount on their cost reports as required by 42 C.F.R. § 405.1835(a)(1)(ii) as evidenced by a statement under Tab D of the jurisdictional documents. Some of the Providers included protested amounts on Worksheet E, Part A, Line 75, but the protested amounts did not involve requests for additional amounts of outlier reimbursement based on an allegedly incorrect FLT.

Provider # 5, Denver Health Medical Center, claimed $390,679 as a protested amount on Line 75 of Worksheet E, Part A. The list of items being protested includes the Rural Floor Budget Neutrality (RFBN) issue and a disproportionate share hospital (DSH)/Supplemental Security Income (SSI) adjustment. The calculation of the amount of the RFBN issue includes a component of outliers from Worksheet E, Part A that were paid ($1,451,342). The Provider is seeking $244,604 for the RFBN correction and $146,075 for the DSH/SSI adjustment which totals $390,679 and which equals the amount that was protested ($390,679). On the Schedule of Providers, the Provider claimed $330,827 as the amount in dispute for outlier issue.

Decision of the Board

The Board concludes that it lacks jurisdiction over the appeals of the Providers on the enclosed Schedule of Providers and hereby dismisses the Providers from this case. The Board also concludes that it lacks jurisdiction over Provider # 5 Denver Health Medical Center because the outlier claimed in the RFBN issue described above was the amount of outlier payment received, not the additional amount the Provider would receive if the FLT was revised. Denver Health Medical Center's protested amount did not include a claim for the amount of outlier reimbursement because the FLT was incorrect. Since jurisdiction is a prerequisite to granting a request for EJR, the Board hereby denies the Providers request for EJR. *See* 42 C.F.R. § 405.1842(a).

This appeal was filed based on the provisions of 42 U.S.C. § 1395oo(a) and 42 C.F.R. § 405.1835(a)(3)(ii) which permits providers that have submitted perfected cost reports to their respective MACs to file appeals with the Board where the MAC has not issued a final determination "no later than 180 days after the expiration of the 12 month period for issuance of the intermediary determination." 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[6] 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—

[5] MACs are also known as Intermediaries.
[6] Codified as 42 U.S.C. § 1395ww.

(1) such provider—

(A)(ii) is dissatisfied with the final determination of the Secretary as to the amount of payment under subsection (b) or (d) of section 1886,

(B) has not received such final determination from such intermediary on a timely basis after filing such [cost] report, were such report *complied with the rules and regulations of the Secretary relating to such report*[7] . . .

****

(3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination, or with respect to appeals pursuant to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

(b) The provisions of subsection (a) shall apply to any group of providers of services if each provider of services in such group would upon the filing of an appeal (but without regard to the $10,000 limitation), be entitled to such a hearing, but only if the matters in controversy involve a common question of fact or interpretation of law or regulations and the amount in controversy is, in the aggregate, $50,000 or more.[8]

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—

(i) Including a claim for specific item(s) on its cost report for the period where the provider seeks

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[7] (Emphasis added).
[8] *See also* 42 C.F.R. § 405.1837(a)(3) (the amount in controversy for a group appeal must be $50,000 or more).

> 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)).[9]

This confirms that the general right to hearing at the beginning of the new subsection (a) necessarily encompasses claims for both reasonable cost reimbursement and reimbursement under IPPS. Significantly, the general right to hearing in the new subsection (a) relates to "an intermediary or Secretary *determination*."[10] The definition of "determination" as used therein is defined in 42 C.F.R. § 405.1801. Significantly, the § 405.1801 definition of "determination" has included determinations for both reasonable cost reimbursement and reimbursement under IPPS since September 1983 when CMS revised its regulations to implement IPPS.[11] Indeed, the Board's review of the regulatory history of § 405.1835 suggests that the May 23, 2008 changes simply update and expand the § 405.1835 right to hearing to include any IPPS reimbursement issues that are part of the normal cost report audit, settlement and appeals process as reflected by the historical application of such process.

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.

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

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[9] (Emphasis added)
[10] (Emphasis added.)
[11] *See* 42 C.F.R. § 405.1835 (editions dated Oct. 1, 1983, Oct. 1, 2007, Oct. 1, 2010).

> 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 the Provider Reimbursement Manual (PRM) (CMS Pub. 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).[12]

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 policy, the provider must claim the items as self-disallowed costs "by following the applicable procedures for filing a cost report under protest."

In the preamble to the final rule published on May 23, 2008 ("2008 Final Rule"),[13] the Secretary explained that he believed that requirement to follow the procedures for filing cost reports under protest was appropriate under the decision in *Bethesda Hospital Association v. Bowen.*[14] In *Bethesda*, the providers were dissatisfied with malpractice reimbursement and did not file a claim for the additional reimbursement on their cost report nor did they file a statement with the cost report challenging the validity of the regulation. Hence, there was no final determination with respect to malpractice costs. The Court rejected the Secretary's argument that 42 U.S.C.

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[12] (Emphasis added).
[13] 73 Fed. Reg. 30190 (May 23, 2008).
[14] 485 U.S. 399 (1988).

§ 1395oo(a)(1)(A)(i), which requires dissatisfaction with a final determination of the intermediary, "necessarily incorporates an exhaustion requirement." The Court found that this "strained interpretation" of the statutory dissatisfaction requirement was inconsistent with the express language of the statute.[15] However, the Court agreed, that under § 1395oo(a)(1)(A)(i), a provider's dissatisfaction with the amount of its total reimbursement is a condition of the Board's jurisdiction, but held that "it is clear, however, that the submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations. No statute or regulation expressly mandates that a challenge to the validity of a regulation be submitted first to the intermediary. . . . Thus, [the providers in *Bethesda]* stand on different ground than do providers who bypass clearly prescribed exhaustion requirements or who fail to request from the intermediary reimbursement for costs to which they are entitled under the applicable rules. While such defaults might well establish that a provider was satisfied with the amounts requested in its cost report and awarded by the intermediary, those circumstances are not presented here."[16] The Secretary noted that the Court recognized that an exhaustion requirement could be imposed by regulation, and that a provider who fails to claim all costs to which it is entitled may fail to meet the jurisdictional prerequisite of dissatisfaction.[17] In light of the ability to enact such regulations, 42 C.F.R. § 405.1835(a)(1)(ii) was promulgated, requiring providers to claim all items for which they seek additional reimbursement.

The Secretary went on to state that "[a]lthough there may be nothing in the statute indicating that dissatisfaction must be expressed with respect to "each claim," there also is nothing in the statute indicating that the Secretary cannot interpret the dissatisfaction requirement in this manner."[18] The final determination, which here is the NPR, is not just the total amount of program reimbursement. Rather, it is composed of many individual calculations representing the various items for which a provider seeks payment. Providers generally challenge discrete reimbursement items. Thus, dissatisfaction with total reimbursement is based on dissatisfaction with items that result in total reimbursement. Consequently the Secretary believes it is reasonable under 42 U.S.C. § 1395oo(a) to require dissatisfaction be shown with respect to each issue being appealed.[19] In light of this and the requirements of the regulation, the challenge to the outlier regulations must be claimed as a protested item and the Providers failed to comply with this requirement.

In the preamble, the Secretary also confirmed 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. . . .

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[15] 73 Fed. Reg. at 30196 citing *Bethesda* at 404.
[16] *Id.* at 404-405.
[17] *Id.*
[18] 73 Fed. Reg. at 30197.
[19] *Id.*

> **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.[20]

For purposes of IPPS providers, filing a cost report under protest is achieved by entering such costs on Worksheet E, Part A, Line 75 of the cost report. In this regard, PRM 15-2 § 4030.1 requires that IPPS providers:

> Enter the program reimbursement effect of the protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process (See [PRM] 15-2 Chapter 1, § 115.2). Attach a schedule showing the details and computations for this line.

The Board notes that 42 C.F.R. § 405.1803(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, in 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. . . .**
>
> (3) 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.

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

[20] *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.

> 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.[21]

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 405.1803(d) respectively, are an integral part of the cost reporting process established under 42 U.S.C. § 1395g(a) that the provider must "furnish[ ] such information as the Secretary may request in order to determine the amounts due such provider."

For the Providers on the attached Schedule of Providers, there is no amount claimed on Worksheet E, Part A, Line 75 of the cost reports at issue as required to protest the amount of outlier reimbursement pursuant to § 405.1835(a)(1)(ii).[22] As these cost reports involve a fiscal year that end 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). 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 appeals of the Providers on the attached Schedule of Providers and hereby dismisses the Providers from case. In separate decisions, the Board dismissed the two Providers from the appeal that are not included on the Schedule of Providers that is referenced in this decision. Since there are no remaining Providers in the appeal, the case is hereby closed.

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[21] 73 Fed. Reg. at 30199.
[22] *See May 20, 2014 Schedule of Providers, Tab D for each Provider.*

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: Timothy LeJeune, Novitas (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
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Refer to: 13-3832GC
Certified Mail

JUN 13 2014

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

RE: Patton Boggs/Lee Memorial 2011 Medicare Outlier Group
Provider Nos. Various
FYE 2011
PRRB Case No. 13-3832GC

Dear Mr. Nash:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' May 19, 2014 request for expedited judicial review (EJR) (received May 20, 2014). The Board decision with respect to the request for EJR and jurisdiction for the Providers on the enclosed Schedule of Providers is set forth below.

Background

The Providers are all subsection (d)[1] 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[2] improperly established the "fixed loss thresholds" (FLT) used to calculate the number of cases that 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.[3] Analysis revealed that hospitals had taken advantage of the three vulnerabilities to maximize their outlier payments.[4] The Providers contend that the FFY 2004 FLT used 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 be being using in the compilation of the FLT. This resulted in outlier payments being less than the 5-6 percent of the actual DRG payments as required by 42 U.S.C. § 1395ww(d)(5)(A)(i)-(iv).

The Providers on the enclosed Schedule of Providers all filed appeals under the provisions of 42 C.F.R. § 405.1835(a)(3)(ii). This regulation permits providers that have submitted perfected cost

[1] 42 U.S.C. § 1395ww(d).
[2] of the Department of Health and Human Services.
[3] *See* 68 Fed. Reg. 10,420, 10,423 (March 5, 2003) and 68 Fed. Reg. 34,494, 34,501 (June 9, 2003).
[4] 68 Fed. Reg. 34494, 34496 (June 9, 2003).

reports to their respective Medicare Administrative Contractors (MACs)[5] to file appeals with the Board where the MAC has not issued a final determination "no later than 180 days after the expiration of the 12 month period for issuance of the intermediary determination." Under Tab D of the Schedule of Providers, Worksheet E, Part A, Line 75, for each of the providers, contains no protested amount.

Decision of the Board

The Board concludes that it lacks jurisdiction over the appeals of the Providers on the enclosed Schedule of Providers and hereby dismisses the Providers from this case. Since jurisdiction is a prerequisite to granting a request for EJR, the Board hereby denies the Providers request for EJR. *See* 42 C.F.R. § 405.1842(a).

This appeal was filed based on the provisions of 42 U.S.C. § 1395oo(a) and 42 C.F.R. § 405.1835(a)(3)(ii) which permits providers that have submitted perfected cost reports to their respective MACs to file appeals with the Board where the MAC has not issued a final determination "no later than 180 days after the expiration of the 12 month period for issuance of the intermediary determination." 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[6] 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—
>
> (A)(ii) is dissatisfied with the final determination of the Secretary as to the amount of payment under subsection (b) or (d) of section 1886,
>
> (B) has not received such final determination from such intermediary on a timely basis after filing such [cost] report, were such report *complied with the rules and regulations of the Secretary relating to such report*[7] . . .
>
> *********
>
> (3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination, or with respect to appeals

[5] MACs are also known as Intermediaries.
[6] Codified as 42 U.S.C. § 1395ww.
[7] (Emphasis added).

> pursuant to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.
>
> (b) The provisions of subsection (a) shall apply to any group of providers of services if each provider of services in such group would upon the filing of an appeal (but without regard to the $10,000 limitation), be entitled to such a hearing, but only if the matters in controversy involve a common question of fact or interpretation of law or regulations and the amount in controversy is, in the aggregate, $50,000 or more.[8]

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—
>
> (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)).[9]

This confirms that the general right to hearing at the beginning of the new subsection (a) necessarily encompasses claims for both reasonable cost reimbursement and reimbursement under IPPS. Significantly, the general right to hearing in the new subsection (a) relates to "an intermediary or Secretary *determination.*"[10] The definition of "determination" as used therein is

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[8] *See also* 42 C.F.R. § 405.1837(a)(3) (the amount in controversy for a group appeal must be $50,000 or more).
[9] (Emphasis added)
[10] (Emphasis added.)

defined in 42 C.F.R. § 405.1801. Significantly, the § 405.1801 definition of "determination" has included determinations for both reasonable cost reimbursement and reimbursement under IPPS since September 1983 when CMS revised its regulations to implement IPPS.[11] Indeed, the Board's review of the regulatory history of § 405.1835 suggests that the May 23, 2008 changes simply update and expand the § 405.1835 right to hearing to include any IPPS reimbursement issues that are part of the normal cost report audit, settlement and appeals process as reflected by the historical application of such process.

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.

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 the Provider Reimbursement Manual (PRM) (CMS Pub. 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*

[11] *See* 42 C.F.R. § 405.1835 (editions dated Oct. 1, 1983, Oct. 1, 2007, Oct. 1, 2010).

> *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).[12]

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 policy, the provider must claim the items as self-disallowed costs "by following the applicable procedures for filing a cost report under protest."

In the preamble to the final rule published on May 23, 2008 ("2008 Final Rule"),[13] the Secretary explained that he believed that requirement to follow the procedures for filing cost reports under protest was appropriate under the decision in *Bethesda Hospital Association v. Bowen.*[14] In *Bethesda*, the providers were dissatisfied with malpractice reimbursement and did not file a claim for the additional reimbursement on their cost report nor did they file a statement with the cost report challenging the validity of the regulation. Hence, there was no final determination with respect to malpractice costs. The Court rejected the Secretary's argument that 42 U.S.C. § 1395oo(a)(1)(A)(i), which requires dissatisfaction with a final determination of the intermediary, "necessarily incorporates an exhaustion requirement." The Court found that this "strained interpretation" of the statutory dissatisfaction requirement was inconsistent with the express language of the statute.[15] However, the Court agreed, that under § 1395oo(a)(1)(A)(i), a provider's dissatisfaction with the amount of its total reimbursement is a condition of the Board's jurisdiction, but held that "it is clear, however, that the submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations. No statute or regulation expressly mandates that a challenge to the validity of a regulation be submitted first to the intermediary. . . . Thus, [the providers in *Bethesda]* stand on different ground than do providers who bypass clearly prescribed exhaustion requirements or who fail to request from the intermediary reimbursement for costs to which they are entitled under the applicable rules. While such defaults might well establish that a provider was satisfied with the amounts requested in its cost report and awarded by the intermediary, those circumstances are not presented here."[16] The Secretary noted that the Court recognized that an exhaustion requirement could be imposed by regulation, and that a provider who fails to claim all costs to which it is entitled may fail to meet the jurisdictional prerequisite of dissatisfaction.[17] In

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[12] (Emphasis added).
[13] 73 Fed. Reg. 30190 (May 23, 2008).
[14] 485 U.S. 399 (1988).
[15] 73 Fed. Reg. at 30196 citing *Bethesda* at 404.
[16] *Id.* at 404-405.
[17] *Id.*

light of the ability to enact such regulations, 42 C.F.R. § 405.1835(a)(1)(ii) was promulgated, requiring providers to claim all items for which they seek additional reimbursement.

The Secretary went on to state that "[a]lthough there may be nothing in the statute indicating that dissatisfaction must be expressed with respect to "each claim," there also is nothing in the statute indicating that the Secretary cannot interpret the dissatisfaction requirement in this manner."[18] The final determination, which here is the NPR, is not just the total amount of program reimbursement. Rather, it is composed of many individual calculations representing the various items for which a provider seeks payment. Providers generally challenge discrete reimbursement items. Thus, dissatisfaction with total reimbursement is based on dissatisfaction with items that result in total reimbursement. Consequently the Secretary believes it is reasonable under 42 U.S.C. § 1395oo(a) to require dissatisfaction be shown with respect to each issue being appealed.[19] In light of this and the requirements of the regulation, the challenge to the outlier regulations must be claimed as a protested item and the Providers failed to comply with this requirement.

In the preamble, the Secretary also confirmed 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.[20]

For purposes of IPPS providers, filing a cost report under protest is achieved by entering such costs on Worksheet E, Part A, Line 75 of the cost report. In this regard, PRM 15-2 § 4030.1 requires that IPPS providers:

> Enter the program reimbursement effect of the protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process (See [PRM] 15-2

[18] 73 Fed. Reg. at 30197.
[19] *Id.*
[20] *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.

> Chapter 1, § 115.2). Attach a schedule showing the details and computations for this line.

The Board notes that 42 C.F.R. § 405.1803(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, in 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. . . .**
>
> (3) 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.

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.[21]

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 405.1803(d) respectively, are an integral part of the cost reporting process established under 42 U.S.C. § 1395g(a) that the provider must "furnish[ ] such information as the Secretary may request in order to determine the amounts due such provider."

For the Providers on the attached Schedule of Providers, there is no amount claimed on Worksheet E, Part A, Line 75 of the cost reports at issue as required to protest the amount of outlier reimbursement pursuant to § 405.1835(a)(1)(ii).[22] As these cost reports involve a fiscal

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[21] 73 Fed. Reg. at 30199.
[22] *See May 20, 2014 Schedule of Providers, Tab D for each Provider.*

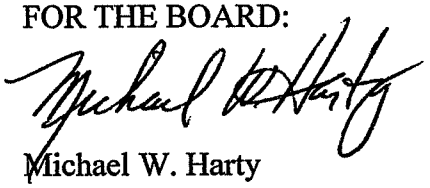
year that end on or after December 31, 2008, self-disallowed items such as the outlier reimbursement at issue must have been filed under protest in order to have "complied with the rules and regulations of the Secretary relating to such [cost] report" and, thereby, established one of the elements for Board jurisdiction under 42 U.S.C. § 1395oo(a)(1). 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 appeals of the Providers on the attached Schedule of Providers and hereby dismisses the Providers from case. Since there are no remaining Providers in the appeal, 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 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 Service Options (w/Schedule of Providers)
Kevin Shanklin, BCBSA (w/Schedule of Providers)

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Refer to:

14-0804GC
CERTIFIED MAIL

JUN 13 2014

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

RE: Patton Boggs/Banner Health 2011 Medicare Outlier Group
Provider Nos. Various
FYE 12/31/2011
PRRB Case No. 14-0804GC

Dear Mr. Nash:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' May 19, 2014 request for expedited judicial review (EJR) (received May 20, 2014) in the above-referenced appeal. The Board finds that EJR is appropriate for the Providers on the enclosed Schedule of Providers.

Issue

The Providers in this case assert that they have not been paid the full amount of supplemental Medicare outlier payments to which they are entitled under 42 U.S.C. § 1395ww(d)(5)(A)(i)-(iv) and (d)(3)(B). The Providers request that the Board grant their request for EJR with respect to the following legal question:

> Whether the specific regulations governing Outlier Case Payments as set forth in the two regulatory sources—the Outlier Payment Regulations[1] and the fixed loss threshold ("FLT") Regulations[2] (collectively, the "Medicare Outlier Regulations")—as promulgated by the Secretary of Health and Human Services ("HHS" or the "Secretary") and the Centers for Medicare [&] Medicaid Services ("CMS"), and as in effect for the appealed years, are contrary to the Outlier Statute and/or are otherwise substantively or procedurally invalid?

[1] See Providers' May 19, 2014 EJR request, Page 2, n. 2.
[2] *Id.* at n. 3.

Providers' Request for EJR

The Providers explain that hospitals are paid for services to Medicare patients under the inpatient prospective payment system (IPPS)[3] under which inpatient operating costs are reimbursed based on a prospectively determined formula. The IPPS legislation contains a number of provisions that provide for additional payment based on specific factors. This case involves one of those factors: outlier payments. Outlier payments are made for patients whose hospitalization is either extraordinarily costly or lengthy.[4] Outlier payments are made from the "outlier pool," which is a regulatory set-aside or subset of the Medicare Part A Trust Fund, maintained by the government to pay for outlier cases. The outlier pool is, in effect, funded by a 5-6 percent reduction in IPPS payments to acute care hospitals.[5] Prior to the start of each fiscal year, the Secretary establishes a FLT beyond which hospitals will qualify for outlier payments at levels that are between 5-6 percent of DRG[6] payments.[7]

The Providers note that beginning in 1997 through 2003, a number of hospitals were reported to have inflated their charge masters an action which the Department of Justice (DOJ) termed "turbo-charging." This practice greatly inflated cost to charge ratios which greatly increased the cost per case. DOJ termed this action a false claim and this also resulted in the Secretary greatly increasing the FLT so that payments for outliers would remain at 5-6 percent of DRG payments. More specifically, beginning in or around Federal fiscal year (FFY) 1998, the Secretary began making upward adjustments to the FLTs which were in excess of the rate of inflationary indices routinely used such as the CPI-Medical Index or the Medicare Market Basket.

In 2002, the Secretary disclosed that he was aware of "turbo-charging" and that would be amending the outlier regulations to fix "vulnerabilities" in the regulations. In the March 5[8] and June 9, 2003[9] Federal Registers, the Secretary acknowledged three flaws in the outlier payment regulations and stated that the vulnerabilities would be fixed. The Providers maintain that the data used to correct the vulnerabilities had always been available and should have been used to calculate outlier reimbursement. The Providers noted that the Secretary stated that he believed that there was the authority to revise the outlier threshold given the manipulation of the outlier policy. However, he elected not

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[3] *See* U.S.C. 42 § 1395ww(d)(5).
[4] Providers' May 19, 2014 EJR request at 3.
[5] *Id.* at 4 n. 9, 42 U.S.C. § 1395ww(d)(3)(B) (Reducing for the Value of Outlier Payments).
[6] Diagnostic Related Group.
[7] Providers' May 19, 2014 EJR request at 4.
[8] 68 Fed. Reg. 10,420, 10,423 (March 5, 2003) (Recent analysis indicates that some hospitals have taken advantage of two vulnerabilities in our methodology to maximize their outlier payments . . . [1] the time lag between the current charges on a submitted bill and the cost–to-charge ratio taken from the most recently settled cost report and [2] in some cases hospitals may increase their charges far above cost that their cost-to-charge ratios fall below 3 standard deviations from the geometric mean of cost-to-charge ratios and a higher statewide average cost-to-charge ratio is applied.)
[9] 68 Fed. Reg. 34,494, 34,501 (June 9, 2003) ([3] even though final payment would reflect a hospital's true cost experience, there would still be the opportunity for a hospital to manipulate its outlier payments by dramatically increasing charges during the year in the discharge occurs. Here, the hospital would receive excessive outlier payments, which, although the hospital would incur an overpayment and have to refund the money when the cost report is settled, this would allow the hospital to obtain excess payments from the Medicare Trust fund on a short-term basis.)

to exercise this authority because of the short amount of time remaining in the FFY. The Providers allege that the Secretary was aware of the problem months before the final rule was published as demonstrated by Provider Exhibit 9, a copy of an Interim Final Rule submitted to the Office of Management and Budget on February 13, 2003.[10] As noted by the Providers,[11] the D.C. District Court in *Banner Health v. Sebelius*, 2013 U.S. Dist. Lexis 69889 (D.D.C. May 16, 2013) noted that the February 13, 2013 proposed rule was virtually identical to the final proposed rule with the exception that the later proposed rule published on March 5, 2013 did not recommend reduction of the FLT and the supporting analysis.

The Providers state that they did not learn of the February 13, 2003 unpublished, interim final rule until their counsel obtained it through a Freedom of Information Act request made to the Office of Management and Budget in 2012. They believe the document is still relevant because the Secretary has not accounted for the impact of the "turbo charging" data, and is, allegedly, still relying on inflated data to calculate outlier reimbursement. As a result, the Providers do not receive the full amount of outlier reimbursement to which they are entitled. Further, in the June 12, 2012 Office of Inspector General (OIG) report, the Inspector General noted that seven years after the 2003 publication of the regulation requiring reconciliation of outlier payments, CMS had not reconciled any of the cost reports screened and reported by Medicare Administrative Contractors (MACs).[12] In a later, 2013 report,[13] OIG noted that although nearly all hospitals receive outlier payments, a small percentage of hospitals receive a significantly higher proportion of payments. The hospitals receiving this higher portion of payments charged Medicare more for the same Medical Severity-Diagnostic Related Groups (MS-DRGs), yet had similar lengths of stay and cost-to-charge ratios. The Providers contend that this is another example of CMS' failure to correct the distribution of outlier payments.[14]

The Providers assert that the FLT, established by the FLT regulations, are invalid for numerous reasons including, but not limited to:

1) The FLTs, established by the FLT regulations, are substantively invalid because, both as written and implemented, they represent agency action that exceeded statutory authority and frustrated the intent of Congress as reflected in the Outlier Statute.

2) Further, under well-settled principles of judicial review of agency action, an agency action is arbitrary and capricious if it:

---

[10] The Providers furnished no evidence that this document was ever published in the Federal Register.
[11] Providers' May 19, 2014 EJR request at 7, n. 15.
[12] *Id.* Ex. 10, OIG Report: The Centers for Medicare & Medicaid Services Did Not Reconcile Medicare Outlier Payments in Accordance with Federal Regulations and Guidance, Report A-07-10-02764 at 7-9 (June 2012).
[13] *Id.* Ex. 11 Medicare Hospital Outlier Payments Warrant Increased Scrutiny, Report OEI-06-10-00520 (November 2013). (incomplete document)
[14] *Id.* at 13.

a) fails to use the best data available for its action and/or does not adequately explain why it is not using such data;

b) fails to consider one or more important aspects of the problems(s); and/or

c) offers explanations for its decisions that run counter to the evidence.[15]

Decision of the Board

The Board has reviewed the submissions of the Providers pertaining to the requests for hearing and expedited judicial review. 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permit expedited judicial 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 Providers are challenging the validity of the outlier regulations, 42 C.F.R. §§ 412.80 through 412.86.[16] The Intermediaries did not oppose the request for EJR. The documentation shows that in each case the estimated amount in controversy exceeds $50,000 threshold for Board jurisdiction over group appeals, the appeals were timely filed. The Providers protested their outlier payments on Worksheet E, Part A, Line 75 as required by 42 C.F.R. § 405.1835(a)(1)(ii).

The Board finds that:

1) it has jurisdiction over the matter for the subject years and the Providers are entitled to a hearing before the Board;

2) based upon the Providers' assertions regarding the outlier regulations, 42 C.F.R. §§ 412.80-412.86, 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 outlier regulations, are valid.

Accordingly, the Board finds that the outlier issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for expedited judicial review for the issue and the subject years. The Providers have 60 days from

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[15] *Id.* at 15-24.

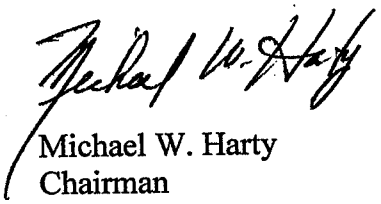
[16] *Id.* at 2 n. 2 (The Outlier Payment Regulations are the base regulations that establish the method for calculating a hospital's imputed costs for a patient case, which are set forth at 42 C.F.R. §§ 412.80 through 412.86. The Payment Regulations were first enacted in 1985 and have been revised periodically over the years . . . .)

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 cases.

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)(1), Schedule of Providers

cc: Byron Lamprecht, WPS (w/Schedules of Providers)
Kevin Shanklin, BCBSA (w/Schedules of Providers)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
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:
14-0804GC
Certified Mail

JUN 13 2014

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

RE: # 1 Banner Baywood Heart Hospital, Provider No. 03-0105, FYE 12/31/11
3 Banner Desert Medical Center, Provider No. 03-0065, FYE 12/31/11
11 Banner Boswell Medical Center, Provider No. 03-0061, FYE 12/31/11
as participants in the
Patton Boggs/Banner Health, 2011 Medicare Outlier Group, PRRB Case No. 14-0804GC

Dear Mr. Nash:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' May 19, 2014 request for expedited judicial review (EJR) (received May 20, 2014) and the accompanying Schedule of Providers and associated jurisdictional documentation. The Board's determination with respect to the above-referenced Providers' request for EJR and jurisdiction over the Providers is set forth below.

Background

Banner Baywood Heart Hospital, Banner Desert Medical Center and Banner Boswell Medical Center, all filed appeals under the provisions of 42 C.F.R. § 405.1835(a)(3)(ii). This regulation permits providers to file appeals with the Board where "the intermediary determination is not issued . . . within 12 months of the date of receipt by the intermediary of the provider's perfected cost report . . . ."

Through e-mail dated June 4, 2014, the Board contacted the Intermediaries[1] involved with this group appeal and asked them to determine if any of the participants in this group appeal had received a final determination for the fiscal year end 2011. The Intermediaries responded and indicated that Banner Baywood Heart Hospital was issued a Notice of Program Reimbursement (NPR) on April 25, 2014; Banner Desert Medical Center was issued an NPR on February 14, 2014; and Banner Boswell Medical Center was issued an NPR on February 12, 2014. *See* screen shots from CMS' System for Tracking Audit and Reimbursement (STAR), attached.

[1] The Group Representative was copied on this e-mail.

Decision of the Board

The appeals of Banner Baywood Heart Hospital (provider number 03-0105), Banner Desert Medical Center (provider number 03-0065) and Banner Boswell Medical Center (provider number 03-0061) were based on the Intermediary's the failure to issue NPRs. Subsequent to filing the initial appeal, the Providers' NPRs were issued on April 25, 2014, February 14, 2014 and February 12, 2014, respectively. The Board finds that Intermediary's issuance of the NPRs for FYE 2011 mooted the failure to issue a final determination. Since the Providers' appeals are moot, the Board concludes that it lacks jurisdiction over the appeals and hereby dismisses the Provider's from the case. Since the Board lacks jurisdiction over the Providers' appeals, the Providers' request for EJR is denied. *See* 42 C.F.R. § 405.1842(a).

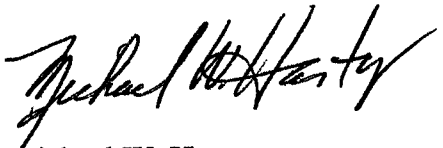
Since the Providers' NPRs were issued on April 25, 2014, February 14, 2014 and February 12, 2014, as of the date of this letter, they are within the 180-day appeal period. If the Providers so choose, they may file appeals of their respective NPRs.

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,
STAR screen shots for Banner Baywood Heart Hospital, Banner Desert Medical Center & Banner Boswell Medical Center

cc: Byron Lamprecht, WPS (w/Enclosures)
Kevin Shanklin, BCBSA (w/Enclosures)

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Refer to:

14-0803GC
CERTIFIED MAIL

JUN 13 2014

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

RE: Patton Boggs/Allina Health 2011 Medicare Outlier Group
Provider Nos. Various
FYE 12/31/2011
PRRB Case No. 14-0803GC

Dear Mr. Nash:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' May 19, 2014 request for expedited judicial review (EJR) (received May 20, 2014) in the above-referenced appeal. The Board finds that EJR is appropriate for the Providers on the enclosed Schedule of Providers.

Issue

The Providers in this case assert that they have not been paid the full amount of supplemental Medicare outlier payments to which they are entitled under 42 U.S.C. § 1395ww(d)(5)(A)(i)-(iv) and (d)(3)(B). The Providers request that the Board grant their request for EJR with respect to the following legal question:

> Whether the specific regulations governing Outlier Case Payments as set forth in the two regulatory sources—the Outlier Payment Regulations[1] and the fixed loss threshold ("FLT") Regulations[2] (collectively, the "Medicare Outlier Regulations")—as promulgated by the Secretary of Health and Human Services ("HHS" or the "Secretary") and the Centers for Medicare [&] Medicaid Services ("CMS"), and as in effect for the appealed years, are contrary to the Outlier Statute and/or are otherwise substantively or procedurally invalid?

[1] See Providers' May 19, 2014 EJR request, Page 2, n. 2.
[2] *Id.* at n. 3.

Providers' Request for EJR

The Providers explain that hospitals are paid for services to Medicare patients under the inpatient prospective payment system (IPPS)[3] under which inpatient operating costs are reimbursed based on a prospectively determined formula. The IPPS legislation contains a number of provisions that provide for additional payment based on specific factors. This case involves one of those factors: outlier payments. Outlier payments are made for patients whose hospitalization is either extraordinarily costly or lengthy.[4] Outlier payments are made from the "outlier pool," which is a regulatory set-aside or subset of the Medicare Part A Trust Fund, maintained by the government to pay for outlier cases. The outlier pool is, in effect, funded by a 5-6 percent reduction in IPPS payments to acute care hospitals.[5] Prior to the start of each fiscal year, the Secretary establishes a FLT beyond which hospitals will qualify for outlier payments at levels that are between 5-6 percent of DRG[6] payments.[7]

The Providers note that beginning in 1997 through 2003, a number of hospitals were reported to have inflated their charge masters an action which the Department of Justice (DOJ) termed "turbo-charging." This practice greatly inflated cost to charge ratios which greatly increased the cost per case. DOJ termed this action a false claim and this also resulted in the Secretary greatly increasing the FLT so that payments for outliers would remain at 5-6 percent of DRG payments. More specifically, beginning in or around Federal fiscal year (FFY) 1998, the Secretary began making upward adjustments to the FLTs which were in excess of the rate of inflationary indices routinely used such as the CPI-Medical Index or the Medicare Market Basket.

In 2002, the Secretary disclosed that he was aware of "turbo-charging" and that would be amending the outlier regulations to fix "vulnerabilities" in the regulations. In the March 5[8] and June 9, 2003[9] Federal Registers, the Secretary acknowledged three flaws in the outlier payment regulations and stated that the vulnerabilities would be fixed. The Providers maintain that the data used to correct the vulnerabilities had always been available and should have been used to calculate outlier reimbursement. The Providers noted that the Secretary stated that he believed that there was the authority to revise the outlier threshold given the manipulation of the outlier policy. However, he elected not

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[3] *See* U.S.C. 42 § 1395ww(d)(5).
[4] Providers' May 19, 2014 EJR request at 3.
[5] *Id.* at 4 n. 9, 42 U.S.C. § 1395ww(d)(3)(B) (Reducing for the Value of Outlier Payments).
[6] Diagnostic Related Group.
[7] Providers' May 19, 2014 EJR request at 4.
[8] 68 Fed. Reg. 10,420, 10,423 (March 5, 2003) (Recent analysis indicates that some hospitals have taken advantage of two vulnerabilities in our methodology to maximize their outlier payments . . . [1] the time lag between the current charges on a submitted bill and the cost–to-charge ratio taken from the most recently settled cost report and [2] in some cases hospitals may increase their charges far above cost that their cost-to-charge ratios fall below 3 standard deviations from the geometric mean of cost-to-charge ratios and a higher statewide average cost-to-charge ratio is applied.)
[9] 68 Fed. Reg. 34,494, 34,501 (June 9, 2003) ([3] even though final payment would reflect a hospital's true cost experience, there would still be the opportunity for a hospital to manipulate its outlier payments by dramatically increasing charges during the year in the discharge occurs. Here, the hospital would receive excessive outlier payments, which, although the hospital would incur an overpayment and have to refund the money when the cost report is settled, this would allow the hospital to obtain excess payments from the Medicare Trust fund on a short-term basis.)

to exercise this authority because of the short amount of time remaining in the FFY. The Providers allege that the Secretary was aware of the problem months before the final rule was published as demonstrated by Provider Exhibit 9, a copy of an Interim Final Rule submitted to the Office of Management and Budget on February 13, 2003.[10] As noted by the Providers,[11] the D.C. District Court in *Banner Health v. Sebelius*, 2013 U.S. Dist. Lexis 69889 (D.D.C. May 16, 2013) noted that the February 13, 2013 proposed rule was virtually identical to the final proposed rule with the exception that the later proposed rule published on March 5, 2013 did not recommend reduction of the FLT and the supporting analysis.

The Providers state that they did not learn of the February 13, 2003 unpublished, interim final rule until their counsel obtained it through a Freedom of Information Act request made to the Office of Management and Budget in 2012. They believe the document is still relevant because the Secretary has not accounted for the impact of the "turbo charging" data, and is, allegedly, still relying on inflated data to calculate outlier reimbursement. As a result, the Providers do not receive the full amount of outlier reimbursement to which they are entitled. Further, in the June 12, 2012 Office of Inspector General (OIG) report, the Inspector General noted that seven years after the 2003 publication of the regulation requiring reconciliation of outlier payments, CMS had not reconciled any of the cost reports screened and reported by Medicare Administrative Contractors (MACs).[12] In a later, 2013 report,[13] OIG noted that although nearly all hospitals receive outlier payments, a small percentage of hospitals receive a significantly higher proportion of payments. The hospitals receiving this higher portion of payments charged Medicare more for the same Medical Severity-Diagnostic Related Groups (MS-DRGs), yet had similar lengths of stay and cost-to-charge ratios. The Providers contend that this is another example of CMS' failure to correct the distribution of outlier payments.[14]

The Providers assert that the FLT, established by the FLT regulations, are invalid for numerous reasons including, but not limited to:

1) The FLTs, established by the FLT regulations, are substantively invalid because, both as written and implemented, they represent agency action that exceeded statutory authority and frustrated the intent of Congress as reflected in the Outlier Statute.

2) Further, under well-settled principles of judicial review of agency action, an agency action is arbitrary and capricious if it:

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a) fails to use the best data available for its action and/or does not adequately explain why it is not using such data;

b) fails to consider one or more important aspects of the problems(s); and/or

c) offers explanations for its decisions that run counter to the evidence.[15]

Decision of the Board

The Board has reviewed the submissions of the Providers pertaining to the requests for hearing and expedited judicial review. 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permit expedited judicial 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 Providers are challenging the validity of the outlier regulations, 42 C.F.R. §§ 412.80 through 412.86.[16] The Intermediaries did not oppose the request for EJR. The documentation shows that in each case the estimated amount in controversy exceeds $50,000 threshold for Board jurisdiction over group appeals, the appeals were timely filed. The Providers protested their outlier payments on Worksheet E, Part A, Line 75 as required by 42 C.F.R. § 405.1835(a)(1)(ii).

The Board finds that:

1) it has jurisdiction over the matter for the subject years and the Providers are entitled to a hearing before the Board;

2) based upon the Providers' assertions regarding the outlier regulations, 42 C.F.R. §§ 412.80-412.86, 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 outlier regulations, are valid.

Accordingly, the Board finds that the outlier issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for expedited judicial review for the issue and the subject years. The Providers have 60 days from

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[15] *Id.* at 15-24.

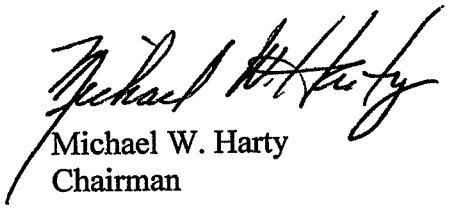
[16] *Id.* at 2 n. 2 (The Outlier Payment Regulations are the base regulations that establish the method for calculating a hospital's imputed costs for a patient case, which are set forth at 42 C.F.R. §§ 412.80 through 412.86. The Payment Regulations were first enacted in 1985 and have been revised periodically over the years . . . .)

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 cases.

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)(1), Schedule of Providers

cc: Danene Hartley, NGS (w/Schedules of Providers)
Kevin Shanklin, BCBSA (w/Schedules of Providers)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to:

JUN 16 2014

CERTIFIED MAIL

Memorial Healthcare System
Mike Parr, CPA
Assistant Director of Reimbursement
3501 Johnson Street
Hollywood, FL 33021

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

RE: Memorial Regional Hospital, Provider No. 10-0038, FYE 04/30/2007
As a Participant in the MHS 2008 Labor Room Days CIRP, Case No. 10-0493GC

Dear Mr. Parr and Mr. Pike:

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

Pertinent Facts:

On January 22, 2010, Memorial Hospital Miramar (10-0285) for FYE 4/30/2008 requested the formation of the MHS 2008 Labor Room Days CIRP Group.[1] The Notice of Program Reimbursement for this Provider was issued on July 28, 2009. The Schedule of Providers included with the appeal request listed three participants that would potentially be participating in the group. The jurisdictional documentation submitted with the appeal request was for Memorial Hospital Miramar only.

On June 29, 2010, Memorial Regional Hospital (10-0038) requested a hearing for FYE 4/30/2007 from an NPR dated September 11, 2009. In the appeal request the Provider indicated that it was the second provider of a related party group which was previously filed on January 22, 2010.[2]

Board Determination:

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

[1] The group appeal request was received by the Board on January 25, 2010.
[2] The appeal request (to be added to case no. 10-0493G) was received by the Board on June 30, 2010.

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.[3]

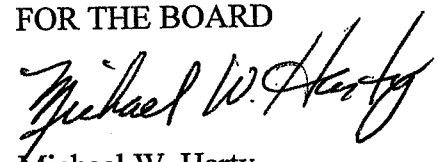
The Board received the request for hearing from Memorial Regional Hospital on June 30, 2010. Pursuant to 42 C.F.R. § 405.1801(a)(1)(iii), the Notice of Program Reimbursement (NPR) is presumed to have been received 5 days after the date of issuance by the intermediary. In this case, the NPR for Memorial Regional Hospital is dated September 11, 2009. The appeal request for Memorial Regional Hospital was received (filed) 287 days after the date of receipt of the NPR; not within 180 days of the date of receipt, as required by 42 C.F.R. § 405.1835. Therefore, it was not timely filed. The Board lacks jurisdiction to grant a hearing on the matter at issue in the appeal for this provider. Consequently, the Board hereby dismisses Memorial Regional Hospital from 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.

Enclosed please find the Board's Standard Remand of Labor/Delivery Room Inpatient Days Under CMS Ruling CMS1498-R for the remaining participant in the group appeal.[4]

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
Standard Remand of Labor/Delivery Room Inpatient Days Under CMS Ruling CMS1498-R
Schedule of Providers

cc: Blue Cross Blue Shield Association
Kevin D. Shanklin, Executive Director
Senior Government Initiatives
225 North Michigan Avenue
Chicago, IL 60601-7680

[3] See, 42 C.F.R. § 405.1835(a)(3) (2009) (A provider has a right to a hearing before the Board if, among other things, the Board receives the provider's hearing request within 180 days of the date of receipt of the intermediary's [final] determination by the provider.)

[4] See Board Alert 7 (Group appeals, including CIRPs, may be remanded even if the group is incomplete.)

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Refer to:

CERTIFIED MAIL

JUN 16 2014

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

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

RE: Jurisdiction Determination for Staten Island University Hospital (33-0160)
FYE 1997 (participant #5) and FYE 1994 (participant #8)
As participants in the East Coast 1991-2004 SSI/DSH Group
PRRB Case No.: 03-1320G

Dear Mr. Roth and Mr. Browning:

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

Background

The Providers filed an initial request for a group appeal on June 17, 2003[1]. This is a group appeal with one issue, SSI percentage, covered under Ruling 1498-R. The Intermediary did not file a jurisdictional challenge in this group appeal. However, on November 28, 2012, the Board sent a letter to the Providers' Representative requesting additional jurisdictional documentation pertaining to the revised Notices of Program Reimbursement (RNPR) for the subject providers. The Providers' Representative responded to the Board's request on December 26, 2012.

Board's Decision

The Board finds that it does not have jurisdiction over Staten Island University Hospital (33-0160) for FYEs 1994 and 1997 because this Provider is appealing from RNPRs 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

[1] The request for a group appeal was received by the Board on June 18, 2003.

> 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).

The version of 42 C.F.R. § 405.1889 in effect prior to the August 2008 rule change 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 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.

With regard to Staten Island University Hospital's FYE 1997 (participant #5), the RNPR indicates that it was issued to include eligible days as prescribed by Ruling 97-2 and CMS Transmittal No. A-99-62. There is no mention of updating the SSI percentage in the RNPR.

Staten Island University Hospital also appealed FYE 1994 (participant #8) from a RNPR. The information provided by the Representative in response to the Board's request for this participant indicate that the litigation precipitating the reopening order, the RNPR, the audit adjustment report, and a fax cover sheet all refer to the reason for and nature of the revision as being related to Ruling 97-2 and paid/non-paid days versus eligible days. There is no mention of updating the SSI percentage.[2]

Because appeals from RNPRs are limited to the specific matters revised in the revised determination the Board finds that it does not have jurisdiction over the subject Provider's RNPR appeals for FYEs 1994 and 1997 because there was no evidence that SSI percentage was actually adjusted.

As the Board lacks jurisdiction over Staten Island University Hospital's (33-0160) appeals from its RNPRs for FYEs 1994 and 1997, participant #s 5 and 8 are dismissed 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.

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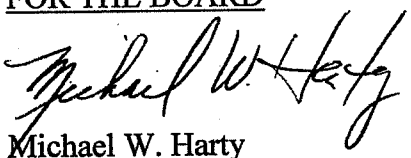
[2] Hooper Lundy & Bookman's 12/21/2012 letter "Response to Request for Documents Relating to Staten Island University Hospital"

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

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: Standard Remand of the SSI fraction under CMS Ruling CMS-1498-R
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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JUN 20 2014

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RE: Request for Expedited Judicial Review
McKay Consulting/Duane Morris DSH SSI Group Appeals
PRRB Case Nos.: Various-List Attached

Dear Mr. McKay and Ms. Erde:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' May 21, 2014 Request for Expedited Judicial Review (EJR) (received May 22, 2014). Set forth below is the Board's decision finding that EJR is not appropriate.

ISSUE:

Should the Provider Reimbursement Review Board grant the Providers' request for EJR over the validity of the provisions of the Centers for Medicare & Medicaid Services (CMS) Ruling 1498-R (Ruling), which if valid, render moot and deny jurisdiction over these appeals of the disproportionate share adjustment (DSH) supplemental security income (SSI) issue?

MEDICARE STATUTORY AND REGULATORY BACKGROUND

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

Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. Those cost reports show the costs incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. § 405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Board if it meets the following conditions: (1) The provider must be dissatisfied with the final determination of the intermediary; (2) the amount in

controversy must exceed $10,000 for an individual appeal (or $50,000 for groups); and (3) the appeal must be filed with the Board within 180 days of the receipt of the final determination. 42 U.S.C. §1395oo(a); 42 C.F.R. §§ 405.1835-405.1837.

The Medicare statute at 42 U.S.C. §1395oo(f)(1) and the regulations at 42 C.F.R. §405.1842(f)(1), require the Board to grant EJR if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling.

Medicare Disproportionate Share Hospital (DSH) Payment

Part A of the Medicare Act covers "inpatient hospital services." 42 U.S.C. § 1395d(a)(1). Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system (PPS). 42 U.S.C. §§ 1395ww(d)(1)-(5); 42 C.F.R. § 412. Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments. *Id.*

One of the PPS payment adjustments is the DSH payment adjustment. The Secretary is required to provide increased PPS reimbursement to hospitals that serve a "significantly disproportionate number of low-income patients." 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106. Whether a hospital qualifies for the DSH adjustment and how large an adjustment it receives depends on the hospital's "disproportionate patient percentage" (DPP). 42 U.S.C. §1395ww(d)(5)(F)(v).

The DPP is defined as the sum of two fractions expressed as a percentage. 42 U.S.C. §1395ww(d)(5)(F)(vi). Both of these fractions look, in part, to whether or not the hospital's patients for such days claimed during the particular cost reporting period were "entitled to benefits" under Medicare Part A.

The first fraction used to compute the DSH payment is commonly known as the Medicare fraction. It is also referred to as the SSI fraction because the numerator is determined by the number of patient days for which the patient was entitled to SSI. The statute defines the SSI fraction as:

> (I) 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) (emphasis added).

The SSI fraction is computed annually by CMS, and the Medicare fiscal intermediaries are required to use CMS's calculation to compute a hospital's DSH payment adjustment. 42 C.F.R. § 412.106(b)(2)-(3).

The second fraction used to compute the DSH payment is the Medicaid fraction, defined as:

> (II) 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 of this chapter, 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) (emphasis added).

According to CMS' regulation, "[t]he 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." 42 C.F.R. §412.106(b)(4).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The underlying issue in dispute in these cases involves the proper amount of Medicare reimbursement due the Providers of medical services. The Providers in these group appeals are challenging CMS' calculation of the Medicare Part A/SSI fraction used to determine the Providers' eligibility for, and the amount of, the Medicare DSH payment. The contested issue in each of these group appeals is the SSI "data matching process" issue.

The Providers contend that the Board should grant their request for EJR because the Ruling conflicts with several higher legal authorities that the Board is bound to uphold, including several provisions of the Medicare statute, the Administrative Procedure Act and the DSH regulation in effect for cost reporting periods that began before October 1, 2004.

The Providers maintain that the recalculation of the SSI fractions pursuant to the Ruling would deviate from the court's decision in *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20, amended by 587 F. Supp. 2d 37 (D.D.C. 2008), the process the agency used to implement the court's decision and the Secretary's representations to the court in that case in one significant respect involving the *second issue* covered by the Ruling.[1] The Providers argue specifically, the Ruling requires CMS to include in the revised SSI fractions the hospital patient days for all patients who

[1] The Ruling applies to three issues in jurisdictionally proper pending appeals concerning the calculation of the Medicare DSH payment: 1) the "data matching process" used to calculate the SSI fraction; 2.) certain "non-covered" days for cost reporting periods with patient discharges before October 1, 2004; and 3.) labor and delivery days for cost reporting periods beginning before October 1, 2009.

were enrolled in Medicare part A, regardless of whether Medicare Part A benefits were paid for those patient days. This would include non-covered patient days such as those attributable to individuals who were enrolled in Medicare Part A but had exhausted Part A benefits for inpatient hospital services ("Part A exhausted benefit days") and days that were not paid by Medicare Part A because Medicare's payment liability was secondary to another payor's primary liability ("Medicare secondary payor" "MSP days"). The Providers contend the court's decision in *Baystate*, however, did not hold that Part A exhausted benefit days and MSP days should be counted in the SSI fraction. Quite to the contrary, the Secretary in that case conceded that exhausted benefit days and Medicare secondary payor days not paid under Medicare are properly excluded from the SSI fraction for the years in question.[2,3]

The Providers maintain the Ruling does not require remand of pending appeals on Medicare Part C days for patients who were receiving Medicare benefits under Part C of the Medicare statute through enrollment in Medicare+Choice or Medicare Advantage plans. Nevertheless, it appears that CMS contemplates that Part C days would be added to the SSI fractions for some years that would be recalculated on remand pursuant to the Ruling. The Ruling itself defines the SSI fraction to include days for patients "who are enrolled in a Medicare Advantage (Part C) plan."[4] The Ruling also notes that Part C days will be included in the SSI fraction "only if the individual is enrolled in Part A or Part C and the hospital has submitted a Medicare claim on behalf of the patient."[5] The Providers contend any inclusion of Part C days in the SSI fraction violates the regulation applicable to the periods at issue, which called for the inclusion only of covered Part A days in the SSI fraction.[6]

The Providers argue CMS, when interpreting the regulation through publication and transmission of the SSI fractions to its contractors for the periods at issue, explicitly stated that the fractions only included covered part A entitled days.[7] The Providers dispute any determination pursuant to the Ruling to include non-covered days, Part A exhausted benefit days, MSP days, Part C days and any other days for which patients were not entitled to have payment made under Medicare Part A in the SSI fraction. These days are not attributable to patients who were entitled to benefits under Part A for those days. Accordingly, the Providers contend those days must be included in the numerator of the Medicaid fraction and excluded from the SSI fraction used to calculate their Medicare DSH payments.[8]

The Providers maintain that they submitted schedules of providers and supporting documentation showing that they met all the jurisdictional requirements for a hearing under 42 U.S.C. § 1395oo(a). Their claims are not moot. CMS' suggestion that some hospitals might be satisfied with a recalculation performed in exactly the opposite way the hospitals contend it should be calculated is nonsensical and not supported by any evidence or analysis. CMS' determination to add the Part A exhausted benefit days, MSP days and Part C days to the SSI fraction cannot

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[2] 545 F. Supp. 2d at 55 n. 37.
[3] Providers' EJR request at 1-2.
[4] CMS Ruling 1498-R at 3 (April 28, 2010).
[5] *Id.* at 8.
[6] *See* 42 C.F.R. § 412.106(b)(2); 52 Fed. Reg. 16772, 16777 (May 6, 1986).
[7] See, e.g., Transmittal 647, CMS Pub. 100-04, Medicare Claims Processing Manual (Aug. 12, 2005) (FFY 2004); Program Memorandum A-01-109 (Sep. 13, 2001) (FFY 2000).
[8] Providers' EJR Request at 2-3.

rationally be said to render moot the Provider's pending claims to have the SSI fraction calculated correctly.

The Providers contend the remands that the Ruling purports to require would violate at least three separate provisions of the Medicare Act (42 U.S.C. §§ 1395oo(a), 1395ww(d)(5)(F)(vi)(I) and 1395hh), the Administrative Procedures Act ("APA") and the DSH regulation (42 C.F.R. § 412.106(b)) that was in effect before October 1, 2004. The Board is bound constitutionally and otherwise to uphold and obey those higher legal authorities. Unlike the Ruling, the statutory provisions it violates are law, and the DSH regulation it violates has the force and effect of law for periods before October 1, 2004. All of those provisions are higher authorities than the CMS Ruling, and all of them are binding on the Board. Accordingly, the Providers contend the Ruling is invalid.[9]

The Providers argue in accordance with the plain meaning of § 1395ww(d)(5)(F)(vi), Part A exhausted benefit days, MSP days and Part C days must be excluded from the SSI fraction, because these patients were not "entitled to benefits" under Part A for their patient days. The Providers contend the Ruling also violates § 1395hh and the APA's notice and comment rulemaking requirements in 5 U.S.C. § 553. Both statutes prohibit retroactive rulemaking. The Ruling has retroactive effect, at least insofar as it purports to require CMS and the contractor to include Part A exhausted benefit days, MSP days or Part C days in the SSI fraction for periods beginning before October 1, 2004. In this respect, the Ruling applies a new substantive rule for prior cost reporting periods that begin before October 1, 2004.[10] The Providers maintain under the DSH regulation in effect prior to October 1, 2004, 42 C.F.R. § 412.106(b), and the agency's long standing interpretation of that regulation, Part A exhausted benefit days, MSP days and Part C days were not included in the SSI fraction. The CMS administrator himself ruled in 1996 that days billed to and paid by Medicaid after patients had exhausted Medicare Part A benefits, may be included in the numerator of the Medicaid fraction.[11]

The Providers contend CMS' Ruling is an improper attempt on the agency's part to camouflage the reimbursement impact of the corrections to the SSI fractions that the agency is required to make under *Baystate*. The positive impact of the correction of those systemic errors and omissions would be effectively masked by an offsetting penalty imposed by the Ruling. The penalty stems from the Ruling's new retroactive requirement to add to Part A exhausted benefit days, MSP days and/or Part C days, which were not covered or paid under Medicare Part A, to the SSI fraction for the years to which the Ruling would apply. This change was not required by the decision in *Baystate* and it was not made by CMS in the revised SSI fractions that the agency calculated and applied to *Baystate* in June 2009 to implement that decision. CMS' change would have the effect of substantially reducing the SSI fractions.[12]

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[9] *Id.* at 5-6.
[10] *Id.* at 7-8.
[11] *Id.* at 9 citing *Presbyterian Med. Ctr. of Philadelphia v. Aetna Life Ins. Co.*, CMS Adm'r Dec., MEDICARE & MEDICAID GUIDE (CCH) ¶ 45,032 (Nov. 29, 1996).
[12] Providers' EJR Request at 9-10.

DECISION OF THE BOARD

The Medicare statute at 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. §405.1842(f)(1), require the Board to grant EJR if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling.

The Providers in these group appeals appealed the SSI "data matching process" issue in their group appeal requests.[13] Some Providers identified the issue under appeal in their hearing requests as "whether the Centers for Medicare & Medicaid Services ("CMS") has correctly determined the 'SSI percentages' used in calculating the Provider's disproportionate patient percentages for purposes of the DSH adjustment. The Providers contend that the SSI percentages are erroneous because of systemic flaws in the data and match process used by CMS in determining the SSI percentages."[14] Other Providers identified the issue under appeal in their hearing requests as "[w]hether the Intermediary used the correct SSI percentage in calculating the disproportionate share adjustment."[15]

However, when the request for EJR was submitted, the issue for which EJR was requested was over CMS' determination to add Part A exhausted benefit days, MSP days and Part C days to the SSI fraction.[16] The Providers argue:

> [s]pecifically the Ruling (at 7-14 & 29-30) requires CMS to include in the revised SSI fractions the hospital inpatient patient days for all patients who were enrolled in Medicare Part A, regardless of whether Medicare Part A benefits were paid for those patient days. As described in the Ruling, this would include non-covered patient days such as those attributable to individuals who were enrolled in Medicare Part A but had exhausted Part A benefits for inpatient hospital services ('Part A exhausted benefit days') and days that were not paid by Medicare Part A because Medicare's payment liability was secondary to another payor's primary liability ('MSP days'). The court's decision in *Baystate*,

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[13] The Providers conceded in their EJR request that the issue under appeal in their group appeals was the SSI "data matching process" issue. The Providers stated "[w]ith respect to the SSI "data matching process" issue, which is contested in each of these group appeals, the Ruling provides (at 4-7 & 29-30) for recalculation of the SSI fractions on remand to the contractors." Providers EJR request at 2.

[14] Providers' Hearing Request at tab 2, for case numbers 08-2969GC, 08-2970GC, 09-0048GC, 09-0536GC, 09-0586GC, 09-0590GC, 09-1666GC, 09-1918GC, 09-1939GC, 09-1953GC, 09-1972GC, 09-1996GC, 09-2015GC, 09-2202GC, 09-2322GC, 10-1183GC, 10-1310GC, 11-0002GC, 12-0163G, 12-0615GC, 12-0658GC.

[15] Providers' Hearing Request at 1, for case numbers 12-0530G, 12-0531G, 12-0532G, 12-0533G, 12-0534G, 12-0535G, 12-0536G, 12-0537G, 12-0540G, 12-0542G, 12-0543G.

[16] The Providers stated "[t]he Providers dispute any determination pursuant to the Ruling to include non-covered days, Part A exhausted benefit days, MSP days, Part C days and any other days for which patients were not entitled to have payment made under Medicare Part A in the SSI fraction." Providers EJR request at 3.

> however, did not hold that Part A exhausted benefit days and MSP days should be counted in the SSI fraction.[17]

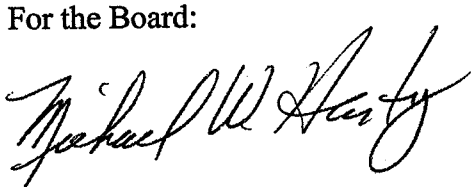
The Providers continue:

> [t]he Ruling does not require remand of pending appeals on Medicare Part C days for patients who were receiving Medicare benefits under Part C of the Medicare statute through enrollment in Medicare+Choice or Medicare Advantage plans. Nevertheless, it appears that CMS contemplates that Part C days would be added to the SSI fractions for some years that would be recalculated on remand pursuant to the Ruling. . . . Any inclusion of Part C days in the SSI fraction violates the regulation applicable to the periods at issue, which called for the inclusion only of covered part A days in the SSI fraction.[18]

The issue appealed in the Providers' group appeal requests and the issue for which the Providers seek EJR is not the same issue. The Providers' Request for EJR does not address the issue appealed, the SSI "data matching process" issue. In addition, the Providers appear to be seeking EJR over whether Part A exhausted benefit days, MSP days and Part C days must be included in the numerator of the Medicaid fraction and excluded from the SSI fraction. These issues are not the subject of the Providers' appeal requests. The deadline for adding issues to the appeals has passed and issues may not be added to group appeals. As such, the Board denies the Providers' request for EJR. These cases will be simultaneously remanded pursuant to CMS Ruling 1498-R.

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

For the Board:



Michael W. Harty
Chairman

Enclosures: Summary of Cases, 42 U.S.C §1395oo(f)

cc: Cecile Huggins, Palmetto GBA
Kyle Browning, National Government Services, Inc.
Bruce Snyder, Novitas Solutions, Inc.
Danene L. Hartley, National Government Services, Inc.
Byron Lamprecht, Wisconsin Physicians Service
Judith E. Cummings, CGS Administrators
Renee Rhone, Cahaba Government Benefit Administrators
Kevin D. Shanklin, Blue Cross Blue Shield Association

[17] Providers' EJR Request at 2.
[18] Providers' EJR request at 2-3.

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JUN 25 2014

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RE: CMS 1498 Remand Review – East Los Angeles Doctor's Hospital
Provider No.: 05-0641
FYE: 12/31/2004
PRRB Case No.: 07-2585

Dear Mr. Dreyfus and Ms. Kalafut,

The Provider Reimbursement Review Board (Board) has reviewed the Provider's request to rescind the Standard Remand of Medicare Dual Eligible Days under CMS Ruling-1498-R submitted on March 10, 2014. The decision of the Board is set forth below.

Pertinent Facts:

February 20, 2007	The Provider is issued a Notice of Program Reimbursement (NPR) for FYE 12/31/2004.
August 15, 2007	The Provider files an appeal request with the Board appealing the following issues: • DSH Medi-Cal Eligible Days • SSI%
November 30, 2007	The Provider submits a Preliminary/Final Position Paper where it withdraws the DSH Medi-Cal Eligible Days issue from the appeal.
March 27, 2008	The Intermediary submits its Final Position Paper
October 17, 2008	Provider requests to add several issues to its appeal: • DSH Dual Eligible Days • DSH Code 2 & 3 Eligible Days • Labor and Delivery Days

December 3, 2013	The Board remands the SSI%, Labor and Delivery Days, and DSH Dual Eligible Days issues pursuant to CMS Ruling 1498-R.
March 10, 2014	The Provider requests that the Board rescind the DSH Dual Eligible Days remand.

Provider's Contentions

The Provider is requesting that the Board rescind its decision to remand the DSH Dual Eligible Days issue. The Provider asserts that the DSH Dual Eligible Days issue that it appealed pertains to Medicare Advantage, Part C days in the Medicaid patient days ratio.

Board's Decision

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 of the date of receipt of the final determination.

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[1] 42 C.F.R. § 405.1835 (2008) 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.[2] In practice this means that new issues had to be added to pending appeals by October 20, 2008.

The Provider added the DSH Dual Eligible Days issue on October 17, 2008. The description of the issue was "We contend that certain dual eligible Medicare/Medicaid patient days should have been included in the disproportionate share entitlement calculation. The patient days pertaining to Medicaid eligible patients whose Part A benefits were exhausted and/or had no Medicare part

[1] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[2] *Id.* at 30240.

A paid claim should be included in the Medicaid eligible days used to calculate the disproportionate share amount. These days should be included because these patients are not Medicare Part A entitled."

The Board finds the DSH Dual Eligible Days issue in the challenge revolves around changes made to 42 C.F.R. §405.1835 as published in the Final Rule at 74 Fed. Reg. 30190 et seq. (May 23, 2008). The change to the requirements of the "Contents of request for a Board hearing" states in part:

> (2) An explanation (for each specific item at issue, see Paragraph (a)(1) of this section) of the provider's dissatisfaction with the intermediary's or Secretary's determination under appeal, including an account of all of the following:
> (i) Why the provider believes Medicare payment is incorrect for each disputed item (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment).
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item. . . .
>
> 42 C.F.R. §405.1835(b)(2) (2008)

Board Rule 8 "Framing Issues for Adjustments Involving Multiple Components" gives additional guidance related to DSH issues. It states in relevant parts:

> **8.1 General** Some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible using the applicable format outlined in Rule 7. See common examples below.
>
> **8.2 Disproportionate Share Cases** (e.g., dual eligible, general assistance, charity care, HMO days, etc.)

The Provider appears to be making the argument that the Part C days is a subcategory of dual eligible days; therefore raising the Dual Eligible Days issue generally in the request to add this issue is sufficient for the Board to find that Part C days had been an issue in the appeal since the request to add issues was submitted in October 2008.

The Board finds the Provider's issue statement is not in compliance with specificity requirements of 42 C.F.R. §405.1835(b)(2) or Board Rule 8. The Provider did not raise Medicare Part C days in its request to add the DSH Dual Eligible Days issue to its appeal. Therefore Medicare Part C days are not part of this appeal.

The Board hereby **denies** the Provider's request to rescind its Standard Remand of Medicare

Dual Eligible Days under CMS Ruling-1498-R. The Board retains jurisdiction under 42 U.S.C. §1395oo(a) regarding other issues appealed that were claimed in the as-filed cost report and adjusted by the Intermediary.

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

JUN 27 2014

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RE: Request for Expedited Judicial Review
Duke 1999 SSI Fraction Numerator/Baystate Errors CIRP Group
Provider Nos.: 34-0030 and 34-0155
FYE: 6/30/99
PRRB Case No.: 13-3893GC

Dear Mr. McKay:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' June 2, 2014 Request for Expedited Judicial Review (EJR) (received June 3, 2014). Set forth below is the Board's decision finding that EJR is not appropriate.

ISSUE:

Should the Provider Reimbursement Review Board grant the Providers' request for EJR over the validity of the provisions of the Centers for Medicare & Medicaid Services (CMS) Ruling 1498-R (Ruling), which if valid, render moot and deny jurisdiction over these appeals of the disproportionate share adjustment (DSH) supplemental security income (SSI) issue?

MEDICARE STATUTORY AND REGULATORY BACKGROUND

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

Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. Those cost reports show the costs incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. § 405.1803. A provider dissatisfied with the intermediary's final determination of total

reimbursement may file an appeal with the Board if it meets the following conditions: (1) the provider must be dissatisfied with the final determination of the intermediary; (2) the amount in controversy must exceed $10,000 for an individual appeal (or $50,000 for groups); and (3) the appeal must be filed with the Board within 180 days of the receipt of the final determination. 42 U.S.C. §1395oo(a); 42 C.F.R. §§ 405.1835-405.1837.

The Medicare statute at 42 U.S.C. §1395oo(f)(1) and the regulations at 42 C.F.R. §405.1842(f)(1), require the Board to grant EJR if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling.

Medicare Disproportionate Share Hospital (DSH) Payment

Part A of the Medicare Act covers "inpatient hospital services." 42 U.S.C. § 1395d(a)(1). Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system (PPS). 42 U.S.C. §§ 1395ww(d)(1)-(5); 42 C.F.R. § 412. Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments. *Id.*

One of the PPS payment adjustments is the DSH payment adjustment. The Secretary is required to provide increased PPS reimbursement to hospitals that serve a "significantly disproportionate number of low-income patients." 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106. Whether a hospital qualifies for the DSH adjustment and how large an adjustment it receives depends on the hospital's "disproportionate patient percentage" (DPP). 42 U.S.C. §1395ww(d)(5)(F)(v).

The DPP is defined as the sum of two fractions expressed as a percentage. 42 U.S.C. §1395ww(d)(5)(F)(vi). Both of these fractions look, in part, to whether or not the hospital's patients for such days claimed during the particular cost reporting period were "entitled to benefits" under Medicare Part A.

The first fraction used to compute the DSH payment is commonly known as the Medicare fraction. It is also referred to as the SSI fraction because the numerator is determined by the number of patient days for which the patient was entitled to SSI. The statute defines the SSI fraction as:

> (I) 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) (emphasis added).

The SSI fraction is computed annually by CMS, and the Medicare fiscal intermediaries are required to use CMS's calculation to compute a hospital's DSH payment adjustment. 42 C.F.R. § 412.106(b)(2)-(3).

The second fraction used to compute the DSH payment is the Medicaid fraction, defined as:

> (II) 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 of this chapter, 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) (emphasis added).

According to CMS' regulation, "[t]he 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." 42 C.F.R. §412.106(b)(4).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The underlying issue in dispute in these cases involves the proper amount of Medicare reimbursement due the Providers of medical services. The Providers in these group appeals are challenging CMS' calculation of the Medicare Part A/SSI fraction used to determine the Providers' eligibility for, and the amount of, the Medicare DSH payment. The contested issue in each of these group appeals is the SSI "data matching process" issue.[1]

The Providers' Individual Hearing Requests

On March 18, 2002, and August 23, 2006, the Providers filed individual hearing requests wherein they identified the SSI issue as "the Provider contends that (1) the SSI percentage as generated by the SSA and put forth by CMS is understated." Duke University Health System, Provider No. 34-0030, went on to explain that "[d]ata produced by CMS has not supported the SSI percentage as found in the PRRB Baystate Decision 2006-D20."[2]

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[1] Providers' EJR Request at 1-2.
[2] Providers' Jurisdictional documents at Tab 1B and 2B.

Request to Transfer to Northeast Region 93-97 SSI Group, case number 01-1347G

On November 25, 2002, and November 29, 2006, the Providers requested that the SSI issue be transferred from their individual appeals to the Northeast Region 93-97 SSI Group appeal, case number 01-1347G. The transfer request in both cases simply stated that the Provider was transferring "the 'SSI Percentage' component of the Disproportionate Share Adjustment (DSH) issue from the individual appeal to . . . Case Number 01-1347G."[3] The issue statement raised in the initial formation of case number 01-1347G was "[w]hether the Intermediary used the correct SSI percentage in calculating the disproportionate share adjustment."[4]

Transfer to McKay 1999 SSI% Group, case number 12-0534G and to Duke 1999 SSI Fraction Numerator/Baystate Errors CIRP Group, case number 13-3893GC

On August 21, 2012, the Board split case number 01-1347G into 12 separate cases by fiscal year for better manageability of participating providers.[5] The Providers in the current appeal were transferred from case number 01-1347G into the optional group for fiscal year 1999, case number 12-0534G, and then subsequently transferred out to form a separate, mandatory CIRP group for the Duke University Health System, case number 13-3893GC.

The Request for EJR

On June 03, 2014, the Providers filed a request for EJR over the validity of the Ruling as it relates to the SSI issue. The Providers contend that the Board should grant their request for EJR because the Ruling conflicts with several higher legal authorities that the Board is bound to uphold, including several provisions of the Medicare statute, the Administrative Procedure Act and the DSH regulation in effect for cost reporting periods that began before October 1, 2004.

The Providers maintain that the recalculation of the SSI fractions pursuant to the Ruling would deviate from the court's decision in *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20, amended by 587 F. Supp. 2d 37 (D.D.C. 2008), the process the agency used to implement the court's decision and the Secretary's representations to the court in that case in one significant respect involving the *second issue* covered by the Ruling.[6] The Providers argue specifically, the Ruling requires CMS to include in the revised SSI fractions the hospital patient days for all patients who were enrolled in Medicare part A, regardless of whether Medicare Part A benefits were paid for those patient days. This would include non-covered patient days such as those attributable to individuals who were enrolled in Medicare Part A but had exhausted Part A benefits for inpatient hospital services ("Part A exhausted benefit days") and days that were not paid by Medicare Part A because Medicare's payment liability was secondary to another payor's primary liability ("Medicare secondary payor" "MSP days"). The Providers contend the court's decision in

[3] Providers' Jurisdictional documents at Tab 1G and 2G.
[4] February 26, 2001 Group Appeal Request at 1.
[5] All providers in case number 01-1347G were transferred to newly formed optional group appeals or to separate CIRP appeals, at which point case number 01-2347G was closed by the Board.
[6] The Ruling applies to three issues in jurisdictionally proper pending appeals concerning the calculation of the Medicare DSH payment: 1) the "data matching process" used to calculate the SSI fraction; 2.) certain "non-covered" days for cost reporting periods with patient discharges before October 1, 2004; and 3.) labor and delivery days for cost reporting periods beginning before October 1, 2009.

Baystate, however, did not hold that Part A exhausted benefit days and MSP days should be counted in the SSI fraction. Quite to the contrary, the Secretary in that case conceded that exhausted benefit days and Medicare secondary payor days not paid under Medicare are properly excluded from the SSI fraction for the years in question.[7,8]

The Providers maintain the Ruling does not require remand of pending appeals on Medicare Part C days for patients who were receiving Medicare benefits under Part C of the Medicare statute through enrollment in Medicare+Choice or Medicare Advantage plans. Nevertheless, it appears that CMS contemplates that Part C days would be added to the SSI fractions for some years that would be recalculated on remand pursuant to the Ruling. The Ruling itself defines the SSI fraction to include days for patients "who are enrolled in a Medicare Advantage (Part C) plan."[9] The Ruling also notes that Part C days will be included in the SSI fraction "only if the individual is enrolled in Part A or Part C and the hospital has submitted a Medicare claim on behalf of the patient."[10] The Providers contend any inclusion of Part C days in the SSI fraction violates the regulation applicable to the periods at issue, which called for the inclusion only of covered Part A days in the SSI fraction.[11]

The Providers argue CMS, when interpreting the regulation through publication and transmission of the SSI fractions to its contractors for the periods at issue, explicitly stated that the fractions only included covered part A entitled days.[12] The Providers dispute any determination pursuant to the Ruling to include non-covered days, Part A exhausted benefit days, MSP days, Part C days and any other days for which patients were not entitled to have payment made under Medicare Part A in the SSI fraction. These days are not attributable to patients who were entitled to benefits under Part A for those days. Accordingly, the Providers contend those days must be included in the numerator of the Medicaid fraction and excluded from the SSI fraction used to calculate their Medicare DSH payments.[13]

The Providers maintain that they submitted schedules of providers and supporting documentation showing that they met all the jurisdictional requirements for a hearing under 42 U.S.C. § 1395oo(a). Their claims are not moot. CMS' suggestion that some hospitals might be satisfied with a recalculation performed in exactly the opposite way the hospitals contend it should be calculated is nonsensical and not supported by any evidence or analysis. CMS' determination to add the Part A exhausted benefit days, MSP days and Part C days to the SSI fraction cannot rationally be said to render moot the Provider's pending claims to have the SSI fraction calculated correctly.

The Providers contend the remands that the Ruling purports to require would violate at least three separate provisions of the Medicare Act (42 U.S.C. §§ 1395oo(a), 1395ww(d)(5)(F)(vi)(I) and 1395hh), the Administrative Procedures Act ("APA") and the DSH regulation (42 C.F.R. §

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[7] 545 F. Supp. 2d at 55 n. 37.
[8] Providers' EJR Request at 1-2.
[9] CMS Ruling 1498-R at 3 (April 28, 2010).
[10] *Id.* at 8.
[11] *See* 42 C.F.R. § 412.106(b)(2); 52 Fed. Reg. 16772, 16777 (May 6, 1986).
[12] See, e.g., Transmittal 647, CMS Pub. 100-04, Medicare Claims Processing Manual (Aug. 12, 2005) (FFY 2004); Program Memorandum A-01-109 (Sep. 13, 2001) (FFY 2000).
[13] Providers' EJR Request at 2-3.

412.106(b)) that was in effect before October 1, 2004. The Board is bound constitutionally and otherwise to uphold and obey those higher legal authorities. Unlike the Ruling, the statutory provisions it violates are law, and the DSH regulation it violates has the force and effect of law for periods before October 1, 2004. All of those provisions are higher authorities than the CMS Ruling, and all of them are binding on the Board. Accordingly, the Providers contend the Ruling is invalid.[14]

The Providers argue in accordance with the plain meaning of § 1395ww(d)(5)(F)(vi), Part A exhausted benefit days, MSP days and Part C days must be excluded from the SSI fraction, because these patients were not "entitled to benefits" under Part A for their patient days. The Providers contend the Ruling also violates § 1395hh and the APA's notice and comment rulemaking requirements in 5 U.S.C. § 553. Both statutes prohibit retroactive rulemaking. The Ruling has retroactive effect, at least insofar as it purports to require CMS and the contractor to include Part A exhausted benefit days, MSP days or Part C days in the SSI fraction for periods beginning before October 1, 2004. In this respect, the Ruling applies a new substantive rule for prior cost reporting periods that begin before October 1, 2004.[15] The Providers maintain under the DSH regulation in effect prior to October 1, 2004, 42 C.F.R. § 412.106(b), and the agency's long standing interpretation of that regulation, Part A exhausted benefit days, MSP days and Part C days were not included in the SSI fraction. The CMS administrator himself ruled in 1996 that days billed to and paid by Medicaid after patients had exhausted Medicare Part A benefits, may be included in the numerator of the Medicaid fraction.[16]

The Providers contend CMS' Ruling is an improper attempt on the agency's part to camouflage the reimbursement impact of the corrections to the SSI fractions that the agency is required to make under *Baystate*. The positive impact of the correction of those systemic errors and omissions would be effectively masked by an offsetting penalty imposed by the Ruling. The penalty stems from the Ruling's new retroactive requirement to add to Part A exhausted benefit days, MSP days and/or Part C days, which were not covered or paid under Medicare Part A, to the SSI fraction for the years to which the Ruling would apply. This change was not required by the decision in *Baystate* and it was not made by CMS in the revised SSI fractions that the agency calculated and applied to *Baystate* in June 2009 to implement that decision. CMS' change would have the effect of substantially reducing the SSI fractions.[17]

DECISION OF THE BOARD

The Medicare statute at 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. §405.1842(f)(1), require the Board to grant EJR if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling.

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[14] *Id.* at 5-6.
[15] *Id.* at 7-8.
[16] *Id.* at 9 citing *Presbyterian Med. Ctr. of Philadelphia v. Aetna Life Ins. Co.*, CMS Adm'r Dec., MEDICARE & MEDICAID GUIDE (CCH) ¶ 45,032 (Nov. 29, 1996).
[17] Providers' EJR Request at 9-10.

The Board hereby dismisses the Medicare Part A exhausted benefit days issue, Medicare Secondary Payor days issue and Part C days issue from the group appeal in case number 13-3893GC because these issues were not part of the individual cases or the initial group appeal to which the issue was transferred. The Board denies the request for EJR because the DSH days that are the subject of the EJR are not properly before the Board in this case. Finally, the Board remands the SSI issue pursuant to CMS Ruling 1498-R because the Providers did not request EJR over the SSI data match issue that is the subject of the appeal.

Jurisdiction

The issues appealed in the Providers' group appeal request in case number 13-3893GC go beyond the limit of a singular issue permitted in a group appeal[18] and beyond the scope of the issue appealed in the Providers' underlying individual appeals and the original group appeal to which the Providers initially transferred. Specifically, the Providers state in their EJR request that it was the "SSI 'data matching process issue' which is contested." However, the Providers did not raise the issues pertaining to Part A exhausted benefit days, MSP days or Medicare Part C days in its initial appeal filings. Rather, these items were only included in the September 23, 2013 issue statement used to establish the current CIRP group, which was created through several reorganizations of prior optional group appeals.

Both Providers' individual hearing requests identified the SSI issue as "the Provider contends that (1) the SSI percentage as generated by SSA and put forth by CMS is understated." Duke University Health System, Provider No. 34-0030, went on to explain that "[d]ata produced by CMS has not supported the SSI percentage as found in the PRRB Baystate Decision 2006-D20." When the SSI issue was initially transferred from the individual appeals, the transfer request in both cases simply stated that the Provider was transferring " the 'SSI Percentage' component of the Disproportionate Share (DSH) adjustment issue from the individual appeal to ... Case Number 01-1347G." The issue statement raised in the initial formation of Case No. 01-1347G was "[w]hether the Intermediary used the correct SSI percentage in calculating the disproportionate share adjustment." This issue statement was carried forward when Case No. 01-1347 was split into 12 separate cases by fiscal year for better manageability of participating providers. The Providers in the current appeal were moved from Case No. 01-1347G into the optional group for fiscal year 1999, Case No. 12-0534G, and then subsequently transferred out to form a separate, mandatory CIRP group for the Duke University Health System.

The Providers' September 23, 2013 request to form the CIRP group and transfer the Duke University Hospital and Durham Regional Hospital to the new group included a statement of the issue that expanded the scope of the initial SSI issue initially raised: the "data matching process" pursuant to the findings in *Baystate*. The addition of these issues is improper because a group contains only a single issue and the 180-day appeal period for creating new group appeals of those issues expired years ago. Therefore, the supplemental issues raised related to CMS'

[18] In accordance with 42 C.F.R. § 405.1837(a)(2) (2008) group appeals are appropriate where "[t]he matter at issue in the group appeal involves a single question of fact or interpretation of law, regulations, or CMS Ruling that is common to each provider in the group."

inclusion of Medicare Part A exhausted benefit days, Medicare Secondary Payor days and Part C days in the denominator of the SSI ratio are hereby dismissed from the current appeal.

EJR Request

The Providers' Request for EJR does not address the issue appealed, the SSI "data matching process" issue but instead seeks EJR over whether Part A exhausted benefit days, MSP days and Part C days must be included in the numerator of the Medicaid fraction and excluded from the SSI fraction. [19] These issues are not the subject of the Providers' underlying individual and prior group appeal requests nor are they permissible issues in the current group appeal. The Board therefore denies the request for EJR and simultaneously remands the SSI issue pursuant to the Ruling.

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

For the Board:
Michael W. Harty
Chairman

Enclosures: Schedule of Providers, 42 U.S.C §1395oo(f)

cc: Cecile Huggins, Palmetto GBA
Kevin D. Shanklin, Blue Cross Blue Shield Association

[19] Providers' EJR Request at 3.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to: 06-1210

CERTIFIED MAIL JUN 30 2014

Felicia Viselli
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RE: Request for Reinstatement
UCLA – Santa Monica Medical Center
Provider No.: 05-0112
FYE: 6/30/2003
PRRB Case No.: 06-1210

Dear Ms. Viselli,

The Provider Reimbursement Review Board (Board) has reviewed the Provider's Request to Reinstate case number 06-1210. The Board's decision is set forth below.

Background

On September 27, 2005, the Provider was issued an original Notice of Program Reimbursement (NPR) for FYE 6/30/2003. On March 17, 2006, the Provider filed a hearing request with the Board in which appealed a single issue: "***SSI% Component of Disproportionate Share (DSH) calculation (Adj.#25)*** – The issue is, was the SSI% incorporated in the NPR correct?"

On April 27, 2009, the Provider states it requested a recalculation of the SSI ratio.[1] On April 7, 2010, the Provider received a letter from the MAC informing it that CMS had sent a recalculated SSI ratio for the Provider that was received on March 31, 2010.[2]

The Board remanded the SSI% issue in case number 06-1210 to the Intermediary pursuant to CMS Ruling 1498-R on September 12, 2012. The Board determined that the SSI% issue was the only issue in the appeal and closed case number 06-1210 when it remanded the appeal. On December 26, 2012, the Board received the Provider's request to reinstate case number 06-1210.

[1] The Provider stated this in its reinstatement request, but a copy of this request was not part of the Board's record and was not submitted with the Provider's reinstatement request.
[2] The letters regarding the recalculated SSI ratio were not part of the Board's original record. The Board was only made aware of them when the Provider's representative submitted the April 7, 2010 letter with the reinstatement request.

Provider's Position

The Provider is requesting reinstatement because it believes that the issue it falls outside the scope of CMS Ruling 1498-R. The Provider argues that the issue it appealed is the SSI recalculation based upon the Provider's cost reporting period. The Provider goes on to say that it requested a recalculation of the SSI ratio on April 27, 2009. It continued its argument by saying that Palmetto agreed to an administrative resolution of incorporating the recalculated SSI ratio into the cost report in an email to the Provider dated June 3, 2010.[3] However, Palmetto later informed the Provider that it could not administratively resolve the case pending further instructions from CMS. The Provider concludes that case number 06-1210 should be reinstated because the SSI recalculation based upon the cost reporting period is outside the scope of 1498- R.

Intermediary's Position

The Intermediary did not file a brief in response to the Provider's request for reinstatement.

Board's Decision

The Board has determined that the Provider actually appealed two separate issues in case number 06-1210: the understatement of the SSI ratio issue as well as the SSI realignment issue. Therefore, the Board grants the Provider's request for reinstatement in order to ensure that both issues have been addressed.

The Provider's original appeal request appealed the understated SSI ratio issue that is subject to the 1498-R remand and was thus properly remanded. In its Final Position Paper submitted on October 25, 2006, the Provider stated its one issue on appeal as, "Whether the SSI ratio used in the DSH payment calculation is correct?" The Provider then goes on to cite 42 C.F.R. § 412.106(b)(2) which explains the computation of the SSI component of the DSH calculation. CMS Ruling 1498-R labels the SSI ratio issue under its provisions as "Appeals of the Data Matching Process Used in Calculating the SSI Fraction." At this point in the appeal, the Provider is still appealing one issue, that the SSI ratio was understated, which is subject to the remand.

However, on April 27, 2009, the Provider did request a realignment of the SSI ratio, which is a second issue that is separate from the understatement. However, the realignment issue was not and could not have been a jurisdictionally valid appeal. Had the Provider appealed the realignment issue in its original appeal request, the issue would have been premature, because the Provider had not yet rquested the realignment. As it stands, the Provider did actually request realignment, so the issue was not premature; however it was untimely for two reasons: the time to reopen the cost report had passed and the time for adding issues to pending appeals had passed. 42 C.F.R. § 405.1885(a) (2004) provides, in relevant part:

> A determination of an intermediary . . . may be reopened with respect to findings on matters at issue in such determination or decision, by such intermediary officer

[3] This email is not a part of the Board's record and was not included with the reinstatement request.

> . . . or on the motion of the provider affected by such determination . . . . Any such request to reopen must be made . . . within 3 years of the date of the notice of the intermediary determination.

The Provider's NPR was issued on September 24, 2005, and it did not request the realignment, which would require reopening the cost report to make adjustments, until April 27, 2009, almost 4 years after the NPR was issued. The regulations only allow 3 years for a cost report reopening request, therefore the Provider was untimely in its realignment request. Additionally, 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.[4] The Provider did not request the realignment until April 27, 2009, well after the October 20, 2008 deadline for adding issues.

In conclusion, the Board acknowledges that the Provider did appeal the SSI realignment issue in addition to the SSI ratio issue that is subject to the remand. The Board has reopened case number 06-1210 in order to address both issues. The SSI ratio understatement issue was properly remanded pursuant to CMS Ruling 1498-R on September 12, 2012. The Board has determined that the Provider also appealed the SSI realignment issue. However, the Board finds that the Provider did not timely request a reopening for the realignment and that the SSI realignment issue was not timely added to this appeal. Therefore, the Board does not have jurisdiction over the SSI realignment issue and dismisses it from case number 06-1210. As no issues remain pending in the appeal, case number 06-1210 is hereby closed.

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

FOR THE BOARD

Michael W. Harty
Chairman

[4] 73 Fed. Reg. 30,190, 30,236 (May 23, 2008).

cc: Kevin D. Shanklin
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