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

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

Refer to: 08-1969GC

AUG 01 2014

CERTIFIED MAIL

Hall, Render, Killian, Heath & Lyman
Maureen O'Brien Griffin
Suite 2000, Box 82064
Indianapolis, IN 46282

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

RE: Regional Hospital of Jackson, Provider No. 44-0189, FYE 12/31/2006, as a participant in Community Health Systems 2006 SSI Days Proxy Group
PRRB Case No.: 08-1969GC

Dear Maureen O'Brien Griffin and Byron Lamprecht,

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

**Background**

The Providers filed an initial request for a group appeal on May 20, 2008. On April 1, 2013, the Board ruled that case number 09-1676GC should be consolidated into case number 08-1969GC, represented by King and Spalding, in order to accurately reflect a single common issue related party (CIRP) group for 2006 per 42 C.F.R. § 405.1837(b)(1). On May 31, 2013, the Providers notified the Board that representation of the group had been transferred to Hall Render. On June 20, 2014, the group filed its schedule of providers and supporting jurisdictional documentation identifying 66 participants in the group.

**Board's Decision**

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1841 (2007), 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 the notice of the intermediary's determination was mailed to the provider.

The Board finds that it does not have jurisdiction over Participant 47, Regional Hospital of Jackson (Provider No. 44-0189, FYE 12/31/2006), because its appeal was not timely. Pursuant to 42 C.F.R. § 405.1835(a)(3)(i) and PRRB rules, an appeal must be filed with the Board no later than 180 days after the provider has received its final determination.

Pursuant to 42 C.F.R. § 405.1801(a)(1)(iii) and PRRB Rule 4.3, the date of receipt of an NPR is presumed to be five days after the date of issuance, unless established by a preponderance of the evidence that it was actually received on a later date. Furthermore, 42 C.F.R. § 405.1801(a)(2) establishes that the date of receipt by the Board is the date of delivery where the document is transmitted by a nationally-recognized next-day courier or, alternatively, the date stamped "received" by the reviewing entity where a nationally-recognized next-day courier is not used.

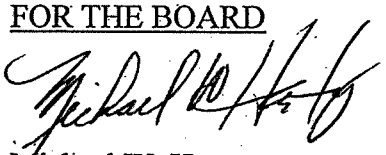
Regional Hospital of Jackson was issued its NPR on April 11, 2008 and presumed to have received it on April 16, 2008. The Provider did not present evidence that the NPR was received later than the five day presumption. An appeal request from this original NPR was received by the Board on October 21, 2008.[1] Thus, the date of filing was 188 days after the presumed date of receipt of the determination from the Intermediary.

Because the appeal request was not received by the Board within 180 days as required by 42 C.F.R. § 405.1835, the Board finds that it was not timely filed. The Board hereby finds that it does not have jurisdiction over Participant 47, Regional Hospital of Jackson, (Provider No. 44-0189, FYE 12/31/06) and hereby dismisses this provider from the group.

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

Board Members Participating
Michael W. Harty
John Gary Bowers, CPA
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

[1] The Provider requested to directly add the SSI issue to group case number 08-0509G, which was subsequently restructured into multiple groups by fiscal year end, including case number 09-1676G. Case number 09-1676G was later consolidated into the current case.

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Refer to:

08-2925G

AUG 04 2014

CERTIFIED MAIL

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

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

RE: Group Name: QRS 2000 DSH/SSI Proxy Group (3)
Provider Name: Hartford Hospital
Provider No.: 07-0025
FYE: 09/30/2000
PRRB Case No.: 08-2925G

Dear Messrs. Browning and Ravindran,

The Provider Reimbursement Review Board (the Board) has reviewed the jurisdiction documentation submitted in the above-captioned case. The Board's jurisdiction decision is set forth below.

**Pertinent Facts**

On March 22, 2010, Hartford Hospital was issued a revised Notice of Program Reimbursement (NPR) for FYE 09/30/2000. The revised NPR specifically stated that the revision was as a result of adjustments to include additional unpaid eligible days, to update the DSH allowable percentage, and to update the prior year intern to bed ratio. The Provider appealed from the revised NPR on September 20, 2010, disputing the following issues: (1) Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific), (2) DSH/SSI% (Systemic Errors), (3) DSH Payment – Medicaid Eligible Connecticut Medical Assistance/General Assistance Days, and (4) DSH Payment – Exhausted Medicare Benefits Medicaid Dual Eligible Days.[1] The Board assigned case number 10-1368 to the Provider's individual appeal.

On April 25, 2011, the Provider transferred to the DSH/SSI% Proxy issue into this appeal under optional case number 08-2925G. On April 11, 2014, the Board received the Schedule of Providers for this optional group appeal.

[1] On May 2, 2011, the Board closed the individual appeal upon written request from the Provider. The jurisdictional merits of any issues transferred prior to closure will be reviewed in their respective appeals.

**Board's Decision**

The Board finds that it does not have jurisdiction over the DSH/SSI% Proxy issue in Hartford Hospital's appeal because it is appealing from a revised NPR which did not adjust the DSH/SSI% Proxy.

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

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

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

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

The Board finds that although there was an adjustment to report payments made to the Provider, that adjustment was not made to the DSH/SSI% Proxy issue which it is now appealing. The DSH/SSI% Proxy calculation was clearly not considered or revised in the revised NPR, and is therefore outside the scope of the appeal from a revised NPR under 42 C.F.R. § 405.1885(b)(2). As the DSH/SSI% Proxy issue is the common issue on appeal, Hartford Hospital's appeal of FYE 09/30/2000 is hereby dismissed from optional appeal case number 08-2925G.

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

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

FOR THE BOARD

Michael W. Harty
Chairman

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

cc: Kevin Shanklin, BCBSA

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Refer to: 07-2768

AUG 06 2014

CERTIFIED MAIL

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

Palmetto GBA
Cecile Huggins
Supervisor
Provider Audit – Mail Code AG-380
2300 Springdale Drive – Bldg. ONE
Camden, SC 29020-1728

RE: Jurisdictional Decision – Presbyterian Hospital
Provider No.: 34-0053
FYE: 9/30/1997
PRRB Case No.: 07-2768

Dear Mr. Ravindran and Ms. Huggins,

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

**Background**

Presbyterian Hospital was issued a revised Notice of Program Reimbursement (NPR) for FYE 9/30/1997 on March 5, 2007. On August 31, 2007, the Board received the Provider's appeal request in which it appealed two issues: DSH/SSI Proxy and Medicaid Percentage (Eligible Days).

On August 11, 2008, the Presbyterian Hospital requested that the following issues be added to the individual appeal then transferred to a group appeal: Medicare managed care days; Medicaid Eligible Days; North Carolina Charity Care days; and SSI percentage. The Intermediary submitted a jurisdictional challenge to the issue of North Carolina Charity Care days on November 19, 2009. In response, the Provider submitted a jurisdictional brief addressing the Intermediary's jurisdictional challenge on December 16, 2009. On April 7, 2010, the Board determined that it did not have jurisdiction over the charity days issue in the appeal and dismissed this issue.

On April 4, 2012, the Board notified the Provider of questions regarding the jurisdiction of the remaining issues: specific SSI percentage; non-specific provider SSI percentage; the Medicare Eligible Managed Care days; and the Medicaid Eligible days. In this notification, the Board requested the Provider submit a jurisdictional brief regarding these issues. On May 4, 2012, the Provider submitted a jurisdictional brief.

**MAC's Position**

While the Intermediary submitted a jurisdictional challenge to the issue of North Carolina charity days, no jurisdictional challenge was submitted addressing the remaining issues in case number 07-2768.

**Provider's Position**

On May 4, 2012, the Board received the Provider's response to the Board's request for a jurisdictional brief regarding case number 07-2768. In the jurisdictional brief the Provider requests that the two SSI percentage issues be withdrawn from the appeal. As such, the jurisdictional brief only addresses the Medicare Managed Care Part C days and the Medicaid eligible days. The Provider contends that the Board may review all matters the intermediary had reconsidered upon reopening the cost report, and not just those items modified at the time the appeal was filed. Though the Provider acknowledges that 42 C.F.R § 405.1889(b)(2) limits the Board's review to only those matters which were actually revised, the Provider argues that it would be fundamentally unfair to apply this section of revised regulations to appeals where were already pending at the time of the revisions of the regulations. The Provider argues that regardless of the regulations, the intermediary adjusted the two issues addressed in the jurisdictional brief. The Provider argues that the language used by the Intermediary in the revised NPR includes a variety of patient days. Furthermore, the Provider contends that unlike the *St. Thomas Hosp v. Sebelius* case, the Intermediary in this situation did not deny reopening on any aspect of the issue of Medicaid eligibility.

The Provider further argues that under 42 U.S.C. § 1395oo the Board has jurisdiction when the Provider is dissatisfied with a final determination as to the total program reimbursement due to the Provider. Since this statute provides no distinction between initial and revised NPRs, the Provider argues that the scope of the Board's jurisdictional is identical in regards to the two types of NPRs. As such, the Provider argues that the Board has jurisdiction over the Providers revised NPR as well as the managed care days and Medicaid eligible days.

**Board's Decision**

Issue #1: Medicare Managed Care Part C days

The Board finds that it does not have jurisdiction over the Provider's appeal regarding Medicare Managed Care Part C days as they were not specifically adjusted in the revised NPR. The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 1885 provides in relevant part:

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

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

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

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

Here, the Provider's audit adjustment report associated with the March 5, 2007 revised NPR shows that DSH was recalculated to adjust for the number of Medicaid eligible-but-unpaid days and Medicaid paid days included in included in the Medicare DSH adjustment payment. Since there was no specific adjustment made to the Provider's Medicare Managed Care Part C days, the Board does not have jurisdiction because the appeal does not meet the specificity requirements for a revised NPR appeal.

Issue #2: Medicaid Eligible Days

the Board finds that it does not have jurisdiction over the Medicaid Eligible Days issue. The Medicaid Eligible days that the Provider is appealing were already adjusted as agreed upon in an Administrative Resolution, PRRB case number 00-1684G on November 10, 2006. In this Administrative Resolution, the Provider agreed to an increase in both paid and unpaid eligible days, a total of 7389 days. The Provider is now appealing to obtain more eligible paid and unpaid days.

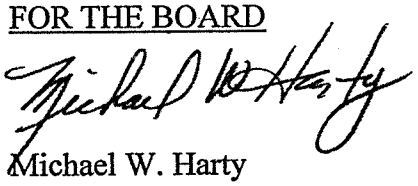
Based on the reasoning put forth in *Illinois Masonic Medical Center v. BCBSA*, PRRB Dec. 2010-D47, the Board finds that it does not have jurisdiction over the Medicaid eligible days issue. In that case the Board determined that the Provider lacked jurisdiction under 42 U.S.C. § 1395oo(a) because the Provider could not be "dissatisfied" with the Intermediary's final determination in the revised NPR. The Board's reasoning in *Illinois Masonic* is applicable to Presbyterian Hospital's appeal of the Medicaid eligible days. In the Administrative Resolution, the provider agreed to a resolution of the eligible days issue. The Provider agreed to the number and withdrew the case. As such, the Provider cannot be "dissatisfied" with the Intermediary's decision and the Board does not have jurisdiction over this issue.

Because the Medicare Managed Care Part C days were not specifically adjusted in the revised NPR and because the Provider cannot be "dissatisfied" with the Medicaid Eligible Days , the Board finds that it does not have jurisdiction over this Provider's appeal. Case number 07-2768 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

cc: Kevin D. Shanklin, BCBSA

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Certified Mail

AUG 07 2014

Nina Adatia Marsden, Esq.
Hooper, Lundy and Bookman
1875 Century Park East, Suite 1600
Los Angeles, CA 90067-2517

RE: HLB 2014 Two Midnights 0.2 Percent IPPS Payment Reduction Groups
See Attached Case Listing

Dear Ms. Marsden:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' requests for hearing appealing the August 19, 2013 Federal Register,[1] the June 3, 2014 request for expedited judicial review (EJR) (received June 4, 2014) and the additional information requested by the Board which was received July 23, 2014. The Board's determination with respect to the request for EJR is set forth below.

**Issues**

The Providers are challenging the 0.2% reduction to IPPS rates for inpatient discharges occurring on or after October 1, 2013 which was announced in the final inpatient prospective payment system (IPPS) rule for Federal fiscal year (FFY) 2014 published in the August 19, 2013 Federal Register.[2] In this final rule the Secretary sought to address concerns regarding "short stays" by adopting a new policy that presumes that (a) inpatient admissions are appropriate if the beneficiaries inpatient stay extends past two midnights and (b) stays shorter than two midnights do not involve services designated as "inpatient only" are "generally inappropriate for payment under Medicare Part A" as inpatient services (and should be provided as outpatient services) unless it is clear from the medical record supporting the physician's order and expectation that the beneficiary would require care spanning at least two midnights (although this ultimately may not occur). This is known as the "two-midnight" policy. After estimating the new policy would increase IPPS expenditures, the Secretary used her "exceptions and adjustments" authority to reduce the standardized amount[3] and

[1] *See District of Columbia Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993), *Medicare and Medicaid Guide (CCH)* ¶ 41,025 (the Administrator held that the publication of the wage index in the Federal Register was a final determination which can be appealed to the Board).
[2] 78 Fed. Reg. 50496.
[3] The standardized amount is the sum of: (1) a labor component which represents labor cost variations among different areas of the country and (2) a non-labor component which represents a geographic calculation based on whether the hospital is located in a large urban or other area. The labor component is then adjusted by the wage index. *See* "Medicare Hospital Prospective Payment System: How DRG Rates are Calculated and Updated" (CMS

the hospital specific rate for all IPPS payments by 0.2% for FFY 2014 to offset the expected increase to inpatient reimbursement.

The issue set forth in the Providers' hearing requests include whether:

(1) the Secretary improperly exercised the authority granted to her through 42 U.S.C. § 1395ww(d)(5)(I);

(2) improperly reduced IPPS and hospital specific payments, including operating capital and any other aspect of IPPS payments that was affected by the 0.2% reduction, and all the components therein, to IPPS hospitals, sole community and Medicare dependent[4] hospitals, including the Providers, for all inpatient stays for FFY 2014 by 0.2% in light of the Secretary's adoption of the "two-midnight" policy, effective October 1, 2013;[5] and

(3) should have imposed a positive rather than a negative adjustment under 42 U.S.C. § 1395ww(d)(5)(I)(i), because the two-midnight policy reduces IPPS expenditures.

**Statutory and Regulatory Background**

In the final IPPS rule for FFY 2014, the Secretary indicated that she had expressed concern in the proposed calendar year (CY) Outpatient PPS rule[6] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving observation services. In recent

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Office of the Inspector General Report OEI-09-00-00200, August 2001) on the internet at http://oig.hhs.gov/oei/reports/oei-09-00-00200.pdf.

[4] Although payments to most hospitals under IPPS are made on the basis of the standardized amounts, some categories of hospitals are paid in whole or in part based on their hospital specific rate, which is determined from their costs in a base year. Sole community hospitals (SCHs) receive payment on the higher of the hospital specific rate based on their updated costs in a base year (the highest of FY 1982, FYE 1987, FY1996, or FY 2006) or the IPPS Federal rate based on their standardized amount whichever yields the greatest payment. Medicare dependent hospitals (MDHs) received the higher of the Federal rate or the Federal rate plus 50% of the amount by which the Federal rate is exceeded by the higher of its FY 1982 or FY 1987 hospital-specific rate. For discharges occurring on or after October 1, 2007, but before October 1, 2013, a MDH would receive the higher of the Federal rate or the Federal rate plus 75% of the amount by which the Federal rate is exceeded by the highest of its FY 1982, FY 1987 or FY 2002 hospital-specific rate. *See* 78 Fed. Reg. 50496, 50509 and 50987 (August 19, 2013). The MDH provision was to expire on 9/30/2013; however, the Bipartisan Budget Act of 2013, P.L. 113-67, § 1106 amended 42 U.S.C. § 1395ww(d)(5)(G), extended the deadline to April 1, 2014.

[5] More specifically see 78 Fed. Reg. at 50949 (The Secretary believes that *all* hospitals, LTCHs and CAHs, with the exception of IRFs, would appropriately be included in our final polices regarding the 2-midnight admission guidance and medical review criteria for determining the general appropriateness of inpatient admission and Part A payment. (emphasis added)).

[6] 77 Fed. Reg. 45061, 45155-45157 (July 30, 2012) and the final rule with comments, 77 Fed. Reg. 68,210, 68426-68433 (November 15, 2012).

years, the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours increased from approximately 3 percent in 2006 to 8 percent in 2011. This raised a concern about the financial impact on Medicare beneficiaries who may incur greater financial liability than they would if they were admitted to the hospital as inpatients.[7]

The Secretary noted that the trend towards the extended observation services may be attributable, in part, to hospitals' concerns about their ability to receive payment from Medicare under Part B when a Part A hospital inpatient claim is denied because a Medicare review contractor determines that the inpatient admission was not reasonable and necessary under 42 U.S.C. § 1395y(a)(1)(A). Centers for Medicare & Medicaid Services (CMS) has been advised by stakeholders that the hospitals appear to be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays that may later be denied upon contractor review by electing to treat beneficiaries as outpatients receiving observation services for long periods of time, rather than admitting them as inpatients. These hospitals believe that Medicare's standards for inpatient admission were not clear.[8]

In response to this concern, the Secretary proposed clarifications and changes regarding hospital payment under both Part A and Part B. The Secretary proposed to revise Part B inpatient payment policy to allow payment under Part B for all hospital services that furnished and were reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted as an inpatient. This policy would apply when a Medicare Part A hospital inpatient claim was denied or when a hospital determines after a discharge that the inpatient visit was not reasonable and necessary. The timely filing restrictions for Part B billing were not changed (claims must be filed within 1 year from the date of service).[9]

Medicare Part A

In addition, the Secretary reviewed hospital inpatient status criteria to improve CMS' policies governing when a Medicare beneficiary should be admitted as an inpatient and how hospitals should be paid for associated costs. The Medicare Benefit Policy Manual[10] states that the typical decision to admit a beneficiary as an inpatient should be made within 24 to 48 hours after observation care and that an overnight stay may be a factor in the admission decision. Physicians should use the 24-hour or overnight period as a benchmark, i.e., they should order admission for patients who are expected to need care for 24 hours or overnight. Generally, a beneficiary is considered an inpatient if formally admitted with the expectation that he or she will remain in the hospital overnight, whether or not there is a later transfer or discharge and the patient is not present overnight. Only rarely and in exceptional cases do reasonable and necessary observation services span more than 48 hours. Length of stay is not the basis for payment and it is the physician responsible for patient care who decides if the patient should be admitted.[11]

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[7] *78 Fed. Reg.* at 50907.
[8] *Id.*
[9] *Id.*
[10] Chapter 6, §20.6 and Chapter 1, §10.
[11] 78 Fed. Reg. at 50907-08.

In the Federal fiscal year (FFY) 2014 IPPS proposed rule[12] the Secretary proposed a new benchmark for purposes of medical review of hospital inpatient admissions (Medicare Part A payment). Under this proposal, beneficiaries who were expected to remain in the hospital to receive medically necessary care surpassing 2-midnights after the initiation of care would generally be appropriate for inpatient admission and inpatient payment (known as the "2-midnight rule"). Medicare contractors were to consider all the time after the initiation of care at the hospital in applying the benchmark that inpatient admissions are generally reasonable and necessary (as long as a hospital was not prolonging the provision of care to surpass the 2-midnight timeframe).[13]

Medicare Part B

In the final IPPS rule, the Secretary noted there had been an increasing number of cases in which hospitals had appealed Part A inpatient claim denials in which it was determined the inpatient admission was not reasonable or necessary. These claims had received partial favorable treatment by the Medicare Appeals Council or Administrative Law Judges (ALJs). In those cases, the Medicare review contractor determinations that the inpatient admission was not reasonable or necessary was upheld, but the Medicare Appeals Council and ALJ decisions ordered payment of the services as if they were rendered in an outpatient or observation level of care. These decision effectively required Medicare to issue payment for all Part B services that would have been payable had the patient been treated as an outpatient (rather than an inpatient). In addition, these payments were made whether the subsequent hospital claim for payment was made within the applicable time limit for filing Part B claims. The Secretary pointed out that this was contrary to longstanding polices that permit billing only for a limited list of Part B inpatient services and require the services be billed within specific timeframes.[14]

As a result of the number of these administrative adjudications, the CMS Administrator issued CMS Ruling CMS-1455-P[15] (the Ruling) which established a standard process for effectuating the decisions granting Part B coverage. Among other things, where the administrative adjudicator had issued an order for payment under Medicare Part B, the request for Part B payment would not be rejected if more than one year had elapsed (the time period for filing Part B claims), if the Part A claim had been submitted timely. The Ruling was to remain in effect until the effective date of regulations that finalized "proposed rule CMS-1455-P." In the August 19, 2013 Federal Register, the Secretary revised the Part B inpatient payment policy to allow payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require outpatient status.[16] The one-year deadline for filing claims remains unchanged and the Secretary stated that she was not creating an exception to this requirement (as found in 42 C.F.R. § 424.44(b)(1)-(4)) even though the contractor claims review and appeal process could exceed the 1-year filing period.[17]

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[12] *See generally* 78 Fed. Reg. 27486 (May 10, 2013).
[13] 78 Fed. Reg. 50908.
[14] *Id.*
[15] *See* 78 Fed. Reg. 16614 (March 18, 2013) and on the internet at http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings.html.
[16] 78 Fed. Reg. at 50909.
[17] *Id.* at 50927.

The 2-Midnight Rule

In the final IPPS rule, the Secretary pointed out that CMS had established policy that recognized that there were certain situations in which an inpatient hospital admission was rarely appropriate. This IPPS rule included instructions that provided a benchmark to ensure that all beneficiaries receive consistent application of their Part A benefits to whatever clinical services were medically necessary.[18]

Due to persistently large, improper payment rates for short-stay hospital inpatient claims, and, in response to requests to provide additional guidance regarding proper billing of those services, the Secretary proposed to modify and clarify 42 C.F.R. § 412.3(c)(1). This regulation designates services that are inpatient only (without regard to duration of care), surgical procedures, diagnostic tests and other treatments that would be appropriate for inpatient admission and inpatient payment under Medicare Part A when the physician expects the beneficiary to require a stay that crosses 2 midnights and admits the beneficiary based on that expectation. The starting point for this 2-midnight instruction would be when the beneficiary is moved from any outpatient area to a bed in the hospital in which additional services would be provided and is based on the judgment of the physician and the physician order (the physician must certify that the inpatient services were medically necessary).[19] The Secretary maintains that she has consistently provided physicians with a time-based admission framework to effectuate appropriate inpatient hospital admission decisions.[20]

The Secretary's actuaries estimated that the 2-midnight rule would increase IPPS expenditures by approximately $220 million. These additional expenditures would result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving from OPPS [outpatient PPS] to IPPS and some encounters of less than 2 midnights moving from IPPS to OPPS. The actuaries estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient from the approximately 11 million encounters paid under IPPS. This shift of 40,000 encounters represents an increase of approximately 1.2 percent in the number of shorter stay hospital inpatient encounters paid under IPPS. This additional expenditure would be partially offset by reduced expenditures from the shift of shorter stay hospital encounters to hospital outpatient encounters. The actuaries estimated that, on average, the per encounter payments for these hospital outpatient encounters would be approximately 30 percent of the per encounter payments for the inpatient encounters. In light of the impact of the 2-midnight rule on IPPS and the systematic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, the Secretary decided it was appropriate to use her exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i) to offset the $220 million in additional IPPS expenditures associated with the 2-midnight policy. Consequently, the standardized amount was reduced by 0.2 percent.[21] The Secretary made the same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[22]

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[18] *Id.* at 50944.
[19] *Id.*
[20] *Id.* at 50945.
[21] *Id.* at 50952-53.
[22] *Id.* at 50990.

**Providers' Request for EJR**

The Providers have requested EJR because they believe that the payment rate reduction should be set aside because it exceeds the Secretary's statutory authority under the prospective payment statute, 42 U.S.C. §§ 1395ww(d) (5)(I), is contrary to the plain language and intent of the statute, and is arbitrary, capricious, not based upon substantial evidence, lacks notice for meaningful comment and otherwise defectively both procedurally and substantively.

**Decision of the Board**

The Board has reviewed the submissions of the Providers pertaining to the requests for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy for the appeal exceeds $50,000, as required for a group appeal. The estimated amount in controversy is subject to recalculation by the Medicare Administrative Contractor for the actual final amount.

The Board finds that:

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

2) based upon the Providers' assertions regarding the 0.2 percent reduction to the standardized amount, the hospital specific rate for some SCH and MDH hospitals and Federal rate of capital cost issues, there are no findings of fact for resolution by the Board;

3) it is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

4) it is without the authority to decide the legal question of whether the Secretary's 0.2 percent reduction to the standardized amount, the hospital specific rate for some SCH and MDH hospitals, and Federal rate of capital cost issues, is valid.

Accordingly, the Board finds that the 0.2 percent reduction 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 year. The Providers have 60 days from the receipt of

this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

Board Members Participating

Michael W. Harty
John Gary 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. § 405.1877 and 405.1877
Schedules of Providers

cc: Kevin Shanklin, BCBSA (w/Schedules of Providers)
Donna Kalafut, Noridian (w/Schedules of Providers)
Danene Hartley, NGC (w/Schedules of Providers)
Bryon Lamprecht, WPS (w/Schedules of Providers)
Renee Rhone, Cahaba GBS (w/Schedules of Providers)
Judith Cummings, CGS (w/Schedules of Providers)
Timothy LeJeune, Novitas (w/Schedules of Providers)
Cecile Huggins, Palmetto GBA (w/Schedules of Providers)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2670
FAX: 410-786-5298
Internet: www.cms.gov/PRRBReview Phone: 410-786-2671

AUG 08 2014

CERTIFIED MAIL

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

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

RE: Jurisdictional Decision – Howard University Hospital, *as a participant in* Ober Kaler 2005 DSH/SSI Percentage Calculation Group
Provider No.: Various
FYE: Various 2005
PRRB Case No.: 09-1644G

Dear Mr. Coons 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 May 11, 2009. This group appeal's single issue, SSI percentage, is covered under Centers for Medicare & Medicaid Services (CMS) Ruling CMS-1498-R.

Howard University Hospital (P.N. 09-0003) ("Provider") was issued an original Notice of Program Reimbursement (NPR) for FYE 6/30/2005 on December 21, 2006. The Provider was issued a revised NPR for the same fiscal year end on January 12, 2007. The Provider submitted two appeal requests to the Board on June 14, 2007; one letter appealed from the original NPR and one appealed from the revised NPR. Both appeal requests included the SSI percentage issue. The Board assigned case number 07-2251 to the Provider's appeal from both its original and revised NPRs. The Provider was transferred to this group appeal as part of the group appeal request on May 11, 2009.

**Board's Decision**

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1841 (2006), 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 the notice of the intermediary's determination was mailed to the provider.

Although jurisdiction was not challenged in this case, the Board finds that it does not have jurisdiction over this Provider with respect to its revised NPR. This Provider appealed from a revised NPR which did not specifically adjust the SSI percentage issue.

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2006) 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 ... , either on motion of such intermediary ... or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings.

A revised NPR is considered a separate and distinct determination from which the provider may appeal. 42 C.F.R. § 405.1889, effective October 1, 2002, through May 22, 2008, stated:

> [w]here a revision is made in a determination or decision on the amount of program reimbursement after such a determination or decision has been reopened ... such revision shall be considered a separate and distinct determination or decision to which the provisions of Secs. 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.

The documentation submitted in Howard University Hospital's appeal request from its revised NPR cites adjustments made to DSH generally but does not establish that there was a specific adjustment to SSI percentage in the reopening of the cost report. Because its jurisdiction over revised NPRs is limited to the specific issues revisited on reopening, the Board finds that it does not have jurisdiction over this provider's revised NPR. Howard University Hospital is hereby dismissed from case number 09-1644GC with respect to its revised NPR. However, the Board notes that this Provider also appealed from its original NPR for the same fiscal year which was jurisdictionally valid and will be remanded to the Intermediary pursuant to CMS Ruling CMS-1498-R along with the other providers in the above-referenced 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 upon final disposition of the appeal.

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

FOR THE BOARD

Michael W. Harty
Chairman

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

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

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**

AUG 08 2014

Roberta Nienhueser
Chief Financial Officer
John Fitzgibbon Memorial Hospital
2305 South Highway 65
P.O. Box 250
Marshall, MO 65340

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

RE: Jurisdictional Decision – John Fitzgibbon Memorial Hospital
Provider No.: 26-0142
FYE: 04/30/2007
PRRB Case No.: 13-1940

Dear Ms. Nienheuser and Mr. Lamprecht:

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**

John Fitzgibbon Memorial Hospital ("Provider") was issued its revised Notice of Program Reimbursement (NPR) for FYE 04/30/2007 on October 26, 2012. On April 25, 2013, the Provider filed its individual appeal request from the revised NPR. The issue statement submitted with the request appears to generally cover issues relating to SSI percentage, Medicare Advantage Days included in the DSH SSI and Medicaid fractions, and Dual Eligible Days included in the DSH SSI and Medicaid fractions. The Provider appealed from adjustments to the SSI fraction and the DSH calculation adjusted to reflect the updated SSI fraction.

On November 12, 2013, the Provider requested to transfer issues to the following group appeals:

1. DSH Medicaid Fraction Medicare Advantage Days issue to case number 13-2387G;
2. DSH Medicaid Fraction Dual Eligible Days issue to case number 13-2352G;
3. DSH Medicare Fraction Medicare Advantage Days issue to case number 13-1168G;
4. DSH Medicare Fraction Dual Eligible Days issue to case number 13-0885G; and
5. DSH SSI Data Match issue to case number 13-1170G.

On April 30, 2014, the Intermediary filed a jurisdictional challenge, specifically contesting the Board's jurisdiction over the transferred Medicaid Fraction Medicare Advantage Days issue. The Intermediary found that the revised NPR included adjustments to the SSI fraction but not to the Medicare Advantage Days within the Medicaid fraction. The Intermediary argued that the Board lacked jurisdiction over this issue because the Provider was limited to appealing issues that were adjusted in the reopening of the cost report. The Intermediary concluded that this issue was not properly pending in the individual appeal prior to the Provider's request to transfer this issue to the group appeal.

On May 30, 2014, the Provider requested to withdraw the Medicaid Fraction Medicare Advantage Days issue from case number 13-2387G.

**Board's Decision**

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), 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.

Medicaid Fraction Medicare Advantage Days Issue

The Provider attempted to transfer the Medicaid Fraction Medicare Advantage Days issue to case number 13-2387G on November 12, 2013. Following the submission of the Intermediary's jurisdictional challenge on April 30, 2014, the Provider withdrew the issue from the group appeal on May 30, 2014. Because the Provider is no longer appealing the issue, the Board finds the Intermediary's jurisdictional challenge to be moot.

SSI Data Match, Medicare Fraction Dual Eligible Days, and Medicare Fraction Medicare Advantage Days Issues

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2008) provides in relevant part:

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

In accordance with 42 C.F.R. § 405.1889 (2008), a revised NPR is considered a separate and distinct determination from which the provider may appeal. The regulation provides:

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

reopened but not revised) may not be considered in any appeal of the revised determination or decision.

The Board finds that it can exercise jurisdiction over the SSI Data Match, Medicare Fraction Dual Eligible Days, and Medicare Fraction Medicare Advantage Days issues. The Provider's timely appeal request included general language contesting the recalculation of the SSI ratio and the inclusion of Dual Eligible and Medicare Advantage Days in that fraction. Furthermore, the revised NPR documents the adjustments to Dual Eligible and Medicare Advantage Days included in the recalculated SSI ratio.

Medicaid Fraction Dual Eligible Days Issue

The Board finds that it does not have jurisdiction over the Medicaid Fraction Dual Eligible Days issue because it was not specifically adjusted in the revised NPR. The Provider's appeal request did not document adjustments to Dual Eligible Days in the Medicaid fraction in the reopening; only days included in the SSI fraction were adjusted. Because the Board's jurisdiction is limited to items that were actually adjusted in the reopening, this issue was not properly pending in the individual appeal prior to the Provider's request to transfer the issue to case number 13-2352G.

As the Board lacks jurisdiction over the Medicaid Fraction Dual Eligible Days issue, it is denied transfer to case number 13-2352G and dismissed from this individual appeal. As the remaining issues originating from this individual appeal were either withdrawn or found to be properly transferred to their respective group appeals, the Board hereby dismisses this appeal and case number 13-1940 is 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
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
Executive Director
Senior Government Initiatives
Blue Cross and Blue Shield Association
225 N. Michigan Ave.
Chicago, IL 60601-7680

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

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

Refer to: 08-2316, 14-3524GC and 14-3525GC

**Certified Mail**

AUG 08 2014

Baptist Health System
Shaw Seeley, CPA
Director of Reimbursement
800 Prudential Drive
Jacksonville, FL 32207

Re: **Denial of Transfer Requests**
Baptist Medical Center, Provider No. 10-0088, FYE 09/30/97, Case No. 08-2316
QRS Baptist Health 1997 DSH Dual Eligible Days CIRP Group, Case No. 14-3524GC
QRS Baptist Health 1997 DSH Medicare HMO Days CIRP Group, Case No. 14-3525GC

Dear Shaw Seeley:

The Provider Reimbursement Review Board (Board) is in receipt of the Provider's recent requests to transfer the following issues: Dual Eligible Days into Case No. 14-3524GC and Medicare HMO Days into Case No. 14-3525GC. The pertinent facts and decision of the Board are set forth below.

**Pertinent Facts**

On July 07, 2008, the Board received the Provider's request to appeal its Notice of Amount of Change of Program Reimbursement dated January 7, 2008. The issues raised are as follows:

1. Whether Medicaid days used to compute the Disproportionate Share (DSH) Medicaid utilization in audit correctly included all allowable Medicaid eligible days even if unpaid.

2. Whether the Medicare Capital reimbursement calculation reflects the proper Medicare DSH adjustment factor as reflected in Issue #1 which requires adjustment as a flow through effect.

3. Whether the Supplemental Security Income (SSI) fraction of the Medicare DSH adjustment to reimbursement is properly calculated by the Federal Government (CMS).

On May 21, 2014, the Provider requested to transfer issues from the individual appeal to two group appeals:

- QRS Baptist Health 1997 DSH Dual Eligible Days CIRP Group, Case No. 14-3524GC
- QRS Baptist Health 1997 DSH Medicare HMO Days CIRP Group, Case No. 14-3525GC

**Board Decision**

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 timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more, and the request for hearing is received by the Board within 180 days of the date of receipt of the Intermediary's final determination.

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.

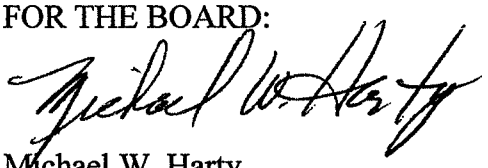
Upon review of the record, the Board finds the Provider did not raise the Dual Eligible Days or Medicare HMO Days issues. Specifically, the Provider appealed the Medicaid Eligible Days, Medicare Capital Reimbursement Calculation and SSI issues, but there was no mention of the Dual Eligible Days or the Medicare HMO Days issues within the text of the issue statement. Further, there is no evidence that these issues were properly added to the appeal.

Therefore, the Board finds that it does not have jurisdiction over the Dual Eligible Days or the Medicare HMO Days issues as they were not timely raised or added to the appeal in accordance with 42 C.F.R. § 405.1835. Since the issues are not pending within the individual appeal, the Board hereby denies transfer of the Dual Eligible Days issue into Case No. 14-3524GC and the Medicare HMO Days issue into Case No. 14-3525GC.

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

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

FOR THE BOARD:



Michael W. Harty
Chairman

Cc: Geoff Pike, First Coast Service Options, Inc. – FL
J.C. Ravindran, Quality Reimbursement Services, Inc.
Kevin D. Shanklin, Blue Cross Blue Shield Association

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

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

Refer to:

CERTIFIED MAIL

AUG 12 2014

CampbellWilson
Manie W. Campbell
15770 North Dallas Parkway
Suite 500
Dallas, TX 75248

RE: Adventist Health 2006 SSI Entitled CIRP Group, PRRB Case No. 10-1038GC
Standard Remand of SSI Proxy Issue

Dear Mr. Campbell:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeal which is subject to remand under CMS Ruling 1498-R. The Board has found jurisdictional impediments with regard to three of the participants in the group appeal. The pertinent facts for these three participants and the Board's determination are set forth below.

Pertinent Facts:

The Adventist Health System 2005 SSI – Entitled CIRP group appeal was filed on May 13, 2010. There are eight participants listed on the Schedule of Providers for the group appeal. Three of the participants, Adventist Medical Center– Portland (38-0060), Feather River Hospital (05-0225) and Ukiah Valley Medical Center (05-0301), (Participant #s 2 through 4) do not have copies of the necessary jurisdictional documentation to support proper appeals of the SSI issue.

Adventist Medical Center – Portland and Feather River Hospital allegedly transferred the SSI Percentage issue from their respective individual appeals to group appeals that were ultimately transferred to this group. Ukiah Valley Medical Center transferred from an individual appeal that is still pending before the Board. None of the documentation submitted shows that the SSI issue was appealed or added to the Providers' individual appeals prior to being transferred to groups.

**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 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 Notice of Program Reimbursement (NPR).

According to the Schedule of Providers, Adventist Medical Center – Portland, Feather River Hospital and Ukiah Valley Medical Center were allegedly transferred to the subject group in 2010. Specifically, Adventist Medical Center (# 2) and Feather River Hospital (#3) transferred the SSI issue from individual appeals (respectively case no. 09-0118 and 09-0247) into group case no. 08-0075G, then transferred to group case no. 07-2707G, then to group case no. 08-1189GC, before ultimately being transferred to this CIRP group. Ukiah Valley Medical Center (# 4) transferred from an individual appeal directly into the subject CIRP group.

None of these participants have proof that the SSI Percentage issue was included in their individual appeals, nor do they have proof that the SSI Percentage issue was added to their individual appeals, prior to being transferred to the subject group. Therefore, the Board dismisses Adventist Medical Center – Portland, Feather River Hospital and Ukiah Valley Medical Center from the group appeal (#s 2 through 4).[1]

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 the SSI fraction under CMS Ruling-1498-R for the remaining participants in the group appeal.

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

For the Board:

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and .1877
Standard Remand of the SSI fraction under CMS Ruling CMS-1498-R

cc: Noridian Healthcare Solutions, LLC (w/enclosures)
Donna Kalafut, JE Part A Appeals Coordinator
P.O. Box 6782
Fargo, ND 58108-6782

BC BS Association (w/enclosures)
Kevin D. Shanklin, Executive Director
Senor Government Initiatives
225 North Michigan Avenue
Chicago, IL 60601-7680

[1] The Representative has requested that they be given an opportunity to cure any defects prior to the Board taking any adverse action on the case. Since the group has been pending since 2010, the Board finds there has been ample time to perfect the appeal.

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

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

Refer to: 10-0394GC

CERTIFIED MAIL

AUG 12 2014

Sutter Health
Wade H. Jaeger
Reimbursement Manager, Appeals/Litigation
P.O. Box 619092
Roseville, CA 95747

Noridian Healthcare Solutions, LLC
Donna Kalafut
JE Part A Appeals Coordinator
P.O. Box 6782
Fargo, ND 58108-6782

RE: Sutter Health 2002 DSH – Labor Delivery Room Days CIRP Group
Provider Names: Alta Bates Medical Center, Summit Medical Center
Provider Nos.: 05-0043, 05-0305
FYE: 06/30/2002 -12/31/2002
PRRB Case No.: 10-0394GC

Dear Mr. Jaeger and Ms. Kalafut,

The Provider Reimbursement Review Board (the Board) has reviewed the jurisdiction documentation submitted in the above-captioned case. The Board's jurisdiction decision is set forth below.

**Pertinent Facts**

On August 3, 2009, Summit Medical Center (Provider Number 05-0043) was issued original NPRs for its fiscal years ending (FYE) 06/30/2002 and 12/31/2002. On August 17, 2009, Alta Bates Medical Center (Provider Number 05-0305) was issued an original NPR for its FYE 12/31/2002. On January 14, 2010, Sutter Health filed a request for a mandatory common issue related party (CIRP) group appeal for its hospitals, noting pending appeals for the above providers and FYEs. The Board assigned case number 10-0394GC to the appeal.

On January 29, 2010, Summit Medical Center (Summit) appealed the Labor and Delivery Room Days (LDR) issue as calculated in the disproportionate share hospital (DSH) payment from both of its NPRs under case numbers 10-0490 (FYE 06/30/2002) and 10-0491 (FYE 12/31/2002). On February 12, 2010, Alta Bates Medical Center (Alta Bates) appealed the LDR issue from its NPR under case number 10-0562. Both hospitals assigned Toyon Associates, Inc. as its Designated Representative for these three appeals.

On January 3, 2011, in response to Summit's request for alternative remand, the Board remanded case numbers 10-0490 and 10-0491 to the Medicare Administrative Contractor (MAC) pursuant to CMS Ruling 1498-R (Ruling). On August 30, 2012, the Board received notification from Alta Bates as to the withdrawal of LDR issue in case number 10-0562 pursuant to an Administrative Resolution (AR) with the MAC.

On October 25, 2013, the Board received a Schedule of Provider with associated jurisdictional documentation for case number 10-0394GC. The schedule of providers included appeal of the LDR issue for Alta Bates Medical Center for FYE 12/31/2002 and Summit Medical Center for FYE 06/30/2002 and 12/31/2002.

**Board's Decision**

The Board finds that it lacks jurisdiction over the appeals of the LDR issue by Alta Bates and Summit because the LDR issue appealed has already been remanded or otherwise settled. CMS has stated, in the relevant part of the Ruling, that:

> [I]t is CMS' further Ruling that the agency and the Medicare contractors will resolve, in accordance with the instructions set forth in Section 5 of this Ruling, each properly pending claim in a DSH appeal, for cost reporting periods beginning before October 1, 2009, in which a provider challenges the exclusion from the DPP of LDR inpatient days.

Under the Ruling, the relief that the Board can give to providers is to remand the appeal to the MAC. Once remanded, the MAC can recalculate the hospital's DSH payment adjustment for the period under appeal. For both of Summit's appeals at issue in this case, the Board has already remanded the LDR issue on January 3, 2011 under case numbers 10-0490 and 10-0491. As the Provider already received the relief which the Board can give, this renders the LDR issue moot. Therefore, Summit's continued appeal of the LDR issue is dismissed from this case.

Alta Bates' continued appeal of the LDR issue following administrative resolution in its individual appeal is also moot. Pursuant to 42 C.F.R. § 405.1835, to be afforded a hearing, a provider must preserve its right to claim dissatisfaction with the amount of Medicare payment for specific items at issue.

Per the appeal withdrawal and transfer request dated August 30, 2012, the Provider and MAC resolved LDR issue as part of the AR in case number 10-0562. While the Provider may have properly claimed dissatisfaction at the payment of labor and delivery room days at the outset of its appeal under case number 10-0562, the resolution in the AR strips the Provider of its ability to further claim dissatisfaction. As the AR renders the LDR issue at appeal in this case number 10-0394GC moot, Alta Bates can no longer continue its appeal over this issue. Therefore, Alta Bates' continued appeal of the LDR issue is also dismissed from this case.

As the LDR issue is the common issue on appeal, Alta Bates Medical Center's appeal for FYE 12/31/2002 and Summit Medical Center's appeals for FYEs 06/30/2002 and 12/31/2002 are hereby dismissed from mandatory CIRP group appeal case number 10-0394GC.

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

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

FOR THE BOARD

Michael W. Harty
Chairman

Enclosures: Schedule of Providers for Case No. 10-0394GC
Alternative Remand Letters for Case Nos. 10-0490 and 10-0491
Appeal Withdrawal and Transfer Letter for Case No. 10-0562
42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin Shanklin, BCBSA

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

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

Refer to: 06-0752

CERTIFIED MAIL AUG 13 2014

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

Noridian Healthcare Solutions, LLC
Donna Kalafut
JE Part A Appeals Coordinator
P.O. Box 6782
Fargo, ND 58108-6782

RE: Jurisdictional Decision – Sutter Medical Center of Santa Rosa
Provider No.: 05-0291
FYE: 12/31/2001
PRRB Case No.: 06-0752

Dear Mr. Blumberg and Ms. Kalafut,

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

**Background**

The Intermediary issued a Notice of Program Reimbursement (NPR) for FYE 12/31/2001 on September 14, 2005. On February 22, 2006, the Provider submitted an Appeal Request to the Board where it appealed the Medicare SSI% issue. Afterwards, the Provider added the following issues to the appeal on the following dates: the Medicare SSI Realignment and Dual Eligible Patient Days issues on October 8, 2008; the Medicare Unbilled Crossover Bad Debt for inpatient and outpatient services on October 17, 2008; and the Rural Floor Budget Neutrality Adjustment issue on October 20, 2008.

Subsequently, the Provider transferred all but one of the issues into group appeals. On October 13, 2009, Medicare Unbilled Crossover Bad Debt issues for inpatient and outpatient services were transferred into case numbers 02-2168G and 99-3524G, respectively. The Dual Eligible Patient Days issue was transferred into case number 08-2622G on November 12, 2010. The Rural Floor Budget Neutrality Adjustment issue was transferred to case number 09-0644GC on November 8, 2011. The Medicare SSI% issue was transferred into case number 09-1932GC on December 12, 2012.

After the transfers, the sole issue remaining in the appeal is the Medicare SSI Realignment issue, in which the Provider claims that it may exercise its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period once it obtains and reconciles the underlying data.

**Board's Decision**

The Board has chosen to review whether it has jurisdiction over the SSI realignment issue in this appeal on its own motion and finds that it does not have jurisdiction as the appeal is premature. 42 C.F.R. § 405.1835 (2005) states:

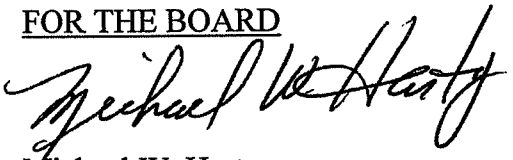
> "The provider... has a right to a hearing before the Board about any matter designated in § 405.1801(a)(1), if...[a]n intermediary determination has been made with respect to the provider."

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. Therefore, the SSI realignment issue is hereby dismissed. Since the SSI Realignment Issue was the sole remaining issue in the appeal, case number 06-0752 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
L. Sue Anderson
John Gary Bowers, CPA
Clayton J. Nix, Esq.

FOR THE BOARD



Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, BCBSA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2670
Phone: 410-786-2671
Internet: www.cms.gov/PRRBReview FAX: 410-786-5298

Refer to: 14-3736G, 14-3813GC
Certified Mail

AUG 13 2014

Stephanie A. Webster, Esq.
Akin, Gump, Strauss, Hauer & Feld
Robert S. Strauss Building
1333 New Hampshire Avenue, NW
Washington, DC 20036-1564

RE: Akin Gump 2012 Post-Allina Decision Medicare Part C Days Group, Provider Nos. Various, FY 2012, PRRB Case No. 14-3736G
Allina Health 2012 Post-Allina Decision Medicare Part C Days, Provider Nos. Various, FY 2012, PRRB Case No. 14-3813GC

Dear Ms. Webster:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' July 17, 2014 request for expedited judicial review (EJR) (received July 18, 2014) in case number 14-3736G and the July 25, 2014 EJR request (received July 28, 2014) in case number 14-3813GC. The Board decision granting the request for EJR is set forth below.

## Issue before the Board

The issue before the Board in these cases is whether "enrollees in [Medicare] Part C are 'entitled to benefits' under Part A, such that they should be counted in the Medicare [Part A/SSI] fraction [of the disproportionate share (DSH) adjustment], or whether, if not regarded as 'entitled to benefits under Part A,' they should instead be included in the Medicaid fraction of the DSH adjustment."[1]

## Background on Medicare Part C

### Medicare Health Maintenance Organizations and the Medicare Advantage Program[2, 3]

The Medicare program permits its beneficiaries to receive services from managed care entities. The managed care statute implementing payments to health maintenance organizations (HMOs) and competitive medical plans (CMPs) is found at 42 U.S.C. § 1395mm. The statute at 42 U.S.C. §

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[1] Providers' Requests for EJR at 4.
[2] *See http://www.medicare.gov/glossary/m.html.* (A Medicare Advantage Plan is a type of Medicare health plan offered by a private company that contracts with Medicare to provide beneficiaries with all Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If a beneficiary is enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and are not paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.) (last visited August 4, 2014).
[3] *See http://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/* (The [Medicare + Choice (M+C)] program in Part C of Medicare was renamed the Medicare Advantage (MA) Program under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which was enacted in December 2003. The MMA further established the Medicare prescription drug benefit (Part D) program, and amended the Part C program to allow most MA plans to offer prescription drug coverage.) (last visited August 4, 2014).

1395mm(a)(5) provides for "payment to the eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter . . . ." Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days. In the September 4, 1990 Federal Register, the Secretary[4] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[5]

At that time, Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[6]

With the creation of Medicare Part C in 1997,[7] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the intermediaries to calculate DSH payments for the FY 2001-2004.[8]

No further guidance regarding the treatment of Part C days in the DSH calculation was provided until the Federal fiscal year (FFY) 2004 Inpatient Prospective Payment System (IPPS) proposed rules were published in the May 9, 2003 Federal Register. In that notice the Secretary stated that:

> . . . an individual is eligible to elect an M+C plan if he or she is entitled to Medicare Part A and enrolled in Part B. However, once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the*

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[4] of Health and Human Services.
[5] 55 Fed. Reg. 35,990, 39,994 (September 4, 1990).
[6] *Id.*
[7] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ."
[8] 69 Fed. Reg. 48,918, 49,099 (August 11, 2004).

> *DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction.*[9]

The Secretary purportedly changed her position in the FFY 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [M+C] beneficiaries in the Medicare fraction of the DSH calculation."[10] In response to a comment regarding this change, the Secretary explained that:

> *. . . we do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A.* We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. [11]

Although change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until the FFY 2008 final rule was published in the August 22, 2007 Federal Register.[12] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule, published in the August 11, 2004 Federal Register. As a result, Part C days were required to be included in the Medicare fraction as of October 1, 2004. In this Federal Register notice the Secretary stated that:

> In the FY 2005 IPPS final rule (69 FR 49099), we discussed in the preamble our policy change to reflect the inclusion of the days associated with Medicare+Choice (now Medicare Advantage) beneficiaries under Medicare Part C in the Medicare fraction of the DSH calculation. In that rule, we indicated that we were revising the regulation text at [42 C.F.R.] § 412.106(b)(2)(i) to incorporate this policy. However, we inadvertently did not make a change in the regulation text to conform to the preamble language. We also inadvertently did not propose to change § 412.106(b)(2)(iii) in the FY 2005 final rule, although we intended to do so. Section 412.106(b)(2)(i) of the regulations discusses the numerator of the Medicare fraction of the Medicare disproportionate patient percentage

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[9] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003) (emphasis added)
[10] 69 Fed. Reg. 49,098, 49,099 (August 11, 2004).
[11] *Id.(emphasis added)*
[12] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).

> (DPP) calculation while § 412.106(b)(2)(iii) of the regulations discusses the denominator of the Medicare fraction of the Medicare DPP. We intended to amend the regulation text with respect to both the numerator and the denominator of the Medicare fraction of the Medicare DPP. Therefore, in this final rule with comment period, we are making this technical correction to § 412.106(b)(2)(i) and to § 412.106(b)(2)(iii) to make them consistent with the preamble language of the FY 2005 IPPS final rule and to effectuate the policy iterated in that rule.
>
> With respect to the technical correction that we are making to § 412.106(b)(2)(iii), we note that we ordinarily publish a notice of proposed rulemaking in the Federal Register to provide for a period for public comment before a provision such as this would take effect. However, we can waive this procedure if an agency finds good cause that a notice and comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the notice issued. We find it unnecessary to undertake notice and comment rulemaking in this instance for the additional change to § 412.106(b)(2)(iii) because this notice merely provides technical corrections to the regulations and does not make any substantive changes to the regulations or our existing policy. Therefore, under 5 U.S.C. 533(b)(B), for good cause, we waive notice and comment procedures.[13]

Federal Court Decisions in *Allina Health Services v. Sebelius (Allina)*[14]

In the District Court decision in *Allina* the Court concluded that the Secretary's interpretation of the fractions used in the DSH calculation and not added to the Code of Federal Regulations until the summer of 2007 (FFY 2008) were not a logical outgrowth of the notice of proposed rulemaking in 2003. In fact, the Secretary's actions were a 180-degree shift in position and a reasonable person would not have understood that such a conclusion would be reached. The Court found that the 2003 notice of proposed rulemaking did not provide adequate notice of the interpretation of the DSH fraction adopted by the Secretary in 2004 in violation of the Administrative Procedures Act and Medicare Act. The Court determined that vacatur was appropriate because the Secretary did not validly change her interpretation of the DSH calculation prior to 2007 and ordered recalculation without using the interpretation in the 2004 rule.[15]

On appeal, the D.C. Circuit Court[16] affirmed the vacatur, but determined that remanding for payment without using the 2004 Final Rule was not correct. Rather than telling the Secretary how to calculate the hospitals' reimbursement, the case should have been remanded with the error identified. The Circuit Court limited its ruling to finding that the change to the policy was not a logical outgrowth of the proposed rule. The Secretary had argued that she might obtain the same result [application of the

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[13] *Id.*
[14] 904 F. Supp. 2d 75 (D.D.C. 2012)
[15] *Id.* at 95.
[16] 746 F.3d. 1102 (D.C. Cir. 2014).

invalid rule] through adjudication and since that issue was not before the court, the district court erred in ordering recalculation.[17]

**Providers' Requests for EJR**

The Providers explain that they were all participants in the *Allina* cases[18] discussed above in which the Federal courts vacated the Secretary's 2004 change to the treatment of Medicare Part C days in the DSH calculation. The Providers were all reimbursed by applying the regulation that was invalidated by the Courts. They are seeking an expeditious ruling on whether the rule remains valid and applicable after the *Allina* decisions or whether the Secretary's actions constitutes unlawful nonacquiecence of binding D.C. Circuit law and a violation of statutory procedural requirements. The Providers do not believe the Board has the authority to grant the relief sought.

The Providers note that in 2013 the Secretary recalculated the Part A/SSI fractions for FFYs 2010 and 2011 for all hospitals nationwide to include Part C days. However, in accordance with the Court's vacatur of the 2004 rule, the Secretary calculated revised fractions for the Providers that excluded the Part C days consistent with the pre-2004 policy. In addition, while *Allina* was pending in the courts, the Secretary engaged in rule making by issuing a new notice and comment stating that the agency proposed to readopt the policy of counting Part C days in the Medicare fraction.[19]

Although the time for the Secretary to file a petition for *certiorari* from the *Allina* decision expired June 30, 2014, the Secretary has not issued a notice acquiescing in the D.C. Circuit Court's vacatur. In mid-June of 2014, the agency published the Part A/SSI fractions for 2012, including Part C days for all hospitals. The Providers notified the Secretary of their view that the inclusion of Part C days in the Medicare fraction violated the D.C. Circuit court's decision and new fractions should be calculated. The Providers indicate the Secretary responded that new fractions would not be calculated. The Providers contend that the vacatur restores the previously governing policy until there is a change through valid rulemaking.

**Decision of the Board**

The Board finds that EJR is appropriate for the issue under dispute in these cases. 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permit expedited judicial review where the Board determines that has jurisdiction over the appeal but it does not have the authority to decide a question of law, regulation or CMS ruling. In this case, the Providers are challenging the whether "enrollees in [Medicare] Part C are 'entitled to benefits' under Part A, such that they should be counted in the Medicare [Part A/SSI] fraction [of the DSH adjustment], or whether, if not regarded as 'entitled to benefits under Part A,' they should instead be included in the Medicaid fraction of the DSH adjustment."[20]

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[17] *Id.* at 1111.
[18] Generally, the *Allina* cases heard in the District of Columbia district and circuit courts involve the FFYs 2007 and 2008. The current cases involve later FFYs.
[19] *See* 78 Fed. Reg. 50,496, 50,615 (August 19, 2013).
[20] Providers' Requests for EJR at 4.

The Board has reviewed the submissions of the Providers pertaining to the request for hearing and expedited judicial review. The Intermediary did not oppose the request for EJR. The documentation shows that the estimated amount in controversy exceeds $50,000 for a group appeal and the appeals were timely filed. In addition, the Providers protested the issue on their as-filed cost reports 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 year and the Providers are entitled to a hearing before the Board;

2) based upon the Providers' unopposed assertions regarding the Medicare Part C issue and the Secretary's actions subsequent to the decision in *Allina*, there are no findings of fact for resolution by the Board;

3) it is bound by the regulation; and

4) it is without the authority to decide the legal question of whether the regulation regarding the treatment of Medicare Part C days is valid and whether the Secretary's actions subsequent to the decision in *Allina* are legal.

Accordingly, the Board finds that the Medicare Part C days issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provider's request for expedited judicial review for the issue and the subject year. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the cases.

Board Members Participating

Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo (f)(1), Schedules of Providers

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

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

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

Internet: www.cms.gov/PRRBReview

Refer to: 13-0953

AUG 20 2014

CERTIFIED MAIL

Mercy Health
Blake Cosper
Regional Director, Reimbursement
Revenue Integrity & Reimbursement
1235 E. Cherokee
Springfield, MO 65804

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

RE: Mercy Hospital Springfield
Provider No.: 26-0065
FYE: 06/30/2007
PRRB Case No.: 13-0953

Dear Messrs. Cosper and Lamprecht,

The Provider Reimbursement Review Board (the Board) has reviewed the jurisdiction documentation submitted in the above-captioned case. The Board's jurisdiction decision is set forth below.

**Pertinent Facts**

On August 13, 2009, Mercy Hospital Springfield (Provider) was issued a Notice of Program Reimbursement (NPR) for fiscal year end (FYE) 06/30/2007. On October 25, 2012, the Provider was issued a revised NPR for the same FYE. The audit adjustment report from the revised NPR specifically stated that the revision was to adjust the Supplemental Security Income percentage (SSI%) and Disproportionate Share Hospital percentage (DSH%) to the correct amount. On February 27, 2013, the Board received an appeal based on the revised NPR.[1] The Provider disputed the following issues:

- accuracy of SSI Days (SSI Accuracy),
- use of the Federal fiscal year for the Provider's cost report (SSI Realignment),
- exclusion of Dual Eligible Medicaid and Medicare Part A Days from the Medicaid Fraction (Dual Eligible Days – Medicaid Fraction),
- inclusion of Medicare Part C Days in the SSI% (Part C Days – SSI Fraction), and

[1] Case No. 13-0953 was established on February 27, 2013, but the original submission included enclosures for FYE 06/30/2008. The Board notified the Provider of the incorrect enclosures, and the Board received the corrected appeal on March 7, 2013.

- exclusion of Medicare Part C Days from the Medicaid Fraction (Part C Days – Medicaid Fraction).

On November 1, 2013, the Board received the Provider's request to transfer the following issues into these respective mandatory CIRP group appeals: SSI Accuracy into 13-3955GC; both Part C Days – SSI Fraction and Part C Days – Medicaid Fraction into 13-3954GC; and Dual Eligible Days into 14-0454GC.

On January 14, 2014, the Board received three jurisdiction challenges from the Medicare Administrative Contractor (MAC), Wisconsin Physicians Service. The Provider has not filed a responsive brief regarding jurisdiction.

**MAC's Jurisdictional Challenges**

For the first and second jurisdictional challenges, the MAC contends that the Provider did not timely appeal the accuracy of the Dual Eligible Days and Part C Days issues because the current appeal request, dated February 26, 2013, was filed 1,293 days after the original NPR, dated August 13, 2009, was mailed. The MAC argues that the Provider is attempting to utilize the date of the revised NPR to meet the timeliness requirement, but the sole issue addressed within the revised NPR was the SSI%.

For the third jurisdictional challenge, the MAC contends that the SSI Realignment issue is suitable for reopening, but the issue itself is not appealable. The MAC states that the decision to realign its SSI% with its FYE is a hospital election, not a MAC determination. Because the Provider did not make this election for realignment, and the MAC did not make a final determination on this issue, the MAC claims the Board lacks jurisdiction over the SSI Realignment issue.

**Provider's Response**

The Provider did not respond to the MAC's jurisdictional challenges.

**Board's Decision**

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 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 Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2008) provides in relevant part:

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

> matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the intermediary (with respect to intermediary determinations) or by the reviewing entity that made the decision (as described in § 405.1885(c) of this subpart).

In accordance with 42 C.F.R. § 405.1889 (2008), a revised NPR is considered a separate and distinct determination from which the provider may appeal.[2] The regulation provides:

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

In this appeal, the MAC issued the revised NPR on October 25, 2012. The Board established the appeal for the Provider upon receipt of its initial appeal request on February 27, 2013. The timespan from the issuance of the revised NPR to the receipt of the appeal was 125 days, which is well within the 180 day timeliness requirement. Therefore, the Board finds that the appeal from the revised NPR was timely filed in accordance with 42 C.F.R. § 405.1835(a)(3)(i).

However, the Board has reviewed the jurisdictional validity of the specific issues within the Provider's appeal from its revised NPR. Here, the Provider's audit adjustment report associated with the October 25, 2012 revised NPR shows that SSI% was specifically adjusted, which has a flow-through effect to the DSH%, but there was no adjustment made to Medicaid days.

Because Medicaid days, whether Dual Eligible Part A or Part C, were not specifically adjusted in the revised NPR, the Board finds that it does not have jurisdiction over the Dual Eligible Days – Medicaid Fraction and the Part C Days – Medicaid Fraction issues. Therefore, the Board dismisses these issues from the case and denies the transfer of the issues to the CIRP groups at Case Nos. 14-0454GC and 13-3954GC, respectively.

However, as the SSI% was specifically revised, the Board does have jurisdiction over the SSI Accuracy and Part C Days – SSI Fraction issues. The Board acknowledges the transfer of the

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[2] *See also, HCA Health Services v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

SSI Accuracy issue into Case No. 13-3955GC and the Part C Days – SSI Fraction issue into Case No. 13-3954GC.[3]

Lastly, the Board finds that it lacks jurisdiction over the SSI Realignment issue as the appeal of this issue is premature. Realignment is a remedy the Provider may pursue if it is dissatisfied with MEDPAR SSI data and in its appeal request, the Provider indicates that it "retains the right to evaluate the propriety of requesting a change in the time period upon which the SSI calculation is based ..."[4] The Provider has not yet decided whether it will request realignment and there was no final determination made by the MAC. Therefore the SSI Realignment issue is dismissed from the appeal.

As the Dual Eligible Days – Medicaid Fraction, Part C Days – Medicaid Fraction, and SSI Realignment issues have been dismissed from this appeal, and the SSI Accuracy and Part C Days – SSI Fraction issues have been transferred to other appeals, there are no remaining issues in dispute for Case No. 13-0953. The appeal is hereby closed and removed from the Board's docket.

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

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

cc: Kevin Shanklin, BCBSA

[3] The Board will address the bifurcation of Case No. 13-3954GC in a separate letter to account for the different issues, specifically the inclusion of Medicare Part C Days in the SSI% vs. the exclusion of Medicare Part C Days from the Medicaid Fraction.
[4] Provider appeal request, Tab 3 at 1.

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

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

Refer to: 07-1356

AUG 20 2014

CERTIFIED MAIL

Hall Render Killian Heath & Lyman
Keith D. Barber, Esq.
One American Square
Suite 2000, P.O. Box 82064
Indianapolis, IN 46282

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

RE: St. Vincent Mercy Hospital
Provider No. 15-1308
FYE June 30, 2005
PRRB Case No. 07-1356

Dear Mr. Barber and Mr. Lamprecht:

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, the Parties' positions and the Board's jurisdictional determination are set forth below.

## BACKGROUND

The Provider filed its initial appeal on March 19, 2007, for its cost reporting period ending June 30, 2005, from a notice of program reimbursement dated September 28, 2006. The Provider appealed one issue –

> The Fiscal Intermediary's disallowance of all costs related to the hospital's Medical Specialty clinic was inappropriate. Costs for this clinic were permitted by the Fiscal Intermediary in prior years with similar documentation. Audit Adjustment No. 25.

The Intermediary filed its final position paper on December 19, 2013 challenging the Board's jurisdiction over the subject appeal. On February 25, 2014, the Provider filed a responsive brief to the Intermediary's challenge.

## INTERMEDIARY'S CONTENTIONS:

The Intermediary challenges the Board's jurisdiction over the sole issue in the subject appeal, Medical Specialty clinic costs. The Intermediary does not believe that the Board has jurisdiction over this issue

because the Provider failed to meet the requirements of 42 C.F.R. § 405.1835(a)(1).[1] The Intermediary did not make an adjustment for the Medical Specialty clinic "costs." The Intermediary adjusted the charges for the Medical Specialty clinic due to lack of documentation. The Intermediary notes that the Provider "consolidated two cost centers together for the Medical Specialty clinic costs (60-Clinic and 53.01-Oncology)."[2] The Intermediary contends that the Provider was not precluded from properly classifying the costs of the Medical Specialty clinic in the proper cost centers on its as filed cost report. Therefore, the Intermediary identifies these as "unclaimed costs."

The Intermediary cites to a recent PRRB Board decision that address "unclaimed costs."[3] In *St. Vincent* the costs were claimed on the as filed cost report however there was no adjustment to the costs. The Intermediary maintains that since this Provider is located in the Seventh Circuit, the *St. Vincent* decision applies to the subject appeal.

**PROVIDER'S CONTENTIONS:**

The Provider believes the Board has jurisdiction over the Medical Specialty clinic "costs." The Provider argues that these costs were included on the as filed cost report. Therefore, the instant case is distinguishable from the *St. Vincent* and *Little Company of Mary*[4] decisions.

The Provider contends that the Intermediary adjusted the charges associated with the Medical Specialty clinic thereby it has a right to appeal the costs associated with the Medical Specialty clinic.

**RECOMMENDATION:**

The Board finds that the Provider does not have a right under 42 U.S.C. § 1395oo(a) to a hearing on the Medical Specialty clinic cost issue. The Provider received reimbursement for the items and services claimed on its as filed cost report and, therefore, is not dissatisfied under § 1395oo(a). Also, the Board declines to hear this matter under its discretionary powers of review pursuant to 42 U.S.C. § 1395oo(d).

42 U.S.C. § 1395oo(a) establishes the Board's jurisdiction. It provides in relevant part:

> Any provider of services which has filed a required cost report within the time specified in the regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board . . . if –
>
> (1) such provider
>
> (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for

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[1] The Intermediary refers to 42 C.F.R. § 405.1825 in its final position paper at 9; the correct regulation is 42 C.F.R. § 405.1835.

[2] *See* Provider final position paper at 4.

[3] *See St. Vincent v. BlueCross BlueShield Ass'n,*, PRRB Decision 2013-D39 (Sept. 13, 2013), *declined review*, CMS Administrator (Nov. 4, 2013).

[4] *See Little Company of Mary Hosp. v. Shalala*, 24 F.3d 984 (7th Cir. 1994) and *Little Company of Mary Hosp. v. Shalala*, 165 F.3d 1162 (7th Cir. 1999)

> the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by this report . . .

After jurisdiction is established under 42 U.S.C. § 1395oo(a) the Board has the discretionary power to make a determination over all matters covered by the cost report under 42 U.S.C. § 1395oo(d) which states in relevant part:

> The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

The Provider does not have a right to hearing on the Medical Specialty clinic costs that it did not properly report on its as filed cost report under 42 U.S.C. § 1395oo(a). In *Bethesda Hospital Association v. Bowen*,[5] the provider failed to claim a cost because a regulation dictated that it would have been disallowed. In that situation, the Supreme Court found section 1395oo(a) permitted jurisdiction over the "self disallowed" claim. The Court wrote:

> [U]nder subsection (a)(1)(A)(i), a provider's dissatisfaction with the amount of its total reimbursement is a condition to the Board's jurisdiction. 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.*[6]

The Court recognized that a situation where a regulation pre-determines a disallowance is distinct from those in which a provider simply neglects to include an item on the cost report for which it would be due reimbursement:

> Thus, petitioners stand on different ground than do providers who bypass a clearly prescribed exhaustion requirement or *who fail to request from the intermediary reimbursement for all costs to which they are entitled under 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 fiscal intermediary, those circumstances are not presented here.[7]

The Seventh Circuit has adopted an interpretation of *Bethesda* that precludes Board jurisdiction where the provider's request would not have been clearly futile. Specifically, in 1994 in *Little Co. of Mary Hosp. v. Shalala* ("*Little Co. I*"),[8] the Seventh Circuit relied on the *Bethesda* dicta, noting that a provider's failure to claim all the reimbursement to which it is entitled under program policies is tantamount to a "failure to exhaust" administrative remedies before the fiscal intermediary, which

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[5] *Bethesda,* 485 U.S. 399 (1988).
[6] *Id.* at 1258, 1259. (Emphasis added).
[7] *Id.* at 1259. (Emphasis added).
[8] 24 F.3d 984 (7th Cir. 1994).

establishes that the provider is not "dissatisfied" with the intermediary's final reimbursement determination.[9]

Subsequently, in 1999, the Seventh Circuit addressed the same issue in a case involving the same provider ("*Little Co. II*").[10] In *Little Co.II*, the Seventh Circuit held that the Board lacked jurisdiction over an appeal of an issue that the Intermediary had not considered, and distinguished *Bethesda* on the grounds that the cost issue on appeal in *Little Co. II* did not involve an "issue of policy" like the *Bethesda* plaintiffs' challenge to the malpractice regulations.[11] The Seventh Circuit noted:

> But while the statute is curiously worded, the intent is plain that the provider must give the intermediary a first shot at the issue, provided the issue is within the intermediary's competence...[12]

Citing *Little Co. II,* the preamble to the 2008 final rule (while not controlling for this cost reporting year under appeal) states that it has been the agency's "longstanding view that providers that fail to claim on their cost reports costs that are allowable under Medicare law and regulations cannot meet the 'dissatisfaction' requirement" of subsection (a).[13] The Agency policy of presentment aims to prevent an end-run around the Intermediary. The Agency further states that it "interpret[s] section 1878(d) of the Act as permitting the Board to make revisions to cost report items that directly flow from the determination with which the Provider has expressed dissatisfaction and from which the provider has filed a jurisdictionally proper appeal under section 1878(a) of the Act."[14]

The errors for reporting the costs of the Medical Specialty clinic were due solely to the Provider's negligence in understanding the Medicare regulations governing the reimbursement of such costs on the Medicare cost report. Only in hindsight did the Provider determine that it could (and should) have reported these costs in separate cost centers, thereby potentially increasing the amount of reimbursement. Rather, this case is precisely the situation described by the Supreme Court as being "on different ground" because the Provider "fail[ed] to request from the intermediary reimbursement for all costs to which [it was] entitled under applicable rules."[15]

The Board gleans from these cases the principle that a provider does not have a <u>right</u> to an appeal of an expense inadvertently omitted from the cost report or mistakenly reported. As the Ninth Circuit stated in *Loma Linda Univ. Med. Ctr. V Leavitt,* 492 F.3d (9th Cir. 2007), "[t]here is no dispute that 1395oo(a) is the gateway provision for Board jurisdiction."[16] Nor does the case law stand for the proposition that § 1395oo(d) is a grant of "alternate" jurisdiction. That view ignores the very essence of the Courts' holdings. These decisions make it clear the Board's power under § 1395oo(d) is discretionary. The Board may hear the appeals of <u>claims inadvertently omitted or mistakenly reported</u> on the cost report but the Board is not required to hear those claims.

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[9] *Little Co. I,* 24 F.3d at 992.
[10] *Little Co. of Mary Hosp. v. Shalala,* 165 F.3d 1162 (7th Cir. 1999).
[11] *Little Co. II,* 165 F.3d at 1165.
[12] *Id.*
[13] 73 Fed. Reg. at 30196.
[14] 73 Fed. Reg. at 30203.
[15] *Bethesda,* 485 U.S. at 404-405.
[16] *Loma Linda* at 1070.

The Board finds that the Seventh Circuit decisions in *Little Co. I* and *Little Co. II* are controlling precedent in this case. Since the only issue in this appeal does not give the Board jurisdiction under subsection (a) pursuant to this controlling precedent, the Board cannot exercise its discretion under subsection (d) to make any other revisions on matters covered by the cost report.

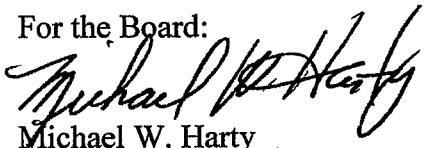
Even if the Seventh Circuit decisions were not controlling precedent, the Board would reach the same result. The Board generally has interpreted 42 U.S.C. § 1395oo(a) as the gateway to establishing Board jurisdiction to hear an appeal and requiring a provider to establish a right to appeal on a claim-by-claim or issue-specific basis. Accordingly, the Board finds that only when the provider has established jurisdiction under § 1395oo(a) with respect to one or more of such claims/issues can the Board then exercise discretion to hear other claims not considered by the intermediary (*e.g.*, unclaimed costs).[17] Further, the Board has consistently declined to exercise discretion under 42 U.S.C. § 1395oo(d) to hear appeal of other issues involving unclaimed costs when reimbursement of those costs was not precluded by a specific law, regulation, CMS Ruling or manual instruction and has dismissed those appeals when the sole issue(s) in the case involves unclaimed costs.[18]

Therefore, the Board dismisses the Medical Specialty clinic costs issue from the subject appeal as it lacks jurisdiction over the issue under § 1395oo(a) and thereby cannot exercise its discretionary power under § 1395oo(d). As no other issues remain, the Board hereby closes the subject 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.

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

For the Board:



Michael W. Harty
Chairman

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

cc: Kevin Shanklin, Managing Director, BCBSA

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[17] *See, e.g., Affinity Med. Ctr. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2010-D15 (Mar. 11, 2010), *declined review*, CMS Administrator (May 3, 2010) ("*Affinity*") (analyzing a provider's right to a hearing on an issue-specific basis rather than a general basis). *See also* Board Rule 7; 73 Fed. Reg. at 30197.

[18] *Id.* This would not be a case in which the Board would deviate from this practice.

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

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

Refer to:

CERTIFIED MAIL

AUG 21 2014

Hooper Lundy & Bookman, P.C.
Robert L. Roth
401 9th Street, N.W., Suite 550
Washington. DC 20004

RE: Staten Island University Hospital, Provider No. 33-0160, FYE 1997
*as a participant in* East Coast 1991-2004 SSI/DSH Group, PRRB Case No.: 03-1320G

Dear Mr. Roth:

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above-referenced appeal in response to your July 31, 2014 request for reinstatement/reconsideration of jurisdiction. The Board's jurisdictional determination is set forth below.

**Background**

The Providers filed an initial request for a group appeal on June 17, 2003. This group appeal's single issue, SSI percentage, is covered under Centers for Medicare & Medicaid Services (CMS) Ruling CMS-1498-R.

Staten Island University Hospital (33-0160) (Staten Island) was issued an original Notice of Program Reimbursement (NPR) for FYE 12/31/1997 on June 26, 2000. Staten Island was issued a revised NPR for the same fiscal year end on June 12, 2003. The Provider filed an appeal of its original NPR on July 24, 2000, to which the Board assigned case number 00-3636. The appeal of the revised NPR was submitted on June 12, 2003. Both appeal requests appealed the Disproportionate Share Adjustment (but did not specify the SSI percentage issue.) The Board assigned case number 03-1357 to the Provider's appeal from the revised NPR. The SSI percentage issue was transferred from both of Staten Island's appeals in the letter used to establish the subject group appeal, dated June 14, 2004.

**Board's Decision**

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1841 (2006), 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 the notice of the intermediary's determination was mailed to the provider.

The Board finds that it does not have jurisdiction over this Provider with respect to its revised NPR because the Provider appealed from a revised NPR which did not specifically adjust the SSI

percentage issue.

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2006) 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 ... , either on motion of such intermediary ... or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings.

A revised NPR is considered a separate and distinct determination from which the provider may appeal. 42 C.F.R. § 405.1889, effective October 1, 2002, through May 22, 2008, stated:

> [w]here a revision is made in a determination or decision on the amount of program reimbursement after such a determination or decision has been reopened ... such revision shall be considered a separate and distinct determination or decision to which the provisions of Secs. 405.1811, 405.1835, 405.1875, and 405.1877 are applicable.

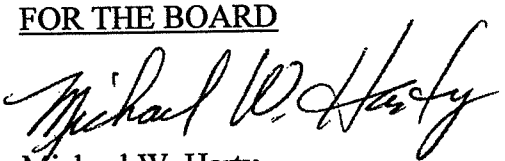
This regulation has also been addressed and explained in the decision *HCA Health Services of Oklahoma v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994). In that case the Court held that when a fiscal intermediary reopens its original determination regarding the amounts of reimbursement that a Medicare provider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

The documentation submitted in Staten Island's appeal request from its revised NPR cites adjustments made to DSH generally but does not establish that there was a specific adjustment to the SSI percentage in the reopening of the cost report. Because its jurisdiction over revised NPRs is limited to the specific issues revisited on reopening, the Board finds that it does not have jurisdiction over this provider's revised NPR. Therefore, the Board reaffirms its determination to deny Staten Island's participation in group 03-1320G with respect to its revised NPR. The Board notes that this Provider's appeal from its original NPR for the same fiscal year, which was jurisdictionally valid, was remanded to the Intermediary pursuant to CMS Ruling CMS-1498-R along with the other providers in the above-referenced 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.

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

FOR THE BOARD



Michael W. Harty
Chairman

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

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

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore, MD 21244-2670
Phone: 410-786-2671 Fax: 410-786-5298

**CERTIFIED MAIL**

AUG 21 2014

Providence Health & Services
Megan Menkveld
Manager, Reimbursement Services
2001 Lind Avenue, SW
Suite 300
Renton, WA 98055

RE: **Providence General Medical Center**
Provider Number: 50-0014
FYE: 12/31/2006
PRRB Case Number: 09-1158

Dear Ms. Menkveld:

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 19, 2009, and filed from a Notice of Program Reimbursement (NPR) dated October 1, 2008. The Provider appealed the following issues:

1. DSH/SSI Percentage
2. DSH-SSI Realignment

On November 5, 2009, Quality Reimbursement Services (QRS) submitted a request to transfer the DSH/SSI issue to CIRP Group Case No. 09-1746GC.

**Board Determination:**

**SSI Realignment Issue:**

In its description of the SSI Ratio Alignment issue, the Provider stated:

> The Provider seeks to reconcile its records with CMS data and identify records that CMS may have failed to include in their determination of the SSI percentage. *The Provider may exercise its' right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period....* (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:

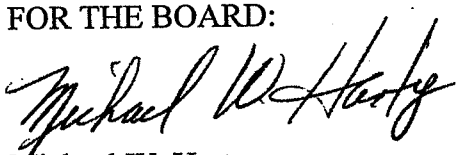
> The provider ... has a right to a hearing before the Board about any matter designated in §405.1801(a)(1), if ... [a]n intermediary determination has been made with respect to the provider.

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
Lee Crooks
Appeals Coordinator
JF Provider Audit Appeals
P.O. Box 6722
Fargo, ND 58108-6722

Kevin D. Shanklin
Executive Director
Senior Government Initiatives
BC & BS Association
225 North Michigan Avenue
Chicago, IL 60601-7680

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

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

Refer to: Certified Mail

AUG 21 2014

Keith D. Barber, Esq.
Hall, Render, Killian, Health & Lyman
One American Square, Suite 2000
Box 82064
Indianapolis, IN 46282

RE: Hall Render Federal Fiscal Year 2014 Two Midnight Rule Group Appeals

See attached List

Dear Mr. Barber:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' July 10, 2014 request for expedited judicial review (EJR) (received July 11, 2014) and the August 6, 2014 response to the Board request for additional information (received August 7, 2014) for the two midnight rule group appeals identified on the attached list. The Board's response to the request for EJR is set forth below.

**Issue**

As Set Forth in the EJR Requests

The common issue before the Board in these cases is whether the Centers for Medicare & Medicaid Services (CMS) [sic the Secretary[1]] properly calculated a 0.2% reduction in the standardized amount to offset supposed increased IPPS [inpatient prospective payment system] costs due to the clarification of inpatient admission standards under the "Two Midnight Rule," which resulted in an understatement of the standardized amount—and consequently all Medicare payments affected by the budget neutrality adjustment—to the Providers for Federal Fiscal Year 2014. . . . [the Secretary] published the [FFY] 2014 standardized amount but failed to properly articulate and give Providers an opportunity for notice and comment, as required by the federal Administrative Procedures Act, its calculation methodology utilized to arrive at the 0.2% reduction in the standardized amount.

As Set Forth in the Hearing Requests

The Providers challenge the negative 0.2% adjustment by CMS [sic the Secretary] of the Federal Fiscal Year 2014 [IPPS] standardized amount to offset supposed increased IPPS costs due to clarification of inpatient admission standards under the "Two Midnight Rule" as published in the August 19, 2013 Federal Register. *See* 78 Fed. Reg. 50746-50747. The effect of this offset was to arbitrarily and capriciously reduce IPPS payments to hospitals by 0.2% for FFY 2014. [The

[1] of the Department of Health and Human Services

Secretary] assumed, without appropriate data or study, that the clarification of inpatient admission standards reflected in the Two Midnight Rule would increase IPPS payments by 0.2%. Even if [the Secretary's] counter-intuitive assumptions were true, the increased costs would simply reflect the appropriate payment under law for treatment of hospital inpatients. *See generally* 42 U.S.C. § 1395ww. Providers also contend that [the Secretary] failed to provide sufficient notice of the statistical modeling behind this decision and[,] accordingly[,] did not comply with the Administrative Procedures Act as [the Secretary] denied the industry sufficient notice for the industry to respond with informed commentary to the proposed rule. *See* 78 Fed. Reg. 27650-27651 (May 10, 2013). Lastly, the Secretary implemented this payment reduction via a catch-all provision at 42 U.S.C. § 1395ww(d)(5)(I) which states that "*The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate.*" This provision explicitly requires that such adjustments be implemented "by regulation." The Secretary's failure to codify this payment reduction into the Code of Federal Regulations invalidates this payment policy.

**Statutory and Regulatory Background**

In the final IPPS rule for FFY 2014, the Secretary indicated that she had expressed concern in the proposed calendar year (CY) Outpatient PPS rule[2] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving observation services. In recent years, the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours increased from approximately 3 percent in 2006 to 8 percent in 2011. This raised a concern about the financial impact on Medicare beneficiaries who may incur greater financial liability than they would if they were admitted to the hospital as inpatients.[3]

The Secretary noted that the trend towards the extended observation services may be attributable, in part, to hospitals' concerns about their ability to receive payment from Medicare under Part B when a Part A hospital inpatient claim is denied because a Medicare review contractor determines that the inpatient admission was not reasonable and necessary under 42 U.S.C. § 1395y(a)(1)(A). Centers for Medicare & Medicaid Services (CMS) has been advised by stakeholders that the hospitals appear to be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays that may later be denied upon contractor review by electing to treat beneficiaries as outpatients receiving observation services for long periods of time, rather than admitting them as inpatients. These hospitals believe that Medicare's standards for inpatient admission were not clear.[4]

In response to this concern, the Secretary proposed clarifications and changes regarding hospital payment under both Part A and Part B. The Secretary proposed to revise Part B inpatient payment policy to allow payment under Part B for all hospital services that furnished and were reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted as an inpatient. This policy would apply when a Medicare Part A hospital inpatient claim was denied or when a hospital determines after a discharge that the inpatient visit was not

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[2] 77 Fed. Reg. 45061, 45155-45157 (July 30, 2012) and the final rule with comments, 77 Fed. Reg. 68210, 68426-68433 (November 15, 2012).
[3] 78 Fed. Reg. at 50907.
[4] *Id.*

reasonable and necessary. The timely filing restrictions for Part B billing were not changed (claims must be filed within 1 year from the date of service).[5]

Medicare Part A

In addition, the Secretary reviewed hospital inpatient status criteria to improve CMS' policies governing when a Medicare beneficiary should be admitted as an inpatient and how hospitals should be paid for associated costs. The Medicare Benefit Policy Manual[6] states that the typical decision to admit a beneficiary as an inpatient should be made within 24 to 48 hours after observation care and that an overnight stay may be a factor in the admission decision. Physicians should use the 24-hour or overnight period as a benchmark, i.e., they should order admission for patients who are expected to need care for 24 hours or overnight. Generally, a beneficiary is considered an inpatient if formally admitted with the expectation that he or she will remain in the hospital overnight, whether or not there is a later transfer or discharge and the patient is not present overnight. Only rarely and in exceptional cases do reasonable and necessary observation services span more than 48 hours. Length of stay is not the basis for payment and it is the physician responsible for patient care who decides if the patient should be admitted.[7]

In the Federal fiscal year (FFY) 2014 IPPS proposed rule[8] the Secretary proposed a new benchmark for purposes of medical review of hospital inpatient admissions (Medicare Part A payment). Under this proposal, beneficiaries who were expected to remain in the hospital to receive medically necessary care surpassing 2-midnights after the initiation of care would generally be appropriate for inpatient admission and inpatient payment (known as the "2-midnight rule"). Medicare contractors were to consider all the time after the initiation of care at the hospital in applying the benchmark that inpatient admissions are generally reasonable and necessary (as long as a hospital was not prolonging the provision of care to surpass the 2-midnight timeframe).[9]

Medicare Part B

In the final IPPS rule, the Secretary noted there had been an increasing number of cases in which hospitals had appealed Part A inpatient claim denials in which it was determined the inpatient admission was not reasonable or necessary. These claims had received partial favorable treatment by the Medicare Appeals Council or Administrative Law Judges (ALJs). In those cases, the Medicare review contractor determinations that the inpatient admission was not reasonable or necessary was upheld, but the Medicare Appeals Council and ALJ decisions ordered payment of the services as if they were rendered in an outpatient or observation level of care. These decision effectively required Medicare to issue payment for all Part B services that would have been payable had the patient been treated as an outpatient (rather than an inpatient). In addition, these payments were made whether the subsequent hospital claim for payment was made within the applicable time limit for filing Part B claims. The Secretary pointed out that this

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[5] *Id.*
[6] Chapter 6, § 20.6 and Chapter 1, § 10.
[7] 78 Fed. Reg. at 50907-08.
[8] *See generally* 78 Fed. Reg. 27486 (May 10, 2013).
[9] 78 Fed. Reg. 50908.

was contrary to longstanding polices that permit billing only for a limited list of Part B inpatient services and require the services be billed within specific timeframes.[10]

As a result of the number of these administrative adjudications, the CMS Administrator issued CMS Ruling CMS-1455-P[11] (the Ruling) which established a standard process for effectuating the decisions granting Part B coverage. Among other things, where the administrative adjudicator had issued an order for payment under Medicare Part B, the request for Part B payment would not be rejected if more than one year had elapsed (the time period for filing Part B claims), if the Part A claim had been submitted timely. The Ruling was to remain in effect until the effective date of regulations that finalized "proposed rule CMS-1455-P." In the August 19, 2013 Federal Register, the Secretary revised the Part B inpatient payment policy to allow payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require outpatient status.[12] The one-year deadline for filing claims remains unchanged and the Secretary stated that she was not creating an exception to this requirement (as found in 42 C.F.R. § 424.44(b)(1)-(4)) even though the contractor claims review and appeal process could exceed the 1-year filing period.[13]

The 2-Midnight Rule

In the final IPPS rule, the Secretary pointed out that CMS had established policy that recognized that there were certain situations in which an inpatient hospital admission was rarely appropriate. This IPPS rule included instructions that provided a benchmark to ensure that all beneficiaries receive consistent application of their Part A benefits to whatever clinical services were medically necessary.[14]

Due to persistently large, improper payment rates for short-stay hospital inpatient claims, and, in response to requests to provide additional guidance regarding proper billing of those services, the Secretary proposed to modify and clarify 42 C.F.R. § 412.3(c)(1). This regulation designates services that are inpatient only (without regard to duration of care), surgical procedures, diagnostic tests and other treatments that would be appropriate for inpatient admission and inpatient payment under Medicare Part A when the physician expects the beneficiary to require a stay that crosses 2 midnights and admits the beneficiary based on that expectation. The starting point for this 2-midnight instruction would be when the beneficiary is moved from any outpatient area to a bed in the hospital in which additional services would be provided, and is based on the judgment of the physician and the physician order (the physician must certify that the inpatient services were medically necessary).[15] The Secretary maintains that she has consistently provided physicians with a time-based admission framework to effectuate appropriate inpatient hospital admission decisions.[16]

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[10] *Id.*
[11] *See* 78 Fed. Reg. 16614 (March 18, 2013) and on the internet at http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings.html.
[12] 78 Fed. Reg. at 50909.
[13] *Id.* at 50927.
[14] *Id.* at 50944.
[15] *Id.*
[16] *Id.* at 50945.

The Secretary's actuaries estimated that the 2-midnight rule would increase IPPS expenditures by approximately $220 million. These additional expenditures would result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving from OPPS [outpatient PPS] to IPPS and some encounters of less than 2 midnights moving from IPPS to OPPS. The actuaries estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient from the approximately 11 million encounters paid under IPPS. This shift of 40,000 encounters represents an increase of approximately 1.2 percent in the number of shorter stay hospital inpatient encounters paid under IPPS. This additional expenditure would be partially offset by reduced expenditures from the shift of shorter stay hospital encounters to hospital outpatient encounters. The actuaries estimated that, on average, the per encounter payments for these hospital outpatient encounters would be approximately 30 percent of the per encounter payments for the inpatient encounters. In light of the impact of the 2-midnight rule on IPPS and the systematic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, the Secretary decided it was appropriate to use her exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i) to offset the $220 million in additional IPPS expenditures associated with the 2-midnight policy. Consequently, the standardized amount was reduced by 0.2 percent.[17] The Secretary made the same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[18]

**Providers' Request for EJR**

In their EJR requests, the Providers explain that in the 2013 outpatient PPS proposed and final rules[19] the Secretary expressed concern over the trend toward prolonged outpatient treatment periods (lengthy observation services of 24-48 hours) when inpatient admissions would have been justified. As a result in the FFY 2014 IPPS proposed rule she defined standards for inpatient admissions and proposed to create a presumption that claims for inpatient services with lengths of stay greater than two midnights after an admission order would be generally presumed to be appropriate for payment under Part A.

In addition, the Secretary discussed the agency's beliefs regarding the cost of the new two midnight rule and that the actuaries believe the program would "increase IPPS expenditures by approximately $220 million."[20] The Providers do not believe the Federal Register adequately explained how the change in patient stays resulted in the $220 million in additional costs. However, as a result of the proposed change to inpatient admissions the Secretary proposed to reduce the standardized amount by 0.2% by using the authority in 42 U.S.C. § 1395ww(d)(5)(I)(i) to offset the estimated $220 million in additional expenditures.[21]

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[17] *Id.* at 50952-53.
[18] *Id.* at 50990.
[19] 77 Fed. Reg. 45061, 45155-45157 (July 30, 2012) and 77 Fed. Reg. 68210, 68426-68433 (November 15, 2012), respectively.
[20] *See* 78 Fed. Reg. 27649-50.
[21] 78 Fed Reg. at 27650.

The Providers believe that the 0.2% reduction violates 5 U.S.C. § 553(b) and (c) of the APA that requires agency rulemaking provider notice of "either the terms and substance of the proposed rule" and "opportunity to participate in the rulemaking process through submission of written data, views or arguments." This requires an agency identify and make available technical studies and data employed in reaching the decision to propose particular rules. An agency cannot not rely on data that is known only to itself. The Providers believe that the Secretary failed to adequately explain the methods or assumptions that resulted in the conclusion that the two midnight rule would increase program costs by $220 million unless offset by a reduction in the standardized amount. They do not believe the Federal Register afforded the meaningful notice that would allow adequate evaluation of the Secretary's actions and enable them to provide significant or relevant comments.

The Providers also contend that the use of the language of 42 U.S.C. § 1395ww(d)(5)(I)(i) that allows the Secretary to provide by regulations for other exceptions and adjustments to payment amounts as she deems appropriate to "assure that the aggregate payments made under this subsection for such fiscal year are not greater or lesser than those that would have otherwise been made in such fiscal year." The Providers believe that this is a budget neutrality adjustment. They contend that the assumption that the 0.2 percent reduction in payments is not budget neutral because the underlying and unsupported assumption that the two midnight rule would increase inpatient utilization is false. Rather, based on the Secretary's actions, the Providers believe IPPS payments would be reduced, there was no regulation promulgated as required by the statute, and there was inadequate notice to provide Providers the ability to make meaningful comments.

**Decision of the Board**

The Board has reviewed the submissions of the Providers pertaining to the requests for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy for each appeal exceeds $50,000, as required for a group appeal. The estimated amount in controversy is subject to recalculation by the Medicare Administrative Contractor for the actual final amount.

The Board finds that:

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

2) based upon the Providers' unopposed assertions regarding the 0.2 percent reduction to the standardized amount there are no findings of fact for resolution by the Board;

3) it is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

4) it is without the authority to decide the legal question of whether the Secretary's 0.2 percent reduction to the standardized amount is valid.

Accordingly, the Board finds that the 0.2 percent reduction 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 year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the cases identified in the attach list.

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
List of Groups, Schedules of Providers

cc: Bryon Lamprecht, Mutual of Omaha (w/Enclosures)
Renee Rhone, Cahaba GBA (w/Enclosures)
Danene Hartley, NGS (w/Enclosures)
Bruce Snyder, Novitas (w/Enclosures)
Judith Cummings, CGS (w/Enclosures)
Cecile Huggins, Palmetto GBA (w/Enclosures)
Timothy LeJeune (w/Enclosures)
Kyle Browning, NGS (w/Enclosures)
James Ward, Noridian (w/Enclosures)
Geoff Pike, First Coast Service Options (w/Enclosures)

Hall Render

# Two Midnight Rule 0.2% Offset
## List of Groups
## Exhibit EJR-1



| Group Name | Filed | Case No. |
|---|---|---|
| Genesis Health System | 1/30/2014 | 14-2195GC |
| West Tennessee Healthcare | 1/30/2014 | 14-2197GC |
| Mayo Clinic | 1/30/2014 | 14-2198GC |
| Main Line Health | 1/30/2014 | 14-2199GC |
| Beacon Health | 1/30/2014 | 14-2202GC |
| Premier Health | 1/30/2014 | 14-2203GC |
| ProHealth (WI) | 1/30/2014 | 14-2204GC |
| Umass | 1/30/2014 | 14-2225GC |
| Carolinas Healthcare | 1/30/2014 | 14-2226GC |
| Vidant Health | 1/30/2014 | 14-2227GC |
| Spectrum Health | 1/30/2014 | 14-2228GC |
| Methodist Health System (NE) | 1/30/2014 | 14-2229GC |
| Bronson Healthcare | 1/30/2014 | 14-2230GC |
| Community Health Network | 1/30/2014 | 14-2232GC |
| UC Health Alliance | 1/30/2014 | 14-2234GC |
| Franciscan Alliance | 1/30/2014 | 14-2235GC |
| Bayhealth Medical Center | 1/30/2014 | 14-2236GC |
| Valley Health | 1/30/2014 | 14-2237GC |
| Forrest General Health | 1/30/2014 | 14-2238GC |
| Deaconess Health (IN) | 1/30/2014 | 14-2239GC |
| North Mississippi Health Services | 1/30/2014 | 14-2240GC |
| IU Health | 1/30/2014 | 14-2241GC |
| McLaren Health | 1/30/2014 | 14-2242GC |
| Froedtert | 1/30/2014 | 14-2243GC |
| Partners HealthCare System | 1/30/2014 | 14-2244GC |
| Roper St. Francis | 1/30/2014 | 14-2245GC |
| Advocate Health Care | 1/30/2014 | 14-2247GC |
| North Shore LIJ Health System | 1/30/2014 | 14-2248GC |
| St Elizabeth Healthcare | 1/30/2014 | 14-2251GC |
| Rochester General | 1/30/2014 | 14-2255GC |
| CareGroup | 1/30/2014 | 14-2265GC |
| Hartford Healthcare | 1/30/2014 | 14-2266GC |
| Northern Arizona | 1/30/2014 | 14-2268GC |
| Abington (PA) | 1/30/2014 | 14-2269GC |
| Community Healthcare System | 1/30/2014 | 14-2270GC |
| North Memorial Health | 1/31/2014 | 14-2274GC |
| Kettering Health Network | 1/31/2014 | 14-2275GC |
| Ascension | 1/31/2014 | 14-2276GC |
| Lee Memorial | 1/31/2014 | 14-2278GC |
| Allegheny | 1/31/2014 | 14-2279GC |
| Sinai Health System | 1/31/2014 | 14-2280GC |
| Hall Render Group 1 | 1/31/2014 | 14-2282G |
| Hall Render Group 2 | 2/4/2014 | 14-2287G |
| Baystate | 2/4/2014 | 14-2288GC |
| Care New England | 2/14/2014 | 14-2353GC |
| Regional Care | 2/14/2014 | 14-2355GC |
| University of Arizona | 2/10/2014 | 14-2409GC |
| Northwestern Medicine | 1/30/2014 | 14-2443GC |
| Covenant Health | 1/30/2014 | 14-2444GC |
| Sanford Health | 1/30/2014 | 14-2445GC |
| Mountain States Health Alliance | 1/30/2014 | 14-2447GC |
| Lahey | 2/3/2014 | 14-2452GC |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2670
Phone: 410-786-2671
Internet: www.cms.gov/PRRBReview FAX: 410-786-5298

Refer to:

AUG 28 2014

CERTIFIED MAIL

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

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

RE: Saint Vincent's Hospital (33-0290) for FYE 12/31/2001 as a participant in
Saint Vincent Catholic Medical Center 00-01 Dual Eligible Days Group
PRRB Case No. 08-2292GC

Dear Mr. Blumberg and Mr. Browning:

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

**Background**

The Providers filed an initial request for a group appeal on July 10, 2008 (received on July 11, 2008). The issue in dispute in the group is Dual Eligible days, which is covered under CMS Ruling 1498-R. The Intermediary did not file a jurisdictional challenge in this group appeal. However, after reviewing the Schedule of Providers and associated jurisdictional documentation submitted by the Representative on May 13, 2014 the Board noted an impediment with regard to participant 4, Saint Vincent's Hospital (St. Vincent's) for FYE 12/31/2001.

On March 28, 2006, an original Notice of Program Reimbursement (NPR) was issued for St. Vincent's. Subsequently, on April 13, 2006, a revised NPR was issued for the Provider. On October 5, 2006, St. Vincent's filed an appeal specifically from the revised NPR.[1] However, the Provider did not supply evidence that it filed an appeal from its original NPR.

**Board's Determination**

The Board finds that it does not have jurisdiction over Saint Vincent's Hospital (33-0290) for FYE 12/31/2001 because this Provider is appealing from a revised NPR which did not specifically adjust the Dual Eligible Days issue.

[1] Schedule of Providers, Tab 4B.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1841 (2005), 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 the notice of the intermediary's determination was mailed to the provider.

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2005) 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 ... , either on motion of such intermediary ... or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings.

A revised NPR is considered a separate and distinct determination from which the provider may appeal. 42 C.F.R. § 405.1889, effective October 1, 2002, through May 22, 2008, stated:

> [w]here a revision is made in a determination or decision on the amount of program reimbursement after such a determination or decision has been reopened ... such revision shall be considered a separate and distinct determination or decision to which the provisions of Secs. 405.1811, 405.1835, 405.1875, and 405.1877 are applicable.

In *HCA Health Services v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994), the Court held that when a fiscal intermediary reopens its original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening, and does not extend further to all determinations underlying the original NPR.

Saint Vincent's referenced audit adjustment #217, though it is unclear from the adjustment page whether it is from to original or the revised NPR. Adjustment #217 is an adjustment to the total allowable DSH percentage on Worksheet E, Part A, but there is no support for an adjustment specific to Dual Eligible Days, which would have been reflected by an adjustment to the Medicaid Days via Worksheet S-3.

Because an appeal from a revised NPR is limited to the specific matters revised in the revised determination and there is no evidence that Dual Eligible Days were actually adjusted, the Board finds that it does not have jurisdiction over St. Vincent's appeal of the revised NPR for FYE 12/31/2001. Consequently, the Board hereby dismisses St. Vincent's (participant #4) from this group appeal. Review of this determination is available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

The remaining participants in the 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)

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

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

Refer to:

CERTIFIED MAIL

AUG 28 2014

Christopher L. Keough and Stephanie Webster
Akin, Gump, Strauss, Hauer & Feld, LLP
1333 New Hampshire Avenue, NW
Suite 400
Washington DC 20036-1532

RE: Request for Expedited Judicial Review
CHE 92-96 DSH SSI Group, PRRB Case No. 04-0272GC,
CHE 97 DSH SSI Group, PRRB Case No. 04-0273GC,
CHE 98 DSH SSI Group, PRRB Case No. 04-0274GC,
CHE 99 DSH SSI Group, PRRB Case No. 04-0275GC,
CHE 02 DSH SSI Group, PRRB Case No. 05-1867GC, and
Triad Hospitals 01 DSH SSI Group, PRRB Case No. 06-0602G.

Dear Mr. Keough and Ms. Webster:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' July 29, 2014 Request for Expedited Judicial Review (EJR) (received July 30, 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 the Board jurisdiction over the Providers in this appeal 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 these group appeals is the SSI "data matching process" issue.

The Providers contend that the Board should grant their request for EJR because the remand provisions of the Ruling 1498-R are invalid and should be set aside, to the extent that those provisions of the Ruling would require or permit CMS or the Medicare contractors to add Medicare Part A non-covered or Medicare Part C patient days to those Medicare Part A/SSI fractions pursuant to a recalculation performed on remand. The Providers maintain that the Medicare Part A/SSI fractions at issue in these group appeals did not include Medicare Part A non-covered or Medicare Part C patient days. The DSH regulation in effect at the time did not

permit CMS to include those patient days in the Medicare Part A/SSI fractions.[1] The Providers argue they have not claimed that Medicare Part A non-covered or Medicare Part C patient days should be added to, or otherwise included in, the Medicare Part A/SSI fractions at issue. Nevertheless, in direct violation of the regulation governing the calculation of the Medicare Part A/SSI fractions for the 1992-2002 periods at issue, the Ruling would now permit CMS and the contractors to add the Medicare Part A non-covered and Medicare Part C patient days to those fractions on remand of these appeals.

The Providers contend the Ruling is both expanding the issues in these group appeals and at the same time requiring a calculation including the previously-excluded Part A non-covered and Part C patient days in violation of the controlling regulation in effect for the periods at issue. 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.[2]

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.[3] 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 *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.[4,5]

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[1] *See* 42 C.F.R. § 412.106(b) (2004) (limiting the Medicare Part A/SSI fractions to Medicare Part A covered patient days) *Catholic Health Initiatives-Iowa v. Sebelius*, 718 F.3d 914, 921 n.5 (D.C. Cir. 2013) (noting that "[p]rior to 2004, the Secretary interpreted the phrase "entitled to benefits under part A of [Medicare]" in the Medicare fraction to include only "covered Medicare Part A inpatient days"); *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 13-17 (D.C. Cir. 2011) (prohibiting the Secretary from retroactively applying the 2004 rule requiring inclusion of Medicare part C days in the SSI fraction to periods beginning prior to the October 1, 2004 effective date of that rule).

[2] Providers' EJR Request at 1-2.

[3] 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.

[4] 545 F. Supp. 2d at 55 n. 37.

[5] Providers' EJR request at 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."[6] 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."[7] 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.[8]

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.[9] 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.[10]

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). They argue that their claims are not moot and 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 Providers' pending claims to have the SSI fraction calculated correctly.[11]

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. The Providers state that all of those provisions are higher

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[6] CMS Ruling 1498-R at 3 (April 28, 2010).
[7] *Id.* at 8.
[8] *See* 42 C.F.R. § 412.106(b)(2) (2003); 51 Fed. Reg. 16772, 16777 (May 6, 1986).
[9] *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).
[10] Providers' EJR Request at 3-4.
[11] *Id.* at 6-7.

authorities than the CMS Ruling, and all of them are binding on the Board. Accordingly, the Providers contend the Ruling is invalid.[12]

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 contractors 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.[13] 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.[14]

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.[15]

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

*Issues under Appeal*

The Providers in these group appeals appealed the SSI "data matching process" issue in their group appeal requests.[16] Some Providers identified the issue under appeal in their group appeal requests as:

> The participating providers contend that the Health Care Financing Administration ('HCFA') has significantly understated the number of qualifying supplemental security income ('SSI') patient days for purposes of calculating Medicare disproportionate share hospital ('DSH') payments, thereby failing to pay the hospitals' proper DSH entitlement.
>
> ***
>
> The participating providers contend that HCFA has been using flawed and incomplete data to make the calculations. As a consequence, HCFA has been underpaying the amount of DSH payments due hospitals.[17]

Other Providers identified the issue under appeal in their group appeal request as:

> The participating providers contend that the Centers for Medicare & Medicaid Services ('CMS') has improperly computed the fraction reflecting the percentage of the Providers' Medicare inpatients who were entitled to supplemental security income (the 'Medicare fraction'), and thereby failed to pay the hospitals' proper DSH entitlements.
>
> ***
>
> The Providers assert that the numerators of their published Medicare fractions are understated because the SSI data furnished to CMS by SSA was inaccurate and incomplete ... as a result of flaws in the process used by CMS to match its MEDPAR inpatient stay data with the SSI eligibility data received by CMS from SSA.[18]

*EJR Request*

The Providers contend that the CMS Ruling 1498-R purports to expand the issue in this group appeal and require a recalculation to include not only the "same data matching process as the

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[16] The Providers noted 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.

[17] Providers' Hearing Requests at 2-3 for case numbers 04-0272GC, 04-0273GC, 04-0274GC and 04-0275C; Providers' Hearing Request at 1-2 for case number 05-1867GC.

[18] Providers' Hearing Request at 1-2 for case number 06-0602G.

agency used to implement the *Baystate* decision", but also to include Medicare Part A non-covered or Medicare Part C patient days to the Medicare Part A/SSI fractions. The Providers request that the Board grant EJR because the remand provisions of the Ruling 1498-R are invalid and should be set aside, to the extent that those provisions of the Ruling would require or permit CMS or the Medicare contractors to add Medicare Part A non-covered or Medicare Part C patient days to those Medicare Part A/SSI fractions pursuant to a recalculation performed on remand. The Providers maintain that the Medicare Part A/SSI fractions at issue in this group appeal did not include Medicare Part A non-covered or Medicare Part C patient days.

The Providers describe the issue for which EJR is requested over as CMS' determination to add Part A exhausted benefit days, MSP days and Part C days to the SSI fraction.[19] The Providers argue:

> Specifically 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*, however, did not hold that Part A exhausted benefit days and MSP days should be counted in the SSI fraction.
>
> ***
>
> 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. ... 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.[20]

*Challenge to the Validity of Ruling*

The Providers' current EJR request, which was filed over four years after the issuance of CMS Ruling 1498-R, seeks to invalidate the provisions of the Ruling to the extent that those provisions

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[19] 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 4.
[20] Providers' EJR request at 3.

of the Ruling would require or permit CMS or the Medicare contractors to add Medicare Part A non-covered or Medicare Part C patient days to the Medicare Part A/SSI fractions pursuant to a recalculation performed on remand. The EJR refers to the fact that the Board previously issued EJR over the validity of the Ruling provisions in over 132 similar cases.

The Board's earliest decision granting EJR over the validity of certain Ruling provisions was issued in June of 2010, shortly after the Ruling was issued on April 28, 2010. The Board has since issued twelve similar decisions, covering a total of 149 cases. In those cases, EJR was granted over the question of whether "[it] lacks authority to make a determination whether the Ruling deprives it of continuing jurisdiction because the challenged substantive provisions of the Ruling are also the foundation for CMS' claim the Board lacks jurisdiction to grant EJR." This threshold question regarding jurisdiction, which is now being litigated in federal court, allowed the appeals of providers challenging the data matching process to remain open before the Board, thus maintaining the status quo.

Since that time, the challenge to the validity of the Ruling in the courts has been stayed pending issue specific litigation over the inclusion of both the Medicare Part A non-covered days and the Medicare Part C patient days in the Medicare DSH calculation. The abeyance in the courts allowed the separate appeals for the other DSH issues to play out, as they were the underlying dispute in the Providers challenge to the remand required in the data matching cases.

In addition, CMS did begin issuing new SSI percentages on its website for FY 2006-2012. These SSI percentages did include both Medicare Part A non-covered days and Medicare Part C patient days in the Medicare Part A/SSI fractions. Those new SSI percentages have been incorporated into open provider cost reports as well cost reports that had been previously finalized, but had reopening notices issued pending the litigation in the *Baystate* decision. New SSI percentages have not been issued for FY 2005 and prior due to the ongoing litigation referenced above.

*Federal Litigation after the Issuance of CMS Ruling 1498R*

The Federal courts have reviewed the treatment of Medicare Part C days and Medicare/Medicaid dual eligible days in the DSH calculation in four cases. In *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1 (D.C. Cir. 2011), the court held that Congress has not unambiguously foreclosed the Secretary's interpretation that Medicare Part C enrollees are entitled to benefits under Part A, but also held that the Secretary's present interpretation may not be retroactively applied to periods prior to its 2004 rulemaking. More recently in *Allina Health Services v. Sebelius*, 746 F.3d (D.C. Cir. 2014), the court concluded that the Secretary did not provide adequate notice and comment before promulgating the 2004 rule regarding inclusion of Medicare Part C days in the Medicare fraction of the DSH calculation and thus vacatur was an appropriate remedy.[21]

Two circuit courts, the D.C. Circuit Court and the Seventh Circuit, have ruled on the dual eligible days issue finding that exclusion of dual eligible exhausted benefit days from the

[21] Although the rule was promulgated in 2004, the Code of Federal Regulations was never actually amended, so in 2007 the Secretary issued a "technical correction" conforming the language of the C.F.R. to the 2004 rule.

Medicaid fraction was permissible as such patients were "entitled to benefits under part A." *See Metropolitan Hospital v. DHHS*, 712 F.3d 248 (7th Cir. 2013) (*Metropolitan*) and *Catholic Health Initiatives v. Sebelius*, 718 F.3d 914 (D.C. Cir. 2013) (*CHI*). However, the rationale for this conclusion differed significantly. The Seventh Circuit in *Metropolitan* concluded that the Secretary's treatment of dual eligible days was a reasonable interpretation of under step two of a *Chevron* analysis and therefore entitled to deference.[22] The D.C. Circuit in *CHI* found that an earlier administrative decision in *Edgewater Medical Center*[23] set forth the Secretary's policy to exclude Medicare exhausted days from the Medicaid fraction and the Secretary's policy was not unfair retroactive rule-making.

*Denial of EJR Request*

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" Part A 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. Contrary to the EJR decisions rendered in appeals shortly after the Ruling was issued, much is now known about the remand process, as well as to the challenge of the treatment of the Medicare Part A non-covered days and Medicare Part C days in the DSH calculation.

The litigation referenced above related to CMS' inclusion of the Medicare Part C patient days in the Medicare Part A/SSI fractions is distinct litigation from the issues covered by the Ruling. The Board finds that although the Ruling may reference CMS' policy to include Part C days in the Medicare Part A/SSI fraction, the Ruling itself does not direct such days to be included in the Medicare fraction. The final determination regarding the treatment of Part C days will be determined by the outcome of the D.C. Circuit Court litigation. The Ruling does however apply to appeals challenging the inclusion of non-covered Part A days (including exhausted benefit days and MSP days) in the SSI fraction. With final decisions in both *CHI* (for cost reporting periods prior to 10/1/04) and *Metropolitan Hospital* (for periods on or after 10/1/04), the treatment of Medicare Part A non-covered days as still "entitled to benefits under part A" has been upheld by the courts. The Board finds those days are not at issue in these appeals, but there may be no way to bifurcate the recalculation of the SSI percentage to account for only the data matching issue but not the inclusion of the Part A exhausted benefit days and MSP days in the SSI fraction. Therefore, when a provider's appeal of the data matching issue is remanded back to the contractor for inclusion of the new SSI percentage using the proper *Baystate* data matching process, the SSI percentage calculated by CMS should take into account all appropriate categories of days.

The Board finds that 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

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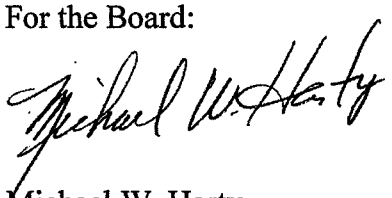
[22] *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984).
[23] *Edgewater Medical Center v. Blue Cross Blue Shield Association*, HCFA Adm. Dec., 2000 WL 1146601 (June 19, 2000).

excluded from the SSI fraction. These issues are not the subject of the Providers' group appeal requests. The deadline for adding issues to an appeal has expired and issues may not be added to group appeals. As such, the Board denies the Providers' request for EJR. The Board finds that these appeals are subject to CMS Ruling 1498-R and are not questioning the validity of the Ruling removing Board jurisdiction in cases where Providers have filed a jurisdictionally valid appeal. Consequently, the Board concludes these cases are appropriate for remand under CMS Ruling 1498-R. Remand letters will be simultaneously issued with this decision remanding the cases to the Intermediary pursuant to the Ruling.

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

cc: Bruce Snyder, Novitas Solutions, Inc.
Byron Lamprecht, Wisconsin Physicians Service
Kevin D. Shanklin, Blue Cross Blue Shield Association

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

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

Refer to: 06-0602G

AUG 28 2014

CERTIFIED MAIL

Akin, Gump, Strauss, Hauer & Feld, LLP
Stephanie A. Webster
1333 New Hampshire Avenue, NW
Suite 400
Washington, DC 20036-1532

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

RE: St. Joseph Medical Center, Provider No. 15-0047, FYE 5/31/2001 and
College Station Medical Center, Provider No. 45-0299, FYE 10/31/2001
*as participants in* Triad Hospitals 2001 DSH SSI Group
PRRB Case No. 06-0602G

Dear Ms. Webster and Mr. Lamprecht,

The Provider Reimbursement Review Board (Board) has reviewed the Schedule of Providers and the associated jurisdictional documents incident to the Providers' July 29, 2014 request for expedited judicial review (EJR) received by the Board on July 30, 2014. The Board's decision regarding jurisdiction for the above-referenced Providers is set forth below.

Background

*St. Joseph Medical Center, Provider No. 15-0047*

On September 30, 2003, a Notice of Program Reimbursement (NPR) was issued to St. Joseph Medical Center (St. Joseph), Provider No. 15-0047, for the cost reporting period ending May 31, 2001.[1] On October 21, 2003, a revised NPR was issued to the Provider.[2] St. Joseph filed an appeal request on March 26, 2004, and the Board established the individual appeal as Case No. 04-1390.

St. Joseph's appeal request referenced the revised NPR dated October 21, 2003 as the final determination in dispute, not the original NPR dated September 30, 2003.[3] The audit adjustment report supplied within the group jurisdictional documents is also from the revised NPR as it is annotated as "AMENDED" and it has a run date of October 8, 2003.[4] This adjustment report shows an adjustment to the total disproportionate share (DSH) percentage as reported on

[1] Schedule of Providers, Tab 6A.
[2] *See* Schedule of Providers, Tab 6B.
[3] Schedule of Providers, Tab 6B.
[4] Schedule of Providers, Tab 6D.

Worksheet E, Part A, Line 4.03, Col. 0, "to properly calculate the DSH add-on payment" but there is no adjustment specific to the supplemental security income (SSI) percentage. [5]

*College Station Medical Center, Provider No. 45-0299*

On September 1, 2004, an NPR was issued to College Station Medical Center (College Station), Provider No. 45-0299, for the cost reporting period ending October 31, 2001. On February 28, 2005, College Station filed an appeal request challenging graduate medical education (GME) and indirect medical education (IME) full time equivalent (FTE) counts. The Board assigned Case No. 05-0825 to the individual appeal. On October 31, 2005, the Provider requested to withdraw its appeal. On November 10, 2005, the Board granted the Provider's withdrawal request and closed Case No. 05-0285.

By a letter dated February 5, 2007, College Station requested to add the DSH SSI percentage issue to its individual appeal, Case No. 05-0825, and to simultaneously transfer the issue to this optional group appeal, Case No. 06-0602G. On March 8, 2007, the Board denied the Provider's request to add the DSH SSI percentage issue to the individual case and to transfer it to the group appeal. The Board noted that Case No. 05-0825, had been previously closed on November 10, 2005 and, thus, there was no case to which the issue could be added. On May 17, 2007, the Provider requested a reinstatement of Case No. 05-0825, but the Board denied this request on July 3, 2007.

Decision of the Board

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

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (specify year) 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 ... , either on motion of such intermediary ... or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings.

A revised NPR is considered a separate and distinct determination from which the provider may appeal. 42 C.F.R. § 405.1889, effective October 1, 2002, through May 22, 2008, stated:

> [w]here a revision is made in a determination or decision on the amount of program reimbursement after such determination or

[5] The DSH SSI ratio is reported on Worksheet E, Part A, Line 4.00 of the Medicare cost report.

> decision has been reopened ... such revision shall be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1835, 405.1875 and 405.1877 are applicable.

In *HCA Health Services of Oklahoma v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994), the Court held that when a fiscal intermediary reopens its original determination regarding the amount of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening and does not extend further to all determinations underlying the original NPR.

In the instant case, St. Joseph did not supply supporting documentation (such as the request for reopening, reopening notice or the audit workpapers) to determine the full scope of the issues reviewed within the revised NPR process. The audit adjustment report shows that although the total DSH calculation was adjusted, the SSI percentage was not specifically revised in the reopening. As such, the Board lacks jurisdiction over the Provider, St. Joseph Medical Center, Provider No. 15-0047, and consequently dismisses this Provider from the group appeal.

Further, College Station's request to add the DSH SSI percentage issue to Case No. 05-0825 and to concurrently transfer the issue to Case No. 06-0602G was previously denied by the Board on March 8, 2007. Therefore, the Board hereby dismisses College Station Medical Center, Provider No. 45-0299, from the group appeal.

Since having jurisdiction over a provider is a prerequisite to granting a request for EJR, the Providers' request for EJR is denied. *See* 42 C.F.R. § 405.1842(a). 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