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

Refer to:

13-1468
Certified Mail

SEP 03 2014

Jeannie A. Adams, Esq.
Hancock, Daniel, Johnson & Nagle, P.C.
4701 Cox Road
Suite 400
Glen Allen, VA 23060

RE: Warren Memorial Hospital
Provider No. 49-0033
FYE 12/31/2007
PRRB Case No. 13-1468

Dear Ms. Adams:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's May 29, 2014 request for expedited judicial review (EJR) (received June 2, 2014) and the August 5, 2014 response (received August 6, 2014) to the Board's June 27, 2014 request for additional information. The Board's response to the Provider's request for EJR is set forth below.

The issue under appeal involves the Medicare Administrative Contractor's (MAC's)[1] authority to correct the Provider's incorrectly established Graduate Medical Education (GME) and Indirect Medical Education (IME) full-time equivalent (FTE) caps. The Provider's legal argument in its position is based on the D.C. Circuit Court's decision in *Kaiser Foundation Hospitals v. Sebelius* (*Kaiser*).[2] In that case, the Court found that the reopening regulation, 42 C.F.R. § 405.1885, allows for modification of predicate facts in closed years (years not subject to reopening) provided the change will only impact the total reimbursement in open years (years subject to reopening).[3] The Provider is challenging the validity of a change to the regulation 42 C.F.R. § 405.1885,[4] made as a result of the decision in *Kaiser*.

[1] Medicare audit and payment functions are conducted by contractors known as MACs or intermediaries. The terms will be used interchangeably in this document.
[2] 708 Fed. 3d 226 (D.C. Cir. 2013).
[3] *Id.* at 232-233.
[4] 78 Fed. Reg. 74826, 75162 (December 10, 2013).

Legislative Background

GME

Under the 1986 amendment to the Medicare Act, 42 U.S.C. § 1395ww(h), Congress enacted a new methodology for reimbursing GME costs incurred by hospitals that participate in the Medicare program. The Secretary was directed to determine for each hospital's base year, the "average amount recognized as reasonable" under the Medicare Act for direct GME costs for each full-time equivalent resident.[5] For residency programs established after January 1, 1995, the hospital's unweighted FTE resident cap may be adjusted based on the product of the highest number of residents in any program year during the third year of the first [residency] program's existence for all new residency training programs and the number of years in which the residents are expected to compete the program based on the minimum accredited length for each type of program. The adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new program.[6]

Reopening Regulations

In the December 10, 2013 Federal Register, the Secretary announced the "Clarification of Reopening of Predicate Facts in Intermediary Determinations of Provider Reimbursement (§ 405.1885)."[7] The Secretary noted that factual underpinnings of a specific determination of the amount of reimbursement due a provider may arise in the cost reporting period that forms the basis for the determination, for example the calculation of the disproportionate share adjustment. In the alternative, the factual underpinnings of a specific determination may first arise in or be determined for a different fiscal period than the cost reporting period under review. Factual determinations made in another cost reporting period are referred to as "predicate facts."

The predicate facts in this case relate to GME FTE counts determined in an earlier cost reporting period. With respect to GME costs, the predicate facts were determined based on information from an earlier cost reporting period, and then applied as part of the reimbursement formula for several fiscal periods thereafter. The facts are not reevaluated annually to determine whether they support the determination that a particular cost is reasonable because the formula is a proxy for reasonable costs. Instead, the formula itself will provide for changes in costs through an updating factor or otherwise.[8]

The Secretary noted that a specific matter at issue may involve a predicate fact that first arose in, or was determined for, an earlier fiscal period and that factual data could be used differently or applied to different reimbursement in one or more later fiscal periods. She noted that the "longstanding policy, interpretation and practice" is that the relevant provisions of the statute and regulations provide for review and potential redetermination of such facts only where there is a timely appeal or reopening of: (1) the NPR for the cost reporting period in which the predicate

---

[5] 42 C.F.R. § 1395ww(h)(2).
[6] 42 C.F.R. § 413.79(e)(1) (2007).
[7] 78 Fed. Reg. 74826, 75162 (December 10, 2013).
[8] *Id.* at 75163.

fact first arose or was determined; or (2) the NPR for the period for which such predicate fact was first used or applied by the intermediary to determine reimbursement.[9]

The Secretary explained that if a provider disputes a base period cost determination, it can either appeal the determination or seek a reopening of its cost report. Unless the appeal or reopening results in a different finding as to the predicate fact in question, there cannot be a finding as to the predicate fact in the base period and a different finding about the same fact in a later cost reporting period. Once the 3-year reopening period for revision of a final determination has expired,[10] neither the intermediary or provider can revisit the predicate fact in the base period that was not changed through appeal or reopening.[11]

This change to the regulation was the result of the decision in *Kaiser*. In that case, the Court held that providers could appeal predicate facts even though such predicate facts were not timely appealed or reopened for the periods where they first arose or were first applied to determine the providers' reimbursement. The Court held that the reopening regulation allows for modification of predicate facts in closed years provided the change will only impact the total reimbursement determination in open years.[12] The Court concluded that the Secretary acted arbitrarily in treating similarly situated parties differently and noted that the Secretary routinely championed a permissive interpretation of the reopening regulations when correction of predicate facts resulted in a windfall to the agency.[13]

The changes to 42 C.F.R. § 405.1885, effectuating the above considerations, were effective for appeals or reopening requests pending on or after the effective date of the final rule even if the intermediary determination preceded the effective date of the rule. The Secretary also stated that if the revisions to § 405.1885 were deemed retroactive, she would consider the retroactive application necessary to comply with the statutory requirements and failing to take such action would be contrary to the public interest.[14] The effective date of the regulation was January 27, 2014.[15]

Background Facts Related to the Request for Hearing and the FTE Recalculation

Request for Hearing

The Provider's request for hearing was dated April 5, 2013 and received in the Board's offices on April 8, 2013. It appealed an NPR dated October 10, 2012, raising the issue of graduate medical education (GME) and indirect medical education (IME) reimbursement. The amount in controversy is $245,024.

---

[9] *Id.* at 75163-75.
[10] *See* 42 C.F.R. § 405.1885(2008).
[11] 78 Fed. Reg. at 75163.
[12] *Kaiser* at 232-233.
[13] *Id.*
[14] 78 Fed. Reg. at 75165.
[15] *Id.* at 75195.

Full-Time Equivalent Recalculation

On December 2, 2010, an auditor for the MAC sent an e-mail to the Provider indicating that he believed that that application of the FTE caps had been "inconsistent and incorrect."[16] The auditor requested a copy of the Provider's rotation schedules for 2002, which would allow him to determine if the GME base year caps were properly calculated.

After receiving the Provider's response, the auditor responded on January 10, 2011, indicating that the Provider's 2003 unweighted FTE cap had been miscalculated. The auditor indicated that the 2003 FTE Cap should have been set at 8.53 FTEs for GME and IME, rather than 6.67. The auditor furnished the Provider with his work and rationale for his recalculation of the 2003 FTE cap.[17] However, there was no indication of how the MAC miscalculated the 2003 FTE cap or why the miscalculation was applied.

Once the Provider was made aware of the miscalculation of the 2003 FTE cap, it took action to reclaim the reimbursement owed. On February 24, 2011, the Provider requested that the cost reports for 2003-2006 be reopened to correct the FTE caps or alternatively, if the 3-year reopening period had been tolled, the Provider asked that the predicate caps be modified in order to rectify the errors in the 2006 open cost report and future cost reports.[18]

The auditor responded to the reopening request on February 11, 2011, stating that the FTE caps for any cost reporting period, whether open or closed could not be changed because they were locked in.[19] Further, the auditor indicated that the caps would not be revised for 2007, 2008 and 2009 because those cost reports were on hold. This was reiterated in emails and a reopening denial dated March 29, 2011.[20]

The Provider attempted to meet with the MAC and was told that the MAC as reviewing the issues and looking at all of the various updates to the GME regulations.[21] The Provider asked the MAC to consider revising its cap in light of the findings in *Kaiser,* but was told, at the time, that the *Kaiser* decision was being appealed.[22]

The Provider's NPR for FYE 2008 was issued on April 24, 2013, and made no reference to the improper caps. In April of 2013, the Provider filed a request to amend its 2008 cost report to correct the IME and GME caps or, in the alternative, submit the amount as a protest.[23]

The Provider is seeking to have its caps revised based on predicate facts, as was done for the Kaiser Hospitals.

---

[16] Provider's Hearing Request, Tab 3, Ex. B.
[17] *Id.* Tab 3, Ex. C.
[18] *Id.* Tab 3, Ex. F.
[19] *Id.* Tab 3, Ex. G.
[20] *Id.* Tab 3, Ex. H.
[21] *Id.* Tab 3, Ex. J.
[22] *Id.* Tab 3, Ex. L.
[23] *Id.* Tab 3, Ex. M.

Provider's Request for EJR

In this case, the Provider is challenging the GME base year FTE caps (6.67 GME and 5.14 IME FTEs) used in the FYE 2007 cost report which was incorrect and resulted in underpayments. The Provider believes that under the decision in *Kaiser* the MAC has the authority to adjust the predicate facts and adjust the FTE caps in the current FYE without reopening the closed cost reports. However, the Provider notes that the changes to the regulation, under the language in the Federal Register, are applicable to its case.

The Provider is seeking to have the MAC correct its incorrectly established GME and IME FTE caps to ensure accurate reimbursement. The Provider's legal argument is based on the D.C. Circuit's decision in *Kaiser* in which the Court held that such corrections did not constitute reopenings under 42 C.F.R. § 405.1885 "because the reopening regulation allows for modification of predicate facts in closed years provided the change will only impact the total reimbursement determination in open years."[24]

The Provider notes that the Final Rule stated that correction of predicate facts may only be accomplished through

The Provider notes that the Final Rule stated that correction of predicate facts may only be accomplished through

> (1) [ ] a timely appeal or reopening of an NPR for the fiscal period in which the predicate fact first arose or the fiscal period for which such fact was first determined by the intermediary; and/or
>
> (2) [ ] a timely appeal or reopening of the NPR for the fiscal period in which the fact was first used (or applied) by the intermediary to determine the provider's reimbursement.[25]

The following revisions to 42 C.F.R. § 405.1885 are the subject of the EJR request. The Secretary revised the reopening regulation, 42 C.F.R. § 405.1885 and added new section (iv) to § 405.1885(b)(2) which states:

> The 3-year period described in paragraph (b)(2)(i) through (b)(2)(iii) of this section applies to, and is calculated separately for, each specific finding on a matter at issue (as described in paragraphs (a)(1)(i) through (a)(1)(iv) of this section, but not to such findings when made as part of a determination of reasonable cost under section 1861(v)(1)(A) of the Act.

The Secretary revised 42 C.F.R. § 405.1885(a)(1) to define "specific matter at issue" to include:

---

[24] *Kaiser* at 232-33.
[25] 78 Fed. Reg. at 75164-75165.

> a predicate fact, which is a finding of fact based on a factual matter that first arose in or was first determined for a cost reporting period that predates the period at issue (in an appeal filed, or a reopening requested by a provider or initiated by an intermediary, under this subpart), and once determined, was used to determine an aspect of the provider's reimbursement for one or more later cost reporting periods.

The Provider challenges the validity of the regulations on two bases: (1) the regulation is arbitrary and capricious because it is inconsistent with long-standing CMS policy; and (2) the application of the regulation to presently pending appeals is retroactive rulemaking because the regulation is substantive, not a clarification, as the Secretary alleges.

The Provider notes that there are no facts in dispute. On November 13, 2013, the Provider and the MAC submitted a Joint Scheduling order in this case in which the MAC agreed that a base year FTE cap was incorrect and an FTE value of 8.53 would result in additional reimbursement to the Provider, although the MAC does not have the authority to grant the relief sought. The Provider believes that EJR is appropriate because the Board is bound by the new reopening regulations by virtue of 42 C.F.R. § 405.1867.

Decision of the Board

The Board finds that the Provider does not have a right under 42 U.S.C. § 1395oo(a) to a hearing on the distinct issue of the GME and IME FTE reimbursement. The Provider received reimbursement for the items and services that it claimed on its as filed cost report and, therefore, is not dissatisfied under § 1395oo(a). Also, the Board declines to hear these matters under its discretionary powers of review pursuant to 42 U.S.C. § 1395oo(d). Since jurisdiction over an appeal is a prerequisite to granting a request for EJR, the Provider's request for EJR is hereby denied.[26]

The crux of this dispute centers around the gateway to Board jurisdiction under 42 U.S.C. § 1395oo(a), which provides in relevant part:

> (a) 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 the items and services furnished to individuals for

[26] *See* 42 C.F.R. § 405.1842(a).

> 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 under 42 U.S.C. § 1395oo(d) to make a determination over all matters covered by the cost report. Specifically, § 1395oo(d) 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 operation of the jurisdictional gateway established by 42 U.S.C § 1395oo(a) was addressed by the Supreme Court in the seminal Medicare case of *Bethesda Hospital Association v. Bowen.*[27] The narrow facts of the *Bethesda* controversy dealt with the self-disallowed apportionment of malpractice insurance costs.[28] The provider failed to claim the cost because a regulation dictated it would have been disallowed. In that situation, the Supreme Court found § 1395oo(a) permitted jurisdiction over the "self-disallowed" claim.

> [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.*[29]

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.[30]

---

[27] *Bethesda,* 485 U.S. 399 (1988).
[28] *Id.* at 401-402.
[29] *Id.* at 404 (emphasis added).
[30] *Id.* at 404-405 (emphasis added).

While the Supreme Court has not had an opportunity to squarely address whether the Board must take jurisdiction of an appeal of a cost that was unclaimed through inadvertence rather than futility, other appellate courts have. However, there is a split among the circuit courts that have addressed the issue of unclaimed or self-disallowed costs since the *Bethesda* decision was issued.

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*),[31] 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 establishes that the provider is not "dissatisfied" with the intermediary's final reimbursement determination.[32]

Subsequently, in 1999, the Seventh Circuit addressed the same issue in a case involving the same provider (*Little Co. II*). 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.[33] 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...[34]

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).[35] 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."[36]

In contrast, the First and Ninth Circuits have determined that the language of the Medicare statute provides for Board jurisdiction over claims not included in the initial cost report, whether they have been inadvertently omitted or "self-disallowed."[37] Both circuits rejected the Seventh Circuit's interpretation of the statute, finding it contained neither an exhaustion requirement to

---

[31] 24 F.3d 984 (7th Cir. 1994).
[32] *Little Co. I,* 24 F.3d at 992.
[33] *Little Co. II,* 165 F.3d at 1165.
[34] *Id.*
[35] 73 Fed. Reg. at 30196.
[36] 73 Fed. Reg. at 30203.
[37] *See Loma Linda Univ. Med. Ctr. v. Leavitt,* 492 F.3d at 1065; *MaineGeneral Med. Ctr. v. Shalala,* 205 F.3d 493 (1st Cir. 2000).

obtain a hearing before the fiscal intermediary, nor a limitation on the Board's scope of review once its jurisdiction was invoked. The progeny of decisions in these circuits have generally regarded subsection (a) to be read in conjunction with subsection (d) and supports the discretionary nature of subsection (d).

The seminal case in the 9th Circuit is the 2009 decision in *Loma Linda Univ. Med. Ctr. v. Leavitt* (*Loma Linda*).[38] In *Loma Linda,* the provider had inadvertently zeroed out reimbursable interest expense in the cost report and filed it without any claim for reimbursement. The intermediary issued its NPR without any adjustments for interest expense. The provider then appealed to the Board and identified six aspects of the Intermediary's final determination with which it was dissatisfied (not including the zeroed out interest expense). When it later discovered its interest error, the provider added the interest expense issue to its pending appeal. The Ninth Circuit Court stated:

> We conclude that once the Board acquires jurisdiction pursuant to 42 U.S.C. § 1395oo(a) over a dissatisfied provider's cost report on appeal from the intermediary's final determination of total reimbursement due for a covered year, it has *discretion under § 1395oo(d) to decide whether to order reimbursement of a cost or expense ... even though that particular expense was not expressly claimed or explicitly considered by the intermediary.*[39]

This holding suggests that the "dissatisfaction" requirement to exercise a right to appeal under § 1395oo(a) applies only to the total amount of program reimbursement reflected on the NPR and that "dissatisfaction" does not need to be tied to a specific gateway claim or issue under § 1395oo(a) before the Board can exercise discretion under § 1395oo(d) to hear a claim or issue not raised with the intermediary (*e.g.*, unclaimed costs).[40] Further, the Ninth Circuit stated it was joining the First Circuit's view as expressed in *MaineGeneral Med. Ctr. v. Shalala* (*MaineGeneral*)[41] and *St. Luke's Hosp. v. Secretary* (*St. Luke's*)[42] which are decisions issued in 2000 and 1987, respectively.[43]

MaineGeneral involved hospitals that listed zero for reimbursable bad debts on their cost reports. The providers did not discover mistakes in their as-filed cost reports until after the NPRs had been issued. The providers appealed several items adjusted by the NPRs, but also appealed certain previously unclaimed bad debts (*i.e.*, costs not claimed due to inadvertence rather than futility). The Board dismissed the bad debt claims for lack of jurisdiction because the claims had not been disclosed on the as-filed cost reports, despite there being no legal impediment. The First Circuit in *MaineGeneral* relied on its prior pre-*Bethesda* decision in *St. Luke's* in which costs were self-disallowed, not inadvertently omitted. However, that First Circuit found the *St. Luke's* decision nevertheless addressed the question of whether the Board has the power to

---

[38] 492 F.3d 1065 (9th Cir. 2007).
[39] *Id.* at 1068 (emphasis added).
[40] *See* 73 Fed. Reg. at 30197.
[41] 205 F.3d 493 (1st Cir. 2000).
[42] *St. Luke's Hosp. v. Secretary*, 810 F.2d 325 (1st Cir. 1987).
[43] *See Loma Linda,* 492 F.3d at 1068.

decide an issue that was not first raised by the intermediary, holding the Board does have the power, but that the power is discretionary. In *St. Luke's*, the First Circuit expressly rejected the provider's assertion that the court should order the Board to hear the case even though it found the hospital had a strong equitable argument favoring review under the particular circumstances.[44] Specifically, the First Circuit wrote: "The statute [*i.e.*, § 1395oo(d)] does not say that the Board *must* consider matters not considered by the intermediary. But, it does say the Board may, it can, it has the 'power' to do so."[45]

The First Circuit in *MaineGeneral* then found that the Board could adopt a policy of hearing such claims or refusing to hear them, or it could opt to decide on a case-by-case basis. The First Circuit further noted that "a rule of consistently refusing to hear inadvertently omitted claims would be rational, given the ability of providers to request the intermediary to reopen an NPR up to three years after it has been issued."[46] Similarly, in *St. Luke's*, the First Circuit opined that, even though the Board has legal power to consider matters not specifically raised before the intermediary, whether to exercise that power is for the Board to decide and, like many similar powers of courts and agencies, should be exercised only sparingly.[47] Although the First Circuit in *MaineGeneral* analyzed appeal rights on a "claim" or issue specific basis, the First Circuit included the following dicta:

> That a cost is listed in a cost report says nothing about whether the provider is "dissatisfied" with the later decision by the intermediary to reimburse or not reimburse costs. ... [N]othing in St. Luke's suggests that the hospital would not have been "dissatisfied" if it omitted to list the cost on a worksheet in the cost report (whether through inadvertence, or in reliance on the agency's earlier determination that the costs were not recoverable). ...Under *St. Lukes's*, the statutory word '"dissatisfied"' is not limited to situations in which reimbursement was sought by the hospital from the intermediary."[48]

This dicta suggests that, similar to the Ninth Circuit in *Loma Linda*, the First Circuit would interpret § 1395oo(a) as not requiring that a specific gateway issue or claim be established under § 1395oo(a) before the Board could exercise discretion under 1395oo(d) to hear an issue or claim not considered by the intermediary (*e.g.*, unclaimed cost). Rather, the First Circuit appears to decouple the listing of costs claimed in the cost report from the ability of the provider to be "dissatisfied" with the later decision by the intermediary to reimburse or not reimburse. This application of § 1395oo(d) is further supported by the D.C. District Court in the 2008 case of *UMDNJ-University Hospital v. Leavitt*.[49] As in *MaineGeneral* and *Loma Linda*, the provider filed its appeal based on several intermediary adjustments to its cost report claims with which it

---

[44] *St. Luke's*, 810 F.2d at 332.
[45] *Id.* at 327-328 (emphasis in original).
[46] *MaineGeneral*, 205 F.3d at 501.
[47] *St. Luke's*, 810 F.2d at 327.
[48] *MaineGeneral*, 205 F.3d at 501.
[49] *UMDNJ Univ. Hosp. v. Leavitt*, 539 F.Supp.2d. 70 (D.D.C. 2008) (*UMDNJ*).

was dissatisfied, but it also included an appeal of costs for its clinical medical education programs that were omitted entirely from the cost report. That court wrote:

> The Board may adopt a policy of hearing claims not initially presented to the fiscal intermediary or of refusing to hear them, or it may decide on a case by case basis. This conclusion comports with the plain language of subsection (d) . . ..[50]

Similar to the Ninth Circuit in *Loma Linda*, the D.C. District Court interpreted § 1395oo(a) as requiring only general dissatisfaction with the amount of total reimbursement on the NPR in order to establish Board jurisdiction under § 1395oo(a).[51]

In the aggregate, the case law of the First and Ninth Circuits and the D.C. District Court consistently conforms to the notion that § 1395oo(d) bestows the Board with a limited discretion, which is preconditioned on first establishing jurisdiction under § 1395oo(a). The case law does not stand for the proposition that § 1395oo(d) is a grant of "alternate" jurisdiction, but instead, these decisions make it clear that, once the Board acquires jurisdiction over a cost report itself pursuant to 42 U.S.C. § 1395oo(a), the Board has the discretionary power under § 1395oo(d) to hear any discrete items and services on the cost report. The Board *may* then hear the appeals of claims inadvertently omitted or mistakenly reported on the cost report, but the Board is *not required* to hear those claims.

Historically, the Board's interpretation of §§ 1395oo(a) and (d) has generally been more closely aligned with the interpretation of the First Circuit rather than arguably broader interpretation of the Ninth Circuit or the more narrow interpretation of the Seventh Circuit. Specifically, the Board generally interprets § 1395oo(a) as: (1) the gateway to establishing Board jurisdiction to hear an appeal; and (2) contrary to *Loma Linda* and *UMDNJ*, requiring that dissatisfaction be expressed with respect to the total reimbursement for "each claim" (as opposed to a general dissatisfaction with the total reimbursement on the NPR) because the Board views the NPR as being comprised of many individual determinations on various items for which the provider has sought payment in the as-filed cost report.[52]

42 U.S.C. § 1395oo(a) dictates that, to obtain jurisdiction, a provider must be "dissatisfied" with a "final determination" of the intermediary. Thus, it follows that a provider must have claimed reimbursement for items and services for the intermediary to make a "final determination" regarding such items and services.

In this instant case, the Provider failed to claim the disputed GME and IME FTEs on its cost report as filed with the Intermediary. As previously noted, 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.

---

[50] *Id.* at 79.
[51] *Id.* at 77.
[52] *See, e.g. Affinity Med. Ctr. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2010-D15 (Mar. 11, 2010) (2010 WL 1484204 (PRRB)), *declined review*, CMS Administrator (May 3, 2010) (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.

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). Further, the Board also notes that it 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.[53] As the issue under appeal in this case involved unclaimed costs, the Board finds that the Provider's appeal request failed to establish gateway jurisdiction under § 1395oo(a) because the appeal request only pertained to issues involving unclaimed costs and failed to include an appeal of a final determination on an issue or claim (*i.e.*, a claim or issue that the Intermediary had reviewed and then adjusted to the Provider's detriment on the NPR).

The Board concludes that GME and IME FTEs in dispute were not claimed on the cost report and, thus, the Provider does not have a right under 42 U.S.C. § 1395oo(a) to a hearing on the distinct issue of the GME and IME FTE reimbursement. Since the Board does not have jurisdiction for any issues under subsection (a), the Board cannot exercise its discretion under subsection (d) to make any other revisions on other matters covered by the cost report. Therefore, the Board hereby dismisses the issue of GME and IME reimbursement from the case and closes the case. Since jurisdiction over an appeal is a prerequisite to granting a request for EJR, the Provider's request for EJR is hereby denied.[54]

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

Board Members Participating

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

FOR THE BOARD:

Michael W. Harty
Chairman

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

cc: Cecile Huggins, Palmetto GBA
Kevin Shanklin, BCBSA

---

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

[54] *See* 42 C.F.R. § 405.1842(a).

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: 14-0216
Certified Mail

SEP 03 2014

Jeannie A. Adams, Esq.
Hancock, Daniel, Johnson & Nagle, P.C.
4701 Cox Road
Suite 400
Glen Allen, VA 23060

RE: Warren Memorial Hospital
Provider No. 49-0033
FYE 12/31/2008
PRRB Case No. 14-0216

Dear Ms. Adams:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's May 29, 2014 request for expedited judicial review (EJR) (received June 2, 2014) and the August 5, 2014 response (received August 6, 2014) to the Board's June 27, 2014 request for additional information. The Board's response to the Provider's request for EJR is set forth below.

Issue Under Dispute

The issue under appeal involves the Medicare Administrative Contractor's (MAC's)[1] authority to correct the Provider's incorrectly established Graduate Medical Education (GME) and Indirect Medical Education (IME) full-time equivalent (FTE) caps. The Provider's legal argument in its position is based on the D.C. Circuit Court's decision in *Kaiser Foundation Hospitals v. Sebelius* (*Kaiser*).[2] In that case, the Court found that the reopening regulation, 42 C.F.R. § 405.1885, allows for modification of predicate facts in closed years (years not subject to reopening) provided the change will only impact the total reimbursement in open years (years subject to reopening).[3] The Provider is challenging the validity of a change to the regulation 42 C.F.R. § 405.1885,[4] made as a result of the decision in *Kaiser*.

[1] Medicare audit and payment functions are conducted by contractors known as MACs or intermediaries. The terms will be used interchangeably in this document.
[2] 708 Fed. 3d 226 (D.C. Cir. 2013).
[3] *Id.* at 232-233.
[4] 78 Fed. Reg. 74826, 75162 (December 10, 2013).

Legislative Background

GME

Under the 1986 amendment to the Medicare Act, 42 U.S.C. § 1395ww(h), Congress enacted a new methodology for reimbursing GME costs incurred by hospitals that participate in the Medicare program. The Secretary was directed to determine for each hospital's base year, the "average amount recognized as reasonable" under the Medicare Act for direct GME costs for each full-time equivalent resident.[5] For residency programs established after January 1, 1995, the hospital's unweighted FTE resident cap may be adjusted based on the product of the highest number of residents in any program year during the third year of the first [residency] program's existence for all new residency training programs and the number of years in which the residents are expected to compete the program based on the minimum accredited length for each type of program. The adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new program.[6]

Reopening Regulations

In the December 10, 2013 Federal Register, the Secretary announced the "Clarification of Reopening of Predicate Facts in Intermediary Determinations of Provider Reimbursement (§ 405.1885)."[7] The Secretary noted that factual underpinnings of a specific determination of the amount of reimbursement due a provider may arise in the cost reporting period that forms the basis for the determination, for example the calculation of the disproportionate share adjustment. In the alternative, the factual underpinnings of a specific determination may first arise in or be determined for a different fiscal period than the cost reporting period under review. Factual determinations made in another cost reporting period are referred to as "predicate facts."

The predicate facts in this case relate to GME FTE counts determined in an earlier cost reporting period. With respect to GME costs, the predicate facts were determined based on information from an earlier cost reporting period, and then applied as part of the reimbursement formula for several fiscal periods thereafter. The facts are not reevaluated annually to determine whether they support the determination that a particular cost is reasonable because the formula is a proxy for reasonable costs. Instead, the formula itself will provide for changes in costs through an updating factor or otherwise.[8]

The Secretary noted that a specific matter at issue may involve a predicate fact that first arose in, or was determined for, an earlier fiscal period and that factual data could be used differently or applied to different reimbursement in one or more later fiscal periods. She noted that the "longstanding policy, interpretation and practice" is that the relevant provisions of the statute and regulations provide for review and potential redetermination of such facts only where there is a timely appeal or reopening of: (1) the NPR for the cost reporting period in which the predicate

[5] 42 C.F.R. § 1395ww(h)(2).
[6] 42 C.F.R. § 413.79(e)(1) (2007).
[7] 78 Fed. Reg. 74826, 75162 (December 10, 2013).
[8] *Id.* at 75163.

fact first arose or was determined; or (2) the NPR for the period for which such predicate fact was first used or applied by the intermediary to determine reimbursement.[9]

The Secretary explained that if a provider disputes a base period cost determination, it can either appeal the determination or seek a reopening of its cost report. Unless the appeal or reopening results in a different finding as to the predicate fact in question, there cannot be a finding as to the predicate fact in the base period and a different finding about the same fact in a later cost reporting period. Once the 3-year reopening period for revision of a final determination has expired,[10] neither the intermediary or provider can revisit the predicate fact in the base period that was not changed through appeal or reopening.[11]

This change to the regulation was the result of the decision in *Kaiser*. In that case, the Court held that providers could appeal predicate facts even though such predicate facts were not timely appealed or reopened for the periods where they first arose or were first applied to determine the providers' reimbursement. The Court held that the reopening regulation allows for modification of predicate facts in closed years provided the change will only impact the total reimbursement determination in open years.[12] The Court concluded that the Secretary acted arbitrarily in treating similarly situated parties differently and noted that the Secretary routinely championed a permissive interpretation of the reopening regulations when correction of predicate facts resulted in a windfall to the agency.[13]

The changes to 42 C.F.R. § 405.1885, effectuating the above considerations, were effective for appeals or reopening requests pending on or after the effective date of the final rule even if the intermediary determination preceded the effective date of the rule. The Secretary also stated that if the revisions to § 405.1885 were deemed retroactive, she would consider the retroactive application necessary to comply with the statutory requirements and failing to take such action would be contrary to the public interest.[14] The effective date of the regulation was January 27, 2014.[15]

Background Facts Related to the Request for Hearing and the FTE Recalculation

Request for Hearing

The Provider's request for hearing was dated October 18, 2013 and received in the Board's offices on October 21, 2013. It appealed an NPR dated April 24, 2013, raising the issue of graduate medical education (GME) and indirect medical education (IME) reimbursement. The amount in controversy is $324,881.

---

[9] *Id.* at 75163-75.
[10] *See* 42 C.F.R. § 405.1885(2008).
[11] 78 Fed. Reg. at 75163.
[12] *Kaiser* at 232-233.
[13] *Id.*
[14] 78 Fed. Reg. at 75165.
[15] *Id.* at 75195.

Full-Time Equivalent Recalculation

On December 2, 2010, an auditor for the MAC sent an e-mail to the Provider indicating that he believed that that application of the FTE caps had been "inconsistent and incorrect."[16] The auditor requested a copy of the Provider's rotation schedules for 2002, which would allow him to determine if the GME base year caps were properly calculated.

After receiving the Provider's response, the auditor responded on January 10, 2011, indicating that the Provider's 2003 unweighted FTE cap had been miscalculated. The auditor indicated that the 2003 FTE Cap should have been set at 8.53 FTEs for GME and IME, rather than 6.67. The auditor furnished the Provider with his work and rationale for his recalculation of the 2003 FTE cap.[17] However, there was no indication of how the MAC miscalculated the 2003 FTE cap or why the miscalculation was applied.

Once the Provider was made aware of the miscalculation of the 2003 FTE cap, it took action to reclaim the reimbursement owed. On February 24, 2011, the Provider requested that the cost reports for 2003-2006 be reopened to correct the FTE caps or alternatively, if the 3-year reopening period had been tolled, the Provider asked that the predicate caps be modified in order to rectify the errors in the 2006 open cost report and future cost reports.[18]

The auditor responded to the reopening request on February 11, 2011, stating that the FTE caps for any cost reporting period, whether open or closed could not be changed because they were locked in.[19] Further, the auditor indicated that the caps would not be revised for 2007, 2008 and 2009 because those cost reports were on hold. This was reiterated in emails and a reopening denial dated March 29, 2011.[20]

The Provider attempted to meet with the MAC and was told that the MAC as reviewing the issues and looking at all of the various updates to the GME regulations.[21] The Provider asked the MAC to consider revising its cap in light of the findings in *Kaiser,* but was told, at the time, that the *Kaiser* decision was being appealed.[22]

The Provider's NPR for FYE 2008 was issued on April 24, 2013, and made no reference to the improper caps. In April of 2013, the Provider filed a request to amend its 2008 cost report to correct the IME and GME caps or, in the alternative, submit the amount as a protest.[23]

The Provider is seeking to have its caps revised based on predicate facts, as was done for the Kaiser Hospitals.

---

[16] Provider's Hearing Request, Tab 3, Ex. B.
[17] *Id.* Tab 3, Ex. C.
[18] *Id.* Tab 3, Ex. F.
[19] *Id.* Tab 3, Ex. G.
[20] *Id.* Tab 3, Ex. H.
[21] *Id.* Tab 3, Ex. J.
[22] *Id.* Tab 3, Ex. L.
[23] *Id.* Tab 3, Ex. M.

Provider's Request for EJR

In this case, the Provider is challenging the GME base year FTE caps (6.67 GME and 5.14 IME FTEs) used in the FYE 2008 cost report which was incorrect and resulted in underpayments. The Provider believes that under the decision in *Kaiser* the MAC has the authority to adjust the predicate facts and adjust the FTE caps in the current FYE without reopening the closed cost reports. However, the Provider notes that the changes to the regulation, under the language in the Federal Register, are applicable to its case.

In this case, the Provider is seeking to have the MAC correct its incorrectly established GME and IME FTE caps to ensure accurate reimbursement. The Provider's legal argument is based on the D.C. Circuit's decision in *Kaiser* in which the Court held that such corrections did not constitute reopenings under 42 C.F.R. § 405.1885 "because the reopening regulation allows for modification of predicate facts in closed years provided the change will only impact the total reimbursement determination in open years." [24]

The Provider notes that the Final Rule stated that correction of predicate facts may only be accomplished through

> (1) [ ] a timely appeal or reopening of an NPR for the fiscal period in which the predicate fact first arose or the fiscal period for which such fact was first determined by the intermediary; and/or
>
> (2) [ ] a timely appeal or reopening of the NPR for the fiscal period in which the fact was first used (or applied) by the intermediary to determine the provider's reimbursement.[25]

The following revisions to 42 C.F.R. § 405.1885 are the subject of the EJR request. The Secretary revised the reopening regulation, 42 C.F.R. § 405.1885 and added new section (iv) to § 405.1885(b)(2) which states:

> The 3-year period described in paragraph (b)(2)(i) through (b)(2)(iii) of this section applies to, and is calculated separately for, each specific finding on a matter at issue (as described in paragraphs (a)(1)(i) through (a)(1)(iv) of this section, but not to such findings when made as part of a determination of reasonable cost under section 1861(v)(1)(A) of the Act.

The Secretary revised 42 C.F.R. § 405.1885(a)(1) to define "specific matter at issue" to include:

> a predicate fact, which is a finding of fact based on a factual matter that first arose in or was first determined for a cost reporting period that predates the period at issue (in an appeal filed, or a reopening

---

[24] *Kaiser* at 232-33.
[25] 78 Fed. Reg. at 75164-75165.

> requested by a provider or initiated by an intermediary, under this subpart), and once determined, was used to determine an aspect of the provider's reimbursement for one or more later cost reporting periods.

The Provider challenges the validity of the regulations on two bases: (1) the regulation is arbitrary and capricious because it is inconsistent with long-standing CMS policy; and (2) the application of the regulation to presently pending appeals is retroactive rulemaking because the regulation is substantive, not a clarification, as the Secretary alleges.

The Provider notes that there are no facts in dispute. On November 13, 2013, the Provider and the MAC submitted a Joint Scheduling order in Case No. 13-1468 (2007) in which the MAC agreed that a base year FTE cap was incorrect and an FTE value of 8.53 would result in additional reimbursement to the Provider, although the MAC does not have the authority to grant the relief sought. The Provider believes that EJR is appropriate because the Board is bound by the new reopening regulations by virtue of 42 C.F.R. § 405.1867.

Decision of the Board

The Board finds that the Provider does not have jurisdiction over the appeal for fiscal year end 2008 because the Provider failed to file a claim for reimbursement as a protested amount as required by 42 C.F.R. § 405.1835(a)(1)(ii). Since jurisdiction over an appeal is a prerequisite to granting a request for EJR, the Provider's request for EJR is hereby denied.[26]

This appeal was filed based on the provisions of 42 U.S.C. § 1395oo(a) and 42 C.F.R. § 405.1835(a)(3)(i) which permits providers that have submitted perfected cost reports to their respective MACs to file appeals with the Board where the MAC has issued a final determination. In this regard, 42 U.S.C. § 1395oo(a) states in relevant part:

> [] any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if--
>
> (1) such provider--
>
> (A)(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 the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report, or

[26] *See* 42 C.F.R. § 405.1842(a).

> (ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title,
>
> (B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied with the rules and regulations of the Secretary relating to such report. ...
>
> ********
>
> (3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i), or with respect to appeals under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination, or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

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

> (a) Criteria. A provider ... has a *right to a Board hearing*, as a single provider appeal, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination, *only if*—
>
> (1) *The provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for specific item(s) at issue, by* either—
>
> (i) Including a claim for specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or
>
> (ii) Effective with cost reporting periods that end on or after December 31, 2008, *self-disallowing the specific item(s) by following the applicable procedures for filing a cost report under protest*, where the provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy (for example, if the intermediary lacks discretion to award the reimbursement the provider seeks for the item(s)).[27]

This confirms that the general right to hearing at the beginning of the new subsection (a) necessarily encompasses claims for both reasonable cost reimbursement and reimbursement

---

[27] (Emphasis added).

under IPPS. Significantly, the general right to hearing in the new subsection (a) relates to "an intermediary or Secretary *determination.*"[28] The definition of "determination" as used therein is defined in 42 C.F.R. § 405.1801. Significantly, the § 405.1801 definition of "determination" has included determinations for both reasonable cost reimbursement and reimbursement under IPPS since September 1983 when CMS revised its regulations to implement IPPS.[29] Indeed, the Board's review of the regulatory history of § 405.1835 suggests that the May 23, 2008 changes simply update and expand the § 405.1835 right to hearing to include any IPPS reimbursement issues that are part of the normal cost report audit, settlement and appeals process as reflected by the historical application of such process.

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

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

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

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

> 115.1 **Provider Disclosure of Protest**.--When you file a cost report under protest, the disputed item and amount *for each issue* must be specifically identified in footnotes to the settlement worksheet and the fact that the cost report is filed under protest must be disclosed.
>
> 115.2 **Method for Establishing Protested Amounts**.--The effect of *each nonallowable cost report item is estimated* by applying reasonable methodology which closely approximates the actual

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

> effect of the item as if it had been determined through the normal cost finding process. In addition, *you must submit*, with the cost report, *copies of the working papers used to develop the estimated adjustments* in order for the contractor/contractor to evaluate the reasonableness of the methodology for purposes of establishing whether the cost report is acceptable. The cumulative effect on reimbursement for all disputed issues is shown as an adjustment to balance due to the program (provider) in the reimbursement settlement computation. The actual effect on reimbursable cost(s) is determined after final adjudication of the issue(s).[30]

Effective with cost report periods that end on or after December 31, 2008, CMS amended the regulations governing cost report appeals to incorporate PRM 15-2 § 115 *et seq.* into the regulations at 42 C.F.R. § 405.1835(a)(1)(ii) (2008) by specifying that, where a provider seeks payments that it believes may not be allowable or may not be in accordance with Medicare policy, the provider must claim the items as self-disallowed costs "by following the applicable procedures for filing a cost report under protest."

In the preamble to the final rule published on May 23, 2008 ("2008 Final Rule"),[31] the Secretary explained that he believed that requirement to follow the procedures for filing cost reports under protest was appropriate under the decision in *Bethesda Hospital Association v. Bowen.*[32] In *Bethesda*, the providers were dissatisfied with malpractice reimbursement and did not file a claim for the additional reimbursement on their cost report nor did they file a statement with the cost report challenging the validity of the regulation. Hence, there was no final determination with respect to malpractice costs. The Court rejected the Secretary's argument that 42 U.S.C. § 1395oo(a)(1)(A)(i), which requires dissatisfaction with a final determination of the intermediary, "necessarily incorporates an exhaustion requirement." The Court found that this "strained interpretation" of the statutory dissatisfaction requirement was inconsistent with the express language of the statute.[33] However, the Court agreed, that under § 1395oo(a)(1)(A)(i), a provider's dissatisfaction with the amount of its total reimbursement is a condition of the Board's jurisdiction, but held that "it is clear, however, that the submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations. No statute or regulation expressly mandates that a challenge to the validity of a regulation be submitted first to the intermediary. … Thus, [the providers in *Bethesda]* stand on different ground than do providers who bypass clearly prescribed exhaustion requirements or who fail to request from the intermediary reimbursement for costs to which they are entitled under the applicable rules. While such defaults might well establish that a provider was satisfied with the amounts requested in its cost report and awarded by the intermediary, those circumstances are not presented here."[34] The Secretary noted that the Court recognized that an exhaustion requirement could be imposed by regulation, and that a provider who fails to claim all

---

[30] (Emphasis added).
[31] 73 Fed. Reg. 30190 (May 23, 2008).
[32] 485 U.S. 399 (1988).
[33] 73 Fed. Reg. at 30196 citing *Bethesda* at 404.
[34] *Id.* at 404-405.

costs to which it is entitled may fail to meet the jurisdictional prerequisite of dissatisfaction.[35] In light of the ability to enact such regulations, 42 C.F.R. § 405.1835(a)(1)(ii) was promulgated, requiring providers to claim all items for which they seek additional reimbursement.

The Secretary went on to state that "[a]lthough there may be nothing in the statute indicating that dissatisfaction must be expressed with respect to "each claim," there also is nothing in the statute indicating that the Secretary cannot interpret the dissatisfaction requirement in this manner."[36] The final determination, which here is the NPR, is not just the total amount of program reimbursement. Rather, it is composed of many individual calculations representing the various items for which a provider seeks payment. Providers generally challenge discrete reimbursement items. Thus, dissatisfaction with total reimbursement is based on dissatisfaction with items that result in total reimbursement. Consequently the Secretary believes it is reasonable under 42 U.S.C. § 1395oo(a) to require dissatisfaction be shown with respect to each issue being appealed.[37] In light of this and the requirements of the regulation, the challenge to the GME and IME FTE caps must be claimed as a protested item and the Providers failed to comply with this requirement.

In the preamble, the Secretary also confirmed that this regulation codified the PRM rules governing cost reports filed under protest:

> **Comment**: One commenter recommended that the text of section 115 *et seq.* of the PRM, Part II, be placed in the regulations. The commenter noted that these sections of the PRM have not changed since 1980. . . .
>
> **Response**: We are adopting the proposal, which is essentially a codification of the protested amount line procedures set forth in section 115 *et seq.* of the PRM, Part II.[38]

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

> Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the

---

[35] *Id.*
[36] 73 Fed. Reg. at 30197.
[37] *Id.*
[38] *Id.* at 30195. Similarly, the preamble to the 2008 Final Rule states the following regarding the documentation requirements for filing a cost report under protest: "We are attempting to strike a balance between, on the one hand, having provider present enough information so as to put the intermediaries on notice as to the actual or potential reimbursement disputes, and, on the other hand, not making it unduly burdensome for providers to file cost reports." *Id.* The preamble further states: "We believe it reasonable to require provider to notify their intermediaries, via their cost report submission, of all items for which they potentially may be claiming reimbursement." *Id.* at 30198.

> normal cost finding process. (See [PRM 15-2 Chapter 1,] § 115.2). Attach a schedule showing the details and computations for this line.

The Board notes that 42 C.F.R. § 405.1803(d) (2008) provides further evidence that the "rules and regulations governing [cost] reports" are, in part, located in 42 C.F.R. Part 405, Subpart R. This regulation governs implementation of decisions to award, in part or in full, self-disallowed items filed under protest:

> (d) **Effect of certain final agency decisions and final court judgments: audits of self-disallowed and other items.** ...
>
> (3) CMS may require the intermediary to audit any item, including any self-disallowed item, at issue in an appeal or a civil action, before any revised intermediary determination or additional Medicare payment, recoupment, or offset may be determined for an item under paragraph (d)(2) of this section.

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

> The final decision awarding reimbursement for a self-disallowed item may come from the Board, the Administrator, or a court. Although we believe that, in most instances, the administrative or judicial body that issues a decision would not specify a dollar figure for reimbursement, the proposal was intended to ensure that intermediaries, in fact, have the opportunity to determine the correct amount of reimbursement after an award is made. We believe that it would be inappropriate for the administrative or judicial body to award a specific amount for reimbursement without the benefit of an audit by the intermediary.[39]

Thus, the procedures and documentation required for filing an item under protest and the audit of such items when they are awarded (in part or in full) following a successful appeal as codified at 42 C.F.R. §§ 405.1835(a)(1)(ii) and 405.1803(d) respectively, are an integral part of the cost reporting process established under 42 U.S.C. § 1395g(a) that the provider must "furnish[ ] such information as the Secretary may request in order to determine the amounts due such provider."

The Provider did not enter a protested amount Worksheet E, Part A, Line 30 of the cost report at issue as required to protest the amount of IME and GME reimbursement pursuant to § 405.1835(a)(1)(ii).[40] As these cost reports involve a fiscal year that end on or after December 31, 2008, self-disallowed items such as the GME FTE and IME reimbursement at issue must

---

[39] 73 Fed. Reg. at 30199.
[40] *See* Provider's August 5, 2014 letter (the Provider did not claim the revised FTE cap as a protested matter in its 2008 cost report).

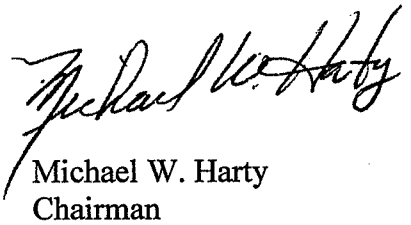
have been filed under protest in order to have "complied with the rules and regulations of the Secretary relating to such [cost] report" and, thereby, established one of the elements for Board jurisdiction under 42 U.S.C. § 1395oo(a)(1). Thus, as the Providers failed to protest the GME and IME FTE reimbursement at issue and that is the sole issue involved in these appeals, the Board lacks jurisdiction over the appeal and hereby dismisses this issue and closes the case. Since jurisdiction over an appeal is a prerequisite to granting a request for EJR, the Provider's request for EJR is hereby denied.[41]

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

Board Members Participating

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

FOR THE BOARD:



Michael W. Harty
Chairman

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

cc: Cecile Huggins, Palmetto GBA
Kevin Shanklin, BCBSA

[41] *See* 42 C.F.R. § 405.1842(a).

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

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

Refer to: 13-3738G
CERTIFIED MAIL

SEP 10 2014

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

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

Dear Mr. Nash:

Enclosed are the Provider Reimbursement Review Board's (Board's) Notice of Reopening and determination with respect to expedited judicial review for the above-referenced appeal. These determinations were issued incident to the Centers for Medicare and Medicaid Services Administrator's August 15, 2014 remand in the above-referenced appeal.

Sincerely,

Michael W. Harty
Chairman

Enclosures: Reopening Notice/EJR determination

cc: Timothy LeJeune, Novitas (w/Enclosures)
Kevin Shanklin, BCBSA (w/Enclosures)
Jacqueline Vaughn, Esq., OAA (w/Enclosures)

United States Department of Health and Human Services
Provider Reimbursement Review Board

Provider-Patton Boggs 2011 Outlier Group	*	PRRB Case No. 13-3738G
Provider Nos.- Various	*	
v.	*	
	*	FYE 2011
Intermediary- First Coast Services Options/Blue Cross Blue Shield Association	*	

****

Notice of Reopening Pursuant to the Order of the Administrator's Order of Remand

I

Reopening

This ORDER for reopening is issued pursuant to the August 12, 2014[1] order in which the Administrator of the Centers for Medicare & Medicaid Services (Administrator) remanded case number 13-3738GC to the Provider Reimbursement Review Board (Board).

The Board dismissed the Providers' appeal[2] because it concluded that it lacked jurisdiction over the calculation of outlier payments under the Inpatient Prospective Payment System (IPPS). The Providers claim that the Secretary improperly established the "fixed loss threshold" (FLT) used to calculate the number of cases that qualify for and the amount of outlier payments. The Providers stated that they had all filed perfected cost reports with their respective Intermediaries[3] and filed appeals with the Board, where the Intermediaries had not issued timely final

---

[1] The Administrator of the Centers for Medicare & Medicaid Services signed the order on August 12, 2014; the Office of the Attorney Advisor transmitted the order to the Board through correspondence dated August 14, 2014. The Board received the order on August 15, 2014.

[2] See Administrator's Remand Order at 7, footnote 6. The Administrator's remand identifies three Providers: Billings Clinic, Parkview Medical Center and Cabell Huntington Hospital that were dismissed from case number 13-3738G. These Providers were not dismissed from the case for failure to claim the FLT as a protested amount and, therefore, are not governed by this remand and are not reinstated. Cabell Huntington (provider number 51-0055) and Parkview Medical Center were dismissed from the appeal on November 22, 2013 and June 13, 2014, respectively, because there hearing requests were not timely filed. Billings Clinic was dismissed from this appeal on June 13, 2014 because it had received its Notice of Program Reimbursement (NPR) and filed an appeal of the outlier issue which in case number 14-1429G. The Board found Billings appeal of the lack of an NPR in case number 13-1738G was moot.

[3] The role of the Intermediary is now being performed by Medicare Administrative Contractors (MACs). The term Intermediary will be used in this document.

determinations.[4] The Providers identified on the Schedule of Providers admitted that they did not claim outlier reimbursement as a protested amount on their cost reports as required by 42 C.F.R. § 405.1835(a)(1)(ii) (2008).[5]

In concluding that it lacked jurisdiction over the appeal, the Board explained that pursuant to 42 U.S.C. § 1395oo(a)(1)(B) and 42 C.F.R. § 405.1835(a)(3)(ii), a provider that has submitted a perfected cost report to its intermediary may file an appeal with the Board no later than 180 days after the expiration of the 12 month period for issuance of the intermediary determination.[6] In addition, pursuant to 42 C.F.R. § 405.1835(a), a provider has a right to a hearing if it preserved its right to claim dissatisfaction with the amount of Medicare payment for specific items at issue by including a claim for a specific item on its cost report where the provider seeks payment that it believes is in accordance with Medicare policy.

Effective with cost reporting periods that end on or after December 31, 2008, the regulation was amended to state that a provider must preserve its right to appeal an issue by self-disallowing the specific item by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy, even when appealed from the failure of the intermediary to issue a timely NPR. The Board found that the cost years involved in this case ended on or after December 31, 2008, and, therefore, self-disallowed items such as the outlier reimbursement at issue must have been filed under protest in order to comply with the rules and regulations establishing one of the elements for Board jurisdiction, even when appealing the failure to issue a timely NPR. Since the Providers failed to file the outlier FLT as a protested amount, the sole issue in dispute, the Board concluded that it lacked jurisdiction over the appeal of the Providers in the group.

In her decision remanding the case to the Board, the Administrator noted that 42 U.S.C. § 1395oo provides, in part, that the following criteria must be met for a provider of services to request a hearing before the Board. In particular, § 1395oo states that:

> Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board . . . and . . . any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if--
>
> (1) such provider—
>
> *****

[4] *See* 42 C.F.R. § 405.1835(a)(3)(ii).
[5] *See* Schedule of Providers and Jurisdictional Documents, Global Tab D.
[6] The final intermediary determination in this case would be the Notice of Program Reimbursement (NPR).

> following the applicable procedures for filing a cost report under protest, where the provider seeks payment that it believes may not be allowable or may be in accordance with Medicare policy (for example, if the intermediary lacks discretion to award the reimbursement the provider seeks for the item(s)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839 of this subpart) is $10,000 or more; and[7]
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836 of this subpart, the date of receipt by the Board of the provider's hearing request is--
>
> *****
>
> (ii) If the intermediary determination is not issued (through no fault of the provider) within 12 months of the date of receipt by the intermediary of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of this chapter), no later than 180 days after the expiration of the 12 month period for issuance of the intermediary determination . . . .

The Administrator stated that "the requirement that, when appeal from an [intermediary's failure to issue a timely] NPR, a provider must demonstrate "dissatisfaction" was inadvertently added in the 2008 changes as a result of a drafting error." As a way of explanation, [the Secretary] stated in the technical correction to 42 C.F.R. § 405.1835 in the Federal fiscal year 2015 final Inpatient Prospective Payment System Rates that:

> Before a 2008 final rule (73 FR 30190; May 23, 2008) substantially amended the appeals rules, the regulations tracked fully the statute as to whether provider dissatisfaction was a prerequisite for Board jurisdiction. In the 2007 edition of the appeals regulations, § 405.1835(a) addressed the requirements for Board appeals of final contractor determinations, and referred to § 405.1841(a), which required the provider to set forth its dissatisfaction with specific aspects of the contractor determination. Thus, consistent with section [42 U.S.C § 1395(a)(1)(A)], § 405.1835(a) and § 405.1841(a) of the 2007 regulations required provider dissatisfaction for Board appeals of final contractor determination.

[7] *See* 42 C.F.R. § 405.1837(a)(3) (the amount in controversy for a group appeal, is in the aggregate $50,000 or more)

> By contrast, Board appeals based on untimely contractor determinations were addressed in § 405.1835(c), which did not reference provider dissatisfaction . . . .
>
> *****
>
> As amended by the 2008 final rule (73 FR 30190), § 405.1835(a)'s provisions for Board appeals based on untimely contractor determinations no longer track fully the provisions for such appeals in section 1878(a)(1)(B) of the Act. [8]

Consistent with the foregoing recognition of the drafting error in the 2008 changes to the dissatisfaction requirement, the Department of Health and Human Services (DHHS) has conceded this same matter in response to a Court Order to Show Cause. In particular, DHHS has conceded that, in so far as a provider appealing a contractor's failure to issue a timely NPR, the Secretary would not defend "[42 C.F.R. §] 405.1835(a)(1)'s dissatisfaction" requirement as applied to such appeals. The Secretary subsequently responded to another Order to Show Cause indicating that she would not challenge an order to enjoin DHHS from applying 42 C.F.R. § 405.1835(a)(1) to appeals resulting from the failure to issue a timely NPR under 42 U.S.C. § 1395oo(a)(1)(B).

Subsequently, the United States District Court for the District of Columbia issued several identical orders, dated August 6, 2014,[9] that are controlling in this matter, which state:

> ORDERED that in Defendant's responses to the Court's May 27, 2014 and June 10, 2014 Orders to Show Cause, Defendant made a binding concession that 42 C.F.R. § 405.1835(a)(1)'s requirement that a Medicare provider must establish its "dissatisfaction" by claiming reimbursement for the item in question in its Medicare cost report or by listing the item as a "protested amount" in its cost report, should not apply to [Board] appeals (like those in Charleston-A, Denver Health, and Charleston-B) that are based on the provisions of the Medicare statute, 42 U.S.C. § 1395oo(a)(1)(B), that provide for appeal to the Board where a Medicare contractor does not issue a timely notice of program reimbursement (NPR); and it is
>
> FURTHER ORDERED that the Board, the rest of [DHHS], and all current and future Medicare contractors are enjoined from applying 42 C.F.R. § 405.1835(a)(1)'s "dissatisfaction" requirement to any

[8] 78 Fed. Reg. 49854, 50,200 (August 22, 2014).

[9] An order identical to the one issued in this case has been entered in the following cases: *Charleston Area Medical Center v. Sebelius* (Charleston –A), No 13-643 (D.D.C. filed May 3, 2013); *Charleston Area Medical Center v. Sebelius* (Charleston-B), No 13-766 (D.D.C. filed May 24, 2013); and *Denver Health Medical Center v. Sebelius, (Denver Health)*, No 14-553 (D.D.C. filed April 2, 2014).

> pending or future Board appeal that, pursuant to 42 U.S.C. § 1395oo(a)(1)(B), is based on the Medicare contractor's failure to issue a timely NPR . . . .

The Administrator ordered that:

- The Board, the Administrator, DHHS and all current and future Medicare contractors are enjoined from applying "42 C.F.R. § 405.1835(a)(1)'s dissatisfaction" requirement to any pending or future Board appeal, that pursuant to 42 U.S.C. § 1395oo(a)(1)(B), is based on the Medicare contractor's failure to issue a timely NPR;

- The Providers in this case are subject to the decision as they are appealing based on the Medicare contractor's failure to issue a timely NPR. This case was pending before the Administrator to review the Board's application of 42 C.F.R. § 405.1835(a)(1)'s dissatisfaction requirement denying Board jurisdiction. The Administrator conceded that the decision is subject to the Court's injunction and further concludes that the Board's alternative basis for denial of jurisdiction under the Provider Reimbursement Manual (CMS Pub. 15-2) §§ 115.1 and 115.2 provision cannot be upheld in this case and cannot be relied upon on remand to the Board as a basis for denying jurisdiction.

- The Board and the Administrator are enjoined from applying "42 C.F.R. § 304.1835(a)(1)'s dissatisfaction" requirement as a necessary component for Board jurisdiction in this appeal that is based on the Medicare contractor's failure to issue a timely NPR under 42 U.S.C. § 1395oo(a)(1)(B).

- The decision of the Board denying jurisdiction is reversed. The Board has jurisdiction over the Provider's on the attached Schedule of Providers.

- The case is remanded to the Board for further proceedings on the Provider's appeal, including the request for expedited judicial review, consistent with 42 U.S.C. § 1395oo and the pertinent provisions of 42 C.F.R. § 405.1801 *et seq.*, as enjoined and modified by the United State District Court's August 6, 2014 order.

The Board hereby reopens case number 13-3838G in accordance with the Administrator's remand order.

II

Board Order

The Board's decision with respect to the Providers' request for EJR is attached to this Notice of Reopening and Board Order. The Providers' further actions are governed by the requirements of 42 C.F.R. § 405.1842

SO ORDERED by the
Provider Reimbursement Review Board

Michael W. Harty
Chairman

Date: SEP 10 2014

Attachment: Board Decision with Respect to EJR

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

Refer to:

13-3738G
CERTIFIED MAIL

SEP 10 2014

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

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

Dear Mr. Nash:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's May 19, 2014 request for expedited judicial review (EJR) incident to the Centers for Medicare & Medicaid Services (CMS) Administrator's (Administrator's) August 12, 2014 order[1] remanding the case to the Board. This remand order was issued incident to the United States District Court for the District of Columbia's order, among other things, enjoining the Department of Health and Human Services, the Board and Medicare Contractors from applying 42 C.F.R. § 405.1835(a)(1)'s "dissatisfaction" requirement for Board jurisdiction to any appeal filed based on a contractor's failure to timely issue an Notice of Program Reimbursement pursuant to 42 U.S.C. § 1395oo(a)(1)(B).[2] The Board's decision with respect to its jurisdictional determination and the appropriateness of expedited judicial review (EJR) for the Providers is set forth below.

Issue

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

> Whether the specific regulations governing Outlier Case Payments as set forth in the two regulatory sources—the Outlier Payment Regulations[3] and the fixed loss threshold ("FLT") regulations[4]

[1] The Administrator's order is dated August 12, 2014. The CMS Attorney Advisor transmitted the order to the Board through correspondence dated August 14, 2014. The remand order was received in the Board's offices on August 15, 2014.
[2] The Board has issued a Notice of Reopening for this case in a separate document which will be mailed to the Group Representative concurrently with this decision with respect to the request for EJR.
[3] See Providers' May 19, 2014 EJR request, Page 2, n. 2

(collectively, the "Medicare Outlier Regulations")—as promulgated by the Secretary of Health and Human Services ("HHS") and the Centers for Medicare [&] Medicaid Services ("CMS"), and as in effect for the appealed years, are contrary to the Outlier Statute and/or are otherwise substantively or procedurally invalid?

Providers' Request for EJR

The Providers explain that hospitals are paid for services to Medicare patients under the inpatient prospective payment system (IPPS)[5] under which inpatient operating costs are reimbursed based on a prospectively determined formula. The IPPS legislation contains a number of provisions that provide for additional payment based on specific factors. These cases involve one of those factors: outlier payments. Outlier payments are made for patients whose hospitalization is either extraordinarily costly or lengthy.[6] Outlier payments are made from the "outlier pool," which is a regulatory set-aside or subset of the Medicare Part A Trust Fund, maintained by the government to pay for outlier cases. The outlier pool is, in effect, funded by a 5-6 percent reduction in IPPS payments to acute care hospitals.[7] Prior to the start of each fiscal year, the Secretary establishes a FLT beyond which hospitals will qualify for outlier payments at levels that are between 5-6 percent of DRG[8] payments.[9]

The Providers note that beginning in 1997 through 2003, a number of hospitals were reported to have inflated their charge masters an action which the Department of Justice (DOJ) termed "turbo-charging." This practice greatly inflated cost to charge ratios which greatly increased the cost per case. DOJ termed this action a false claim and this also resulted in the Secretary greatly increasing the FLT so that payments for outliers would remain at 5-6 percent of DRG payments. More specifically, beginning in or around Federal fiscal year (FFY) 1998, the Secretary began making upward adjustments to the FLTs which were in excess of the rate of inflationary indices routinely used such as the CPI-Medical Index or the Medicare Market Basket.[10]

In 2002, the Secretary disclosed that he was aware of "turbo-charging" and that would be amending the outlier regulations to fix "vulnerabilities" in the regulations. In the March 5[11] and June 9, 2003[12] Federal Registers, the Secretary acknowledged three flaws in the outlier payment

---

[4] *Id.* at n. 3.
[5] *See* U.S.C. 42 U.S.C. § 1395ww(d)(5).
[6] Providers' May 19, 2014 EJR request at 3.
[7] *Id.* at 4 n. 9, 42 U.S.C. § 1395ww(d)(3)(B) (Reducing for the Value of Outlier Payments).
[8] Diagnostic Related Group.
[9] Providers' May 19, 2014 EJR request at 4.
[10] *Id.* at 5.
[11] 68 Fed. Reg. 10,420, 10,423 (March 5, 2003) (Recent analysis indicates that some hospitals have taken advantage of two vulnerabilities in our methodology to maximize their outlier payments . . . [1] the time lag between the current charges on a submitted bill and the cost–to-charge ratio taken from the most recently settled cost report and [2] in some cases hospitals may increase their charges far above cost that their cost-to-charge ratios fall below 3 standard deviations from the geometric mean of cost-to-charge ratios and a higher statewide average cost-to-charge ratio is applied.)
[12] 68 Fed. Reg. 34,494,34,501 (June 9, 2003) ([3] even though final payment would reflect a hospital's true cost experience, there would still be the opportunity for a hospital to manipulate its outlier payments by

regulations and stated that the vulnerabilities would be fixed. The Providers maintain that the data used to correct the vulnerabilities had always been available and should have been used to calculate outlier reimbursement. The Providers noted that the Secretary stated that he believed that there was the authority to revise the outlier threshold given the manipulation of the outlier policy. However, he elected not to exercise this authority because of the short amount of time remaining in the FFY. The Providers allege that the Secretary was aware of the problem months before the final rule was published as demonstrated by Provider Exhibit 9, a copy of an Interim Final Rule submitted to the Office of Management and Budget on February 13, 2003.[13] As noted by the Providers[14] the D.C. District Court in *Banner Health v. Sebelius*, 2013 U.S. Dist. Lexis 69889 (D.D.C. May 16, 2013) noted that the February 13, 2013 proposed rule was virtually identical to the final proposed rule with the exception that the later proposed rule published on March 5, 2013 did not recommend reduction of the FLT and the supporting analysis.

The Providers state that they did not learn of the February 13, 2003 unpublished, interim final rule until their counsel obtained it through a Freedom of Information Act request made to the Office of Management and Budget in 2012. They believe the document is still relevant because the Secretary has not accounted for the impact of the "turbo charging" data, and is, allegedly, still relying on inflated data to calculate outlier reimbursement. As a result, the Providers do not receive the full amount of outlier reimbursement to which they are entitled. Further, in the June 12, 2012 Office of Inspector General report, the Inspector General noted that seven years after the 2003 publication of the regulation requiring reconciliation of outlier payments, CMS had not reconciled any of the cost reports screened and reported by Medicare Administrative Contractors (MACs).[15] In a later, 2013 report,[16] OIG noted that although nearly all hospitals receive outlier payments, a small percentage of hospitals receive a significantly higher proportion of payments. The hospitals receiving this higher portion of payments charged Medicare more for the same Medical Severity-Diagnostic Related Groups (MS-DRGs), yet had similar lengths of stay and cost-to-charge ratios. The Providers contend that this is another example of CMS' failure to correct the distribution of outlier payments.[17]

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

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

---

dramatically increasing charges during the year in the discharge occurs. Here, the hospital would receive excessive outlier payments, which, although the hospital would incur an overpayment and have to refund the money when the cost report is settled, this would allow the hospital to obtain excess payments from the Medicare Trust fund on a short-term basis.)

[13] The Providers furnished no evidence that this document was ever published in the Federal Register.

[14] Providers' May 19, 2014 EJR request at 7, n. 15.

[15] *Id.* Ex. 10, OIG Report: The Centers for Medicare & Medicaid Services Did Not Reconcile Medicare Outlier Payments in Accordance with Federal Regulations and Guidance, Report A-07-10-02764 at 7-9 (June 2012).

[16] *Id.* Ex. 11 Medicare Hospital Outlier Payments Warrant Increased Scrutiny, Report OEI-06-10-00520 (November 2013). (incomplete document)

[17] *Id. at 13.*

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

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

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

c) offers explanations for its decisions that run counter to the evidence.[18]

Decision of the Board

The Board has reviewed the submissions of the Providers pertaining to the requests for hearing and expedited judicial review. 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permit expedited judicial review where the Board determines that it does not have the authority to decide a question of law, regulation or CMS ruling. In these cases, the Providers are challenging the validity of the outlier regulations, 42 C.F.R. §§ 412.80 through 412.86.[19] The MAC did not oppose the request for EJR. The documentation shows that the estimated amount in controversy exceeds $50,000 threshold for Board jurisdiction over a group appeal and the appeal was timely filed.

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 outlier regulations, 42 C.F.R. §§ 412.80-412.86, there are no findings of fact for resolution by the Board;

3) it is bound by the regulations; and

4) it is without the authority to decide the legal question of whether the outlier regulations, are valid.

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

---

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

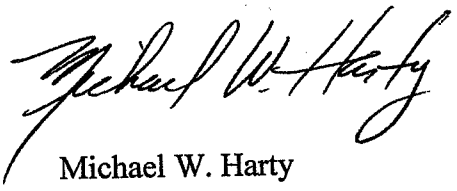
[19] *Id.* at 2 n. 2 (The Outlier Payment Regulations are the base regulations that establish the method for calculating a hospital's imputed costs for a patient case, which are set forth at 42 C.F.R. §§ 412.80 through 412.86. The Payment Regulations were first enacted in 1985 and have been revised periodically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

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

Board Members Participating

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

FOR THE BOARD:



Michael W. Harty
Chairman

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

cc: Timothy LeJeune, Novitas (Certified Mail w/Schedule of Providers)
Kevin Shanklin, BCBSA (Certified Mail w/Schedule of Providers)

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

Refer to: 13-3832GC
CERTIFIED MAIL

SEP 10 2014

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

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

Dear Mr. Nash:

Enclosed are the Provider Reimbursement Review Board's (Board's) Notice of Reopening and determination with respect to expedited judicial review for the above-referenced appeal. These determinations were issued incident to the Centers for Medicare and Medicaid Services Administrator's August 15, 2014 remand in the above-referenced appeal.

Sincerely,

Michael W. Harty
Chairman

Enclosures: Reopening Notice/EJR determination

cc: Geoff Pike, First Coast Service Options (w/Enclosures)
Kevin Shanklin, BCBSA (w/Enclosures)
Jacqueline Vaughn, Esq., OAA (w/Enclosures)

United States Department of Health and Human Services
Provider Reimbursement Review Board

Provider-Patton Boggs/Lee Memorial 2011 Outlier Group	*	PRRB Case No. 13-3832GC
Provider Nos.- Various	*	
v.	*	
	*	FYE 2011
Intermediary- First Coast Services Options/Blue Cross Blue Shield Association	*	

****

Notice of Reopening Pursuant to the Order of the Administrator's Order of Remand

I

Reopening

This ORDER for reopening is issued pursuant to the August 12, 2014[1] order in which the Administrator of the Centers for Medicare & Medicaid Services (Administrator) remanded case number 13-3832GC to the Provider Reimbursement Review Board (Board).

The Board dismissed the Providers' appeal[2] because it concluded that it lacked jurisdiction over the calculation of outlier payments under the Inpatient Prospective Payment System (IPPS). The Providers claim that the Secretary improperly established the "fixed loss threshold" (FLT) used to calculate the number of cases that qualify for and the amount of outlier payments. The Providers stated that they had all filed perfected cost reports with their respective Intermediaries[3] and filed appeals with the Board, where the Intermediaries had not issued timely final determinations.[4] The Providers identified on the Schedule of Providers admitted that they did not claim outlier reimbursement as a protested amount on their cost reports as required by 42 C.F.R. § 405.1835(a)(1)(ii) (2008).[5]

---

[1] The Administrator of the Centers for Medicare & Medicaid Services signed the order on August 12, 2014; the Office of the Attorney Advisor transmitted the order to the Board through correspondence dated August 14, 2014. The Board received the order on August 15, 2014.

[2] See Administrator's Remand Order at 7, footnote 6. The Administrator's remand identifies three Providers: Billings Clinic, Parkview Medical Center and Cabell Huntington Hospital that were dismissed from case number 13-3738G. Those Providers are not participants in the current case, case number 13-3832G, so the discussion regarding their status is not relevant to the order issued in this case.

[3] The role of the Intermediary is now being performed by Medicare Administrative Contractors (MACs). The term Intermediary will be used in this document.

[4] *See* 42 C.F.R. § 405.1835(a)(3)(ii).

[5] *See* Schedule of Providers and Jurisdictional Documents, Global Tab D.

In concluding that it lacked jurisdiction over the appeal, the Board explained that pursuant to 42 U.S.C. § 1395oo(a)(1)(B) and 42 C.F.R. § 405.1835(a)(3)(ii), a provider that has submitted a perfected cost report to its intermediary may file an appeal with the Board no later than 180 days after the expiration of the 12 month period for issuance of the intermediary determination.[6] In addition, pursuant to 42 C.F.R. § 405.1835(a), a provider has a right to a hearing if it preserved its right to claim dissatisfaction with the amount of Medicare payment for specific items at issue by including a claim for a specific item on its cost report where the provider seeks payment that it believes is in accordance with Medicare policy.

Effective with cost reporting periods that end on or after December 31, 2008, the regulation was amended to state that a provider must preserve its right to appeal an issue by self-disallowing the specific item by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy, even when appealed from the failure of the intermediary to issue a timely NPR. The Board found that the cost years involved in this case ended on or after December 31, 2008, and, therefore, self-disallowed items such as the outlier reimbursement at issue must have been filed under protest in order to comply with the rules and regulations establishing one of the elements for Board jurisdiction, even when appealing the failure to issue a timely NPR. Since the Providers failed to file the outlier FLT as a protested amount, the sole issue in dispute, the Board concluded that it lacked jurisdiction over the appeal of the Providers in the group.

In her decision remanding the case to the Board, the Administrator noted that 42 U.S.C. § 1395oo provides, in part, that the following criteria must be met for a provider of services to request a hearing before the Board. In particular, § 1395oo states that:

> Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board . . . and . . . any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if--
>
> (1) such provider—
>
> *****
>
> (B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied with the rules and regulations of the Secretary relating to such report . . .

[6] The final intermediary determination in this case would be the Notice of Program Reimbursement (NPR).

*****

(2) the amount in controversy is $10,000 or more, and

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

(b) Appeals by Groups

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

In addition, pursuant to the 2008 changes to the regulations, 42 C.F.R. § 405.1835 provides that:

(a) Criteria. A provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination, only if--

(1) The provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue, by either--

(i) Including a claim for specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or

(ii) Effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item(s) by following the applicable procedures for filing a cost report under protest, where the provider seeks payment that it believes may not be allowable or may be

> in accordance with Medicare policy (for example, if the intermediary lacks discretion to award the reimbursement the provider seeks for the item(s)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839 of this subpart) is $10,000 or more; and[7]
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836 of this subpart, the date of receipt by the Board of the provider's hearing request is--
>
> *****
>
> (ii) If the intermediary determination is not issued (through no fault of the provider) within 12 months of the date of receipt by the intermediary of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of this chapter), no later than 180 days after the expiration of the 12 month period for issuance of the intermediary determination . . . .

The Administrator stated that "the requirement that, when appeal from an [intermediary's failure to issue a timely] NPR, a provider must demonstrate "dissatisfaction" was inadvertently added in the 2008 changes as a result of a drafting error." As a way of explanation, [the Secretary] stated in the technical correction to 42 C.F.R. § 405.1835 in the Federal fiscal year 2015 final Inpatient Prospective Payment System Rates that:

> Before a 2008 final rule (73 FR 30190; May 23, 2008) substantially amended the appeals rules, the regulations tracked fully the statute as to whether provider dissatisfaction was a prerequisite for Board jurisdiction. In the 2007 edition of the appeals regulations, § 405.1835(a) addressed the requirements for Board appeals of final contractor determinations, and referred to § 405.1841(a), which required the provider to set forth its dissatisfaction with specific aspects of the contractor determination. Thus, consistent with section [42 U.S.C § 1395(a)(1)(A)], § 405.1835(a) and § 405.1841(a) of the 2007 regulations required provider dissatisfaction for Board appeals of final contractor determination.
>
> By contrast, Board appeals based on untimely contractor determinations were addressed in § 405.1835(c), which did not reference provider dissatisfaction . . . .

[7] *See* 42 C.F.R. § 405.1837(a)(3) (the amount in controversy for a group appeal, is in the aggregate $50,000 or more)

*****

> As amended by the 2008 final rule (73 FR 30190), § 405.1835(a)'s provisions for Board appeals based on untimely contractor determinations no longer track fully the provisions for such appeals in section 1878(a)(1)(B) of the Act.[8]

Consistent with the foregoing recognition of the drafting error in the 2008 changes to the dissatisfaction requirement, the Department of Health and Human Services (DHHS) has conceded this same matter in response to a Court Order to Show Cause. In particular, DHHS has conceded that, in so far as a provider appealing a contractor's failure to issue a timely NPR, the Secretary would not defend "[42 C.F.R. §] 405.1835(a)(1)'s dissatisfaction" requirement as applied to such appeals. The Secretary subsequently responded to another Order to Show Cause indicating that she would not challenge an order to enjoin DHHS from applying 42 C.F.R. § 405.1835(a)(1) to appeals resulting from the failure to issue a timely NPR under 42 U.S.C. § 1395oo(a)(1)(B).

Subsequently, the United States District Court for the District of Columbia issued several identical orders, dated August 6, 2014,[9] that are controlling in this matter, which state:

> ORDERED that in Defendant's responses to the Court's May 27, 2014 and June 10, 2014 Orders to Show Cause, Defendant made a binding concession that 42 C.F.R. § 405.1835(a)(1)'s requirement that a Medicare provider must establish its "dissatisfaction" by claiming reimbursement for the item in question in its Medicare cost report or by listing the item as a "protested amount" in its cost report, should not apply to [Board] appeals (like those in Charleston-A, Denver Health, and Charleston-B) that are based on the provisions of the Medicare statute, 42 U.S.C. § 1395oo(a)(1)(B), that provide for appeal to the Board where a Medicare contractor does not issue a timely notice of program reimbursement (NPR); and it is
>
> FURTHER ORDERED that the Board, the rest of [DHHS], and all current and future Medicare contractors are enjoined from applying 42 C.F.R. § 405.1835(a)(1)'s "dissatisfaction" requirement to any pending or future Board appeal that, pursuant to 42 U.S.C. § 1395oo(a)(1)(B), is based on the Medicare contractor's failure to issue a timely NPR . . . .

---

[8] 78 Fed. Reg. 49854, 50,200 (August 22, 2014).

[9] An order identical to the one issued in this case has been entered in the following cases: *Charleston Area Medical Center v. Sebelius* (Charleston –A), No 13-643 (D.D.C. filed May 3, 2013); *Charleston Area Medical Center v. Sebelius* (Charleston-B), No 13-766 (D.D.C. filed May 24, 2013); and *Denver Health Medical Center v. Sebelius, (Denver Health)*, No 14-553 (D.D.C. filed April 2, 2014).

The Administrator ordered that:

- The Board, the Administrator, DHHS and all current and future Medicare contractors are enjoined from applying "42 C.F.R. § 405.1835(a)(1)'s dissatisfaction" requirement to any pending or future Board appeal, that pursuant to 42 U.S.C. § 1395oo(a)(1)(B), is based on the Medicare contractor's failure to issue a timely NPR;

- The Providers in this case are subject to the decision as they are appealing based on the Medicare contractor's failure to issue a timely NPR. This case was pending before the Administrator to review the Board's application of 42 C.F.R. § 405.1835(a)(1)'s dissatisfaction requirement denying Board jurisdiction. The Administrator conceded that the decision is subject to the Court's injunction and further concludes that the Board's alternative basis for denial of jurisdiction under the Provider Reimbursement Manual (CMS Pub. 15-2) §§ 115.1 and 115.2 provision cannot be upheld in this case and cannot be relied upon on remand to the Board as a basis for denying jurisdiction.

- The Board and the Administrator are enjoined from applying "42 C.F.R. § 304.1835(a)(1)'s dissatisfaction" requirement as a necessary component for Board jurisdiction in this appeal that is based on the Medicare contractor's failure to issue a timely NPR under 42 U.S.C. § 1395oo(a)(1)(B).

- The decision of the Board denying jurisdiction is reversed. The Board has jurisdiction over the Provider's on the attached Schedule of Providers.

- The case is remanded to the Board for further proceedings on the Provider's appeal, including the request for expedited judicial review, consistent with 42 U.S.C. § 1395oo and the pertinent provisions of 42 C.F.R. § 405.1801 *et seq.*, as enjoined and modified by the United State District Court's August 6, 2014 order.

The Board hereby reopens case number 13-3832G in accordance with the Administrator's remand order.

II

Board Order

The Board's decision with respect to the Providers' request for EJR is attached to this Notice of Reopening and Board Order. The Providers' further actions are governed by the requirements of 42 C.F.R. § 405.1842

SO ORDERED by the
Provider Reimbursement Review Board

Michael W. Harty
Chairman

Date: SEP 10 2014

Attachment: Board Decision with Respect to EJR

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

Refer to:

13-3832GC
CERTIFIED MAIL

SEP 10 2014

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

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

Dear Mr. Nash:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's May 19, 2014 request for expedited judicial review (EJR) incident to the Centers for Medicare & Medicaid Services (CMS) Administrator's (Administrator's) August 12, 2014 order[1] remanding the case to the Board. This remand order was issued incident to the United States District Court for the District of Columbia's order, among other things, enjoining the Department of Health and Human Services, the Board and Medicare Contractors from applying 42 C.F.R. § 405.1835(a)(1)'s "dissatisfaction" requirement for Board jurisdiction to any appeal filed based on a contractor's failure to timely issue an Notice of Program Reimbursement pursuant to 42 U.S.C. § 1395oo(a)(1)(B).[2] The Board's decision with respect to its jurisdictional determination and the appropriateness of expedited judicial review (EJR) for the Providers is set forth below.

Issue

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

> Whether the specific regulations governing Outlier Case Payments as set forth in the two regulatory sources—the Outlier Payment Regulations[3] and the fixed loss threshold ("FLT") regulations[4]

[1] The Administrator's order is dated August 12, 2014. The CMS Attorney Advisor transmitted the order to the Board through correspondence dated August 14, 2014. The remand order was received in the Board's offices on August 15, 2014.
[2] The Board has issued a Notice of Reopening for this case in a separate document which will be mailed to the Group Representative concurrently with this decision with respect to the request for EJR.
[3] See Providers' May 19, 2014 EJR request, Page 2, n. 2

(collectively, the "Medicare Outlier Regulations")—as promulgated by the Secretary of Health and Human Services ("HHS") and the Centers for Medicare [&] Medicaid Services ("CMS"), and as in effect for the appealed years, are contrary to the Outlier Statute and/or are otherwise substantively or procedurally invalid?

Providers' Request for EJR

The Providers explain that hospitals are paid for services to Medicare patients under the inpatient prospective payment system (IPPS)[5] under which inpatient operating costs are reimbursed based on a prospectively determined formula. The IPPS legislation contains a number of provisions that provide for additional payment based on specific factors. These cases involve one of those factors: outlier payments. Outlier payments are made for patients whose hospitalization is either extraordinarily costly or lengthy.[6] Outlier payments are made from the "outlier pool," which is a regulatory set-aside or subset of the Medicare Part A Trust Fund, maintained by the government to pay for outlier cases. The outlier pool is, in effect, funded by a 5-6 percent reduction in IPPS payments to acute care hospitals.[7] Prior to the start of each fiscal year, the Secretary establishes a FLT beyond which hospitals will qualify for outlier payments at levels that are between 5-6 percent of DRG[8] payments.[9]

The Providers note that beginning in 1997 through 2003, a number of hospitals were reported to have inflated their charge masters an action which the Department of Justice (DOJ) termed "turbo-charging." This practice greatly inflated cost to charge ratios which greatly increased the cost per case. DOJ termed this action a false claim and this also resulted in the Secretary greatly increasing the FLT so that payments for outliers would remain at 5-6 percent of DRG payments. More specifically, beginning in or around Federal fiscal year (FFY) 1998, the Secretary began making upward adjustments to the FLTs which were in excess of the rate of inflationary indices routinely used such as the CPI-Medical Index or the Medicare Market Basket.[10]

In 2002, the Secretary disclosed that he was aware of "turbo-charging" and that would be amending the outlier regulations to fix "vulnerabilities" in the regulations. In the March 5[11] and June 9, 2003[12] Federal Registers, the Secretary acknowledged three flaws in the outlier payment

---

[4] *Id.* at n. 3.
[5] *See* U.S.C. 42 U.S.C. § 1395ww(d)(5).
[6] Providers' May 19, 2014 EJR request at 3.
[7] *Id.* at 4 n. 9, 42 U.S.C. § 1395ww(d)(3)(B) (Reducing for the Value of Outlier Payments).
[8] Diagnostic Related Group.
[9] Providers' May 19, 2014 EJR request at 4.
[10] *Id.* at 5.
[11] 68 Fed. Reg. 10,420, 10,423 (March 5, 2003) (Recent analysis indicates that some hospitals have taken advantage of two vulnerabilities in our methodology to maximize their outlier payments . . . [1] the time lag between the current charges on a submitted bill and the cost–to-charge ratio taken from the most recently settled cost report and [2] in some cases hospitals may increase their charges far above cost that their cost-to-charge ratios fall below 3 standard deviations from the geometric mean of cost-to-charge ratios and a higher statewide average cost-to-charge ratio is applied.)
[12] 68 Fed. Reg. 34,494,34,501 (June 9, 2003) ([3] even though final payment would reflect a hospital's true cost experience, there would still be the opportunity for a hospital to manipulate its outlier payments by

regulations and stated that the vulnerabilities would be fixed. The Providers maintain that the data used to correct the vulnerabilities had always been available and should have been used to calculate outlier reimbursement. The Providers noted that the Secretary stated that he believed that there was the authority to revise the outlier threshold given the manipulation of the outlier policy. However, he elected not to exercise this authority because of the short amount of time remaining in the FFY. The Providers allege that the Secretary was aware of the problem months before the final rule was published as demonstrated by Provider Exhibit 9, a copy of an Interim Final Rule submitted to the Office of Management and Budget on February 13, 2003.[13] As noted by the Providers[14] the D.C. District Court in *Banner Health v. Sebelius*, 2013 U.S. Dist. Lexis 69889 (D.D.C. May 16, 2013) noted that the February 13, 2013 proposed rule was virtually identical to the final proposed rule with the exception that the later proposed rule published on March 5, 2013 did not recommend reduction of the FLT and the supporting analysis.

The Providers state that they did not learn of the February 13, 2003 unpublished, interim final rule until their counsel obtained it through a Freedom of Information Act request made to the Office of Management and Budget in 2012. They believe the document is still relevant because the Secretary has not accounted for the impact of the "turbo charging" data, and is, allegedly, still relying on inflated data to calculate outlier reimbursement. As a result, the Providers do not receive the full amount of outlier reimbursement to which they are entitled. Further, in the June 12, 2012 Office of Inspector General report, the Inspector General noted that seven years after the 2003 publication of the regulation requiring reconciliation of outlier payments, CMS had not reconciled any of the cost reports screened and reported by Medicare Administrative Contractors (MACs).[15] In a later, 2013 report,[16] OIG noted that although nearly all hospitals receive outlier payments, a small percentage of hospitals receive a significantly higher proportion of payments. The hospitals receiving this higher portion of payments charged Medicare more for the same Medical Severity-Diagnostic Related Groups (MS-DRGs), yet had similar lengths of stay and cost-to-charge ratios. The Providers contend that this is another example of CMS' failure to correct the distribution of outlier payments.[17]

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

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

---

dramatically increasing charges during the year in the discharge occurs. Here, the hospital would receive excessive outlier payments, which, although the hospital would incur an overpayment and have to refund the money when the cost report is settled, this would allow the hospital to obtain excess payments from the Medicare Trust fund on a short-term basis.)

[13] The Providers furnished no evidence that this document was ever published in the Federal Register.

[14] Providers' May 19, 2014 EJR request at 7, n. 15.

[15] *Id.* Ex. 10, OIG Report: The Centers for Medicare & Medicaid Services Did Not Reconcile Medicare Outlier Payments in Accordance with Federal Regulations and Guidance, Report A-07-10-02764 at 7-9 (June 2012).

[16] *Id.* Ex. 11 Medicare Hospital Outlier Payments Warrant Increased Scrutiny, Report OEI-06-10-00520 (November 2013). (incomplete document)

[17] *Id. at 13.*

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

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

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

c) offers explanations for its decisions that run counter to the evidence.[18]

Decision of the Board

The Board has reviewed the submissions of the Providers pertaining to the requests for hearing and expedited judicial review. 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permit expedited judicial review where the Board determines that it does not have the authority to decide a question of law, regulation or CMS ruling. In these cases, the Providers are challenging the validity of the outlier regulations, 42 C.F.R. §§ 412.80 through 412.86.[19] The MAC did not oppose the request for EJR. The documentation shows that the estimated amount in controversy exceeds $50,000 threshold for Board jurisdiction over a group appeal and the appeal was timely filed.

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 outlier regulations, 42 C.F.R. §§ 412.80-412.86, there are no findings of fact for resolution by the Board;

3) it is bound by the regulations; and

4) it is without the authority to decide the legal question of whether the outlier regulations, are valid.

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

---

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

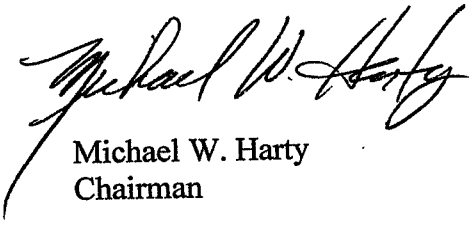
[19] *Id.* at 2 n. 2 (The Outlier Payment Regulations are the base regulations that establish the method for calculating a hospital's imputed costs for a patient case, which are set forth at 42 C.F.R. §§ 412.80 through 412.86. The Payment Regulations were first enacted in 1985 and have been revised periodically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

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

Board Members Participating

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

FOR THE BOARD:



Michael W. Harty
Chairman

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

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

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

Refer to: 14-2092
Certified Mail

SEP 15 2014

Stuart S. Kurlander, Esq.
Latham & Watkins, LLP
555 Eleventh Street, N.W.
Suite 1000
Washington, D.C. 20004-1304

RE: New York-Presbyterian Hospital
Provider No. 33-0101
FFY 2014
PRRB Case No. 14-2092

Dear Mr. Kurlander:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's August 25, 2014 request for expedited judicial review (EJR) (received August 26, 2014. The Board's decision with respect to the request for EJR is set forth below.

Issue

The sole issue under appeal in this case is whether the Secretary's[1] Federal fiscal year (FFY) 2014 merger rule, which disregards an acquired hospital's uncompensated care for purposes of calculating disproportionate share (DSH) payments to the merged, combined entity, is procedurally and or substantively valid. The new policy was finalized in the August 18, 2013 Federal Register[2] and first applied to the Provider on September 30, 2013 when the Medicare DSH Supplemental Data Files were updated in accordance with the notice in the October 3, 2013 Federal Register[3] which included a Correction to the FY 2014 Inpatient Prospective Payment System (IPPS) Final Rule.

Background

Section 3133 of the Patient Protection and Affordable Care Act (PPACA), as amended by section 10316 of PPACA and section 1104 of the Health Care and Education Reconciliation Act (P.L. 111-152) added new section 42 U.S.C. § 1395ww(r) to the statute that modifies the methodology for computing the Medicare DSH payment adjustment beginning in FFY 2014. This legislation is commonly known as section 3133 of ACA.[4]

---

[1] of the Department of Health and Human Services.
[2] 78 Fed. Reg. 50496, 50642 (August 19, 2013).
[3] 78 Fed. Reg. 61192 (October 3, 2013).
[4] 78 Fed. Reg. at 50620.

Until FFY 2014, the Medicare disproportionate share (DSH) adjustment payments were calculated under a statutory formula that considers the hospital's Medicare utilization attributable to beneficiaries who receive Supplemental Security Income (SSI) benefits and the hospital's Medicaid utilization. Beginning for discharges in FY 2014, hospitals that qualify for Medicare DSH payments under 42 U.S.C. § 1395ww(d)(5)(F) will received 25 percent of the amount they previously would have received under the DSH formula. The remaining amount, equal to 75 percent of what otherwise would have been paid as Medicare DSH payments, reduced to reflect changes in the percentage of individuals under age 65 who are uninsured, will be available to make additional payments to each hospital that qualifies for Medicare DSH payments and that has uncompensated care. The payments to each hospital for a fiscal year will be based on the hospital's amount of uncompensated care for a given time period relative to the total amount of uncompensated care for that same time period reported by all hospitals that received Medicare DSH payments for that fiscal year.[5]

This will result in two payments to the hospital. Under 42 U.S.C. § 1395ww(r)(1), beginning in FFY 2014 a hospital that would receive a DSH payment under § 1395ww(d) will receive 25 percent of the amount the hospital would have received under § 1395ww(d)(5)(F) which the Secretary now calls "the empirically justified amount, as determined by the Medicare Payment Advisory Commission in its March 2007 Report to Congress." Section 1395ww(r)(2) provides that for fiscal year end 2014 and subsequent, the Secretary shall pay to each § 1395ww(d) hospital an additional amount equal to the product of three factors, collectively known as uncompensated care. The first factor is the difference between the estimates of "the aggregate amount of payments that would be made to subsection (d) [DSH] hospitals under subsection (d)(5)(F) if this subsection did not apply" and that aggregate amount of payment that are made to subsection (d) hospitals under paragraph [1395ww(r)] (1)." This factor amounts to the 75 percent of the payments that would otherwise have been paid as part of the DSH adjustment.[6]

For FYs 2014-2017, the second factor is for FYs 2014-2017, 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured, determined by comparing the percent of such individuals who are uninsured in FY 2013, the last year before coverage expanded under ACA, minus 0.1 percentage point for FY 2014, and minus 0.2 percent for FYs 2015-2017. For FY 2018 and subsequent years, the second factor is 1 minus the percent change in the percent of individuals who are uninsured, as determined by comparing the percentage of individuals who are uninsured, in 2013 and "who are uninsured in the most recent period for which data is available minus 0.2 percentage points for FFY 2018 and 2019."[7]

The third factor is a percent that for each subsection [1395ww](d) hospital, "represents the quotient of . . . the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on appropriate data . . .)," including the use of alternative data "where the Secretary determines that alternative data is available which is a better proxy for the costs of subsection (d) hospitals for . . . treating the uninsured," and "the aggregate amount of . . . uncompensated care for all subsection (d) hospitals that receive a payment under this subsection."[8]

---

[5] *Id.* at 50621, *See also Id.* at 50627 (Factor 1 is the difference represents the Secretary's estimate of the amount of Medicare DSH payments that would otherwise be made in the absence of the new payment provision; and (2) the amount of empirically justified Medicare DSH payment that are made for FY 2014 and subsequent years, which takes into account the requirement to pay 25 percent of what would have otherwise been paid under [42 U.S.C. § 1395ww(d)(5)(F)].

[6] *Id.*at 50621

[7] *Id.*

[8] *Id.*

The Secretary explains that this third factor represents a hospital's uncompensated care amount for a given time period relative to the uncompensated care amount for that same time period for all hospitals that received Medicare DSH payments in that year, expressed as a percent. For each hospital the product of these three factors represents its additional payment for uncompensated care for the applicable fiscal year.[9]

In addition, the statute, 42 U.S.C. § 1395ww(r)(3), precludes administrative and judicial review under 42 U.S.C. §§ 1395ff (beneficiary appeals) and1395oo Board appeals of:

> (A) Any estimate of the Secretary for purposes of determination factors described in paragraph (2)[10]
> (B) Any period selected by the Secretary for such purposes.

Factor 3 In-depth[11]

Factor 3 is defined in 42 U.S.C. § 1395ww(r)(2)(C) in the calculation of uncompensated care payment. It is a hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) (DSH) hospital with the potential to receive DSH payments relative to the estimated uncompensated care amount for all hospitals estimated to receive DSH payments in the fiscal year for which the uncompensated care payment is to be made. Factor 3 is applied to the product of Factor 1 and Factor 2 to determine the amount of the uncompensated care payment that each eligible hospital will receive for a FFY.[12]

In order to implement the statutory requirements, the Secretary determined:

> (1) the definition of uncompensated care or in other words the specific items that are to be included in the numerator,(that is, the estimated uncompensated care amount for an individual hospital) and denominator, that is the estimated uncompensated care amount for all hospitals estimated to received DSH payments in the applicable FY);
>
> (2) the data sources(s) for the uncompensated care amount; and
>
> (3) the timing and manner of computing the quotient for each hospital estimated to receive DSH payments.[13]

---

[9] *Id.*
[10] Paragraph (2) is a reference to the three factors: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FFY 2014 calculation; and (3) the hospital specific value that express the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. at 50627, 50631 and 50634, respectively.
[11] In the October 3, 2013 Federal Register (78 Fed. Reg. 61191), the Secretary determined that for hospitals with a FYE that spanned two FFYs, the DSH/uncompensated care payments would be prorated between the two FFYs based on a proportion of the applicable FFY that is included in the cost reporting period. In addition, data from the Indian Health Services hospitals would be added to the data issued to compute the "empirical justified amount" and the uncompensated care payment. The Secretary implemented this effective October 1, 2013 and waived the 30-day delay in the effective date under 5 U.S.C. § 553(b)(3)(B).
[12] 78 Fed Reg. at 50634.
[13] *Id.*

The Secretary considered using information from Worksheet S-10 in calculating Factor 3 for FFY 2014, but concluded that providers had not had enough experience with this worksheet to develop reliable calculations. Instead, for FFY 2014, she elected to use the definitions of Medicaid patients found in 42 C.F.R. § 412.106(b)(4) and inpatient days for Medicare-SSI patients found in 42 C.F.R. § 412.106(b)(2)(i). A hospital's individual insured low-income insured days based on this calculation would represent that hospital's numerator for Factor 3. The sum of the low-income insured days under this calculation for all the hospitals that the Secretary estimates would receive DSH payments (and thus uncompensated care payment) would represent the denominator of Factor 3. The Secretary believes that the data in the Medicare cost report (and the data that are used to update the SSI ratios in the cost report) are acceptable for use a source for the alternative data because they include data for all Medicare hospitals. The Secretary considers the data from the Medicare cost reports have been historically publically available, subject to audit and used for payment purposes, are appropriate as alternative data for the costs of subsection (d) (DSH) hospitals for treating the uninsured.[14]

Except for data on Worksheet S-10, which is not used in FFY 2014, the Medicare cost report does not currently include information that would allow calculation of the treatment costs for uninsured patients. Consequently, the Secretary will use information from S-3, Part I of CMS 2552-96 version of the Medicare cost report and Worksheet S-2, Part I of the CMS 2552-10 version of the Medicare cost report and data that are used to update the SSI ratios on Worksheet E, Part A as the source of alternative data to determine Factor 3 for FY 2014.[15]

The statute also allows the Secretary the discretion to determine the time periods from which she will derive the data to estimate the numerator and denominator of Factor 3. The time periods for which to estimate the numerator and denominator of Factor 3 need to be consistent with making interim and final payments. Specifically, Factor 3 values must be available for hospitals that will qualify for Medicare DSH payments, as well as, those hospitals that are not estimated to qualify for DSH payments but ultimately do qualify for DSH payments. The estimates for the numerator and the denominator of Factor 3 were to be determined based on the most recently available full year of Medicare cost report data (including the most recent data used to update the SSI ratios). Therefore, for FFY 2014, data from the 2010/2011 cost reports for Medicaid days and the FY 2011 SSI ratios for the Medicare-SSI days (or if FY 2011 SSI ratios are unavailable, then 2010 SSI ratios) will be used to estimate Factor 3.[16]

The denominator for Factor 3 would reflect the estimated Medicare and Medicaid SSI days based on the data from the 2010/2011 Medicare cost report for all hospitals that are estimated to qualify for empirically justified Medicare DSH payments in 2014. The numerator of Factor 3 would be the estimated Medicaid and Medicare SSI patient days for the individual hospital based on its most recent 2010/2011 Medicare cost report data. This calculation will be done for any subsection (d) hospital that has the potential to receive a DSH payment. Hospitals have 60 days from the date of the display of the IPPS rules to notify CMS of a change in their subsection (d) (DSH) status. Hospitals that become eligible for a DSH payment when their cost reports are settled will receive an uncompensated care payment. Likewise, hospitals that receive DSH and uncompensated care payments for which they are ineligible would be subject to a recovery of an overpayment.[17]

---

[14] *Id. at* 50635-50637 (SSI ratios based on the FFY will be used in this calculation, not SSI ratios calculated on a provider's fiscal year).
[15] *Id.*at 50637.
[16] *Id.* at 50637-50638.
[17] *Id.* at 50640.

Additional Medicaid Days

The Secretary stated that she would identify subsection (d) (DSH hospitals) eligible to receive interim compensation for uncompensated care based on the most recently available Medicaid fraction that is reported on the March 2013 update of the Provider Specific file.[18] In the comments to the proposed rule, hospitals questioned the accuracy of the data used in the calculation of the hospital's Factor 3 or indicated that the Medicaid days reported on Worksheet S-2 did not match Medicaid days reported on S-3. In addition, hospitals submitted supporting documentation of the additional Medicaid days and requested that their Medicaid days used in the calculation of Factor 3 be corrected in the final rule. The Secretary acknowledged that there are inconsistencies in reporting of days on Worksheet S-2 and Worksheet S-3 and that not all Medicaid days were reported on Worksheet S-2, if they were not eligible to received DSH payments based on that cost report. She stated that a transmittal had been released allowing these hospitals to report their Medicaid days on Worksheet S-2 and to ensure Medicaid days reported on Worksheet S-3 align with the Medicaid days reported on Worksheet S-2. The Secretary noted that those changes might not have been reflected on the March 2013 update of the Hospital Cost Report Information System (HCRIS).[19]

As a result, for hospitals that did not claim Medicare DSH payments on their CMS Form 2552-10 Medicare cost report for FY 2010 or 2011, Medicaid days would be calculated from Worksheet S-3 of the Medicare cost report from the most recently available cost report from 2011 or 2010. For DSH hospitals, Medicaid days from Worksheet S-2 of the Medicare cost report from the most recently available cost report from 2011 or 2010 would be used. The Secretary stated that she believed that this action would address most of the commentators concerns. She also reminded hospitals that they attested to the accuracy of the data that they submit on their cost reports.[20]

The October 3, 2013 Update to IPPS[21]

In the October 3, 2013 Federal Register, the Secretary revised certain policies and procedures announced in the FY 2014 IPPS final rule. Among other things, she revised certain operational considerations for hospitals with cost reporting periods spanning more than one FFY and made changes to data that would be used in the uncompensated care payment to include data from the Indian Health Service and, as a result, Factor 1 was revised and recalculated.[22]

With respect to operational considerations, under 42 U.S.C. § 1395ww(r) requires that for "fiscal year 2014 and each subsequent year," "subsection (d) [DSH] hospitals that would otherwise receive a [DSH] payment made under subsection [1395ww] (d)(5)(F)" will receive two separate payments: (1) 25 percent of the amount they previously would have received under subsection (d)(5)(F) for DSH ("the empirically justified amount"); and (2) an additional payment for the DSH hospital's proportion of uncompensated care, determined as a product of three factors. The three factors are: (1) 75 percent of the payments that would otherwise would have been made under subsection (d)(5)(F); (2) 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured (minus 0.1 percentage points for FY 2014, and minus 0.2 percentage points for FY 2015

[18] *Id.* at 50641.
[19] *Id.* at 50642.
[20] *Id.*
[21] 78 Fed. Reg. 61191 (October 3, 2013).
[22] *Id.*

through 2017); and (3) a hospital's uncompensated care amount relative to the uncompensated care amount of all DSH hospitals expressed as a percentage.[23]

The August 19, 2013 final rule stated that providers' uncompensated care would be paid on the basis of the Federal fiscal year because that was how it was to be determined. The amount would be reconciled in the cost reporting period that begins in the Federal fiscal year. However, the Secretary concluded that this policy was inconsistent with the longstanding cost reporting requirements. Generally, payments for discharges are reported in the cost reporting period in which they occur, and all payments made for discharges during a cost reporting period are reconciled on the cost report for that period. However, for hospitals with cost reporting periods that are not concurrent with the Federal fiscal year, the policy adopted departs from these requirements by reconciling interim uncompensated care payments made for the Federal fiscal 2013 cost reporting period on the hospital 2014 cost report.

Ordinarily, under the cost reporting requirements, the payments made during the hospitals 2013 cost reporting period would have been recouped as overpayments. However, under the 2013 IPPS final rule, if the hospital was found to be eligible for DSH payments for its cost reporting period beginning in Federal FY 2014, the hospital would be paid its FY 2014 uncompensated care payment during the settlement of the cost report—repaying the previously recouped uncompensated care payments. This could lead to cash flow difficulties for some hospitals. As a result the Secretary elected to align the final payments for uncompensated care with the hospital's cost reporting periods and to reconcile interim uncompensated care payment amounts on the hospital's cost report for the proportion of the cost reporting period that overlaps with the Federal fiscal year and for which interim payments were or should have been made.[24]

In addition, the Secretary also made corrections to the Medicare DSH files to correct treatment of Indian Health Service (IHS) hospitals eligible to receive empirically justified Medicare DSH payments. Although IHS hospitals can receive Medicare DSH payments, they submit cost reports that are not uploaded to the Hospital Cost Report Information System (HCRIS) database. Therefore, their Medicare data were not included in the estimates used by the Office of the Actuary to calculate Factor 1 or Factor 3. Accordingly, the Secretary revised the policy adopted in the final rule to permit the Agency to consider supplemental cost report data for the IHS hospitals for a revised estimate of Factor 1 and updated calculations of Factor 3 for all hospitals eligible to receive the uncompensated care payment.[25]

Hospital Mergers

In the final IPPS rule for 2014, the Secretary responded to a comment which noted that two hospitals merged in 2011 with one surviving provider number. The hospitals had two cost report and two SSI ratios in 2011. However, in the proposed IPPS rule, Factor 3 had been calculated using only the surviving hospital's cost report data and SSI ratio data. The hospital requested that the merger be accounted for and include both hospital's data in the calculation of the Factor 3 amount.[26]

The Secretary responded by noting that a hospital's Factor 3 is calculated based on the data tied to its CMS certification number (CCN).[27] This is consistent with the treatment of other IPPS payment

---

[23] *Id.*at 61192
[24] *Id.* at 61193.
[25] *Id.* at 61194-61195.
[26] 78 Fed. Reg. at 50642 (August 19, 2013).
[27] *See* 42 C.F.R. § 412.140(a)(3) (2013).

factors, where data used to calculate a hospital's Medicare DSH adjustment, cost to charge ratios for outlier payments and wage index is tied to the CCN. Further, data reported on the cost report associated with the old provider agreement (that of the merged hospital) would not necessarily be used to determine hospitals payments for the CCN associated with the surviving provider agreement. Accordingly, the Secretary concluded, in the case of a merger between two hospitals, Factor 3 would be calculated based on the low-income insured patient days (i.e., Medicaid and SSI days) under the surviving CCN based on the most recent available data from the cost report for 2011 or 2010.[28, 29]

The Provider's Request for EJR

The Provider explains that hospitals qualify for a DSH payment adjustment under a statutory formula that considers their Medicare utilization for beneficiaries who receive SSI benefits and their Medicaid utilization.[30] Section 3133 of ACA added section 42 U.S.C. § 1395ww(r) that modifies the methodology for computing the Medicare DSH adjustment payment beginning in 2014. Under § 1395ww(r), starting with FFY 2014, hospitals that are eligible for Medicare DSH payments would receive 25 percent of the amount they previously receive would have received under the statutory formula for DSH. The remaining amount, equal to approximately 75 percent of what otherwise would have been paid as Medicare DSH payments, reduced for changes in the percentage of individuals under age 65 who are uninsured, will be become available to make additional payments to each hospital that qualifies for Medicare DSH payments and has uncompensated care. Each Medicare DSH hospital will receive an additional amount based on its estimated share of the total amount of uncompensated care report for all Medicare DSH hospitals for a given period of time.

The May 10, 2013 proposed IPPS regulations for 2014 contained no mention of the treatment of merged hospitals in the scenario above. In July of 2013 New York Downtown Hospital (provider number 33-0064) merged with NYPH (provider number 33-0101). Both hospitals received Medicare DSH payments prior to merging and continued to provide significant uncompensated care.

In the final IPPS rule, the Secretary announced that CMS would use a proxy derived from the hospital's 2010/2011 cost report data in its formula to determine each hospital share of uncompensated care payments for 2014. In the preamble to the final rule, the Secretary announced for the first time that, when two hospitals merged, the calculations of uncompensated care will disregard completely the merged hospital's uncompensated care data.

The Provider believes that this response to a comment suggests a shift in treatment of merged hospitals—in the past hospitals received DSH payments that combined their respective DSH payment before the merger. The DSH supplemental data files from the August 19, 2013 final IPPS Rules listed the merged New York Downtown Hospital and surviving NYPH with separate hospital specific-factors for uncompensated care in 2014.

It was not until the September 30, 2013, when CMS updated and revised its Medicare DSH Supplemental Data files in accordance with the later published October 3, 2013 correction to the FY 2014 IPPS final rule that NYPH learned for the first time that all data relating to uncompensated care at New York Downtown Hospital would be excluded from the DSH payment calculations all

---

[28] 78 Fed Reg. at 50642.
[29] The Secretary changed this position in the final rule for FFY 2015 ("We believe that revising our methodology to incorporate data from both of the hospitals that merged could improve our estimate of the uncompensated care burden of the merged hospital.") 79 Fed. Reg. 49854, 50020 (August 22, 2014).
[30] 78 Fed. Reg. at 61192 (October 3, 2013).

together. The only notice the hospital had of this action was the statement in the Federal Register. The Provider does not believe that there would be any way to calculate the amounts properly without including data from both hospitals.

The Provider is challenging the validity of the merger policy shift on the grounds that it was improperly promulgated without proper notice and comment and is arbitrary and capricious and contrary to law. The Provider contends that the proposed rule did not provide hospitals with any notice that the Secretary was considering adopting a novel policy for merged hospitals. Consequently, there was no ability for interested parties to have a meaningful opportunity to comment. As a result, the merger policy was improperly promulgated.

The Provider also contends that the merger policy is arbitrary and capricious, and abuse of discretion, or otherwise not in accordance with the law under the 5 U.S.C. § 706(2) (a) (the APA). The merger policy is not reasonably and reasonably explained as required because: (1) there was no explanation for the decision; and (2) the decision to wholly disregard uncompensated care data from merged hospitals is contrary to the statutory directive in 42 U.S.C. § 1395ww(r)(2)(C)(i) to calculate the amount of uncompensated are "based on appropriate data"(including, in the case where the Secretary determines that alternative data is available which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured, the use of such data.[31]

The Provider believes EJR is appropriate because the Board lacks the authority to decide the procedural and/or substantive validity of the merger rule announced in the Federal Register. The Board cannot fashion or dictate CMS policy nor can it direct CMS to include a merged hospital's uncompensated care for purposes of calculating DSH payments.

Decision of the Board

The Board concludes that it lacks jurisdiction over the merger issue under the provisions of 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 42 C.F.R. § 412.106(f)(2) and hereby dismisses the appeal. Since jurisdiction over an appeal is a prerequisite to granting a request for EJR[32] the Provider's request for EJR is hereby denied.

The statute, 42 U.S.C. § 1395ww(r)(3), precludes administrative and judicial review under 42 U.S.C. §§ 1395ff (beneficiary appeals) or 1395oo (Board appeals of):

> (A) Any estimate of the Secretary for purposes of determination factors described in paragraph (2);
>
> (B) Any period selected by the Secretary for such purposes.

Paragraph (2) is a reference to 42 U.S.C. § 1395ww(r)(2) and describes the three factors as: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FFY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH

[31] This statutory provision was also used to explain and justify way Worksheet S-10 was not being used to derive data to calculate Factor 3.
[32] *See* 42 C.F.R. § 405.1842(a).

payments to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C) (Factor 3).[33]

The regulation, 42 C.F.R. § 412.106(f)(2), precludes administrative or judicial review of (1) any estimate of the Secretary for the purpose of determining the factors in paragraph (g)(1). Paragraph (g)(1) involves the methods used to compute the three factors used for reimbursement for uncompensated care. It states:

> g) Additional payment for uncompensated care.
>
> (1) Payment rules. Hospitals that qualify for payments under this section for fiscal year 2014 and each subsequent year, will receive an additional amount equal to the product of the following three factors:
>
> (i) Factor 1. . . .
>
> ****
>
> (ii) Factor 2. . . .
>
> ****
>
> *(iii) Factor 3. A factor equal to the percent, for each inpatient prospective payment system hospital, that represents the quotient of:*
>
> *(A) The amount of uncompensated care for such hospital as estimated by CMS.*
>
> *(B) The aggregate amount of uncompensated care as estimated by CMS for all hospitals that are estimated to receive a payment under this section.*[34]
>
> *(C) For fiscal year 2014, CMS will base its estimates of the amount of hospital uncompensated care on the most recent available data on utilization for Medicaid and Medicare SSI patients, as determined by CMS in accordance with paragraphs (b)(2)(i) and (b)(4) of this section.*
>
> (iv) The final values for each of the three factors are determined for each fiscal year at the time of development of the annual final rule for the hospital inpatient prospective payment system, and these values are used for both interim and final payment determinations.

---

[33] 78 Fed. Reg. at 50627, 50631 and 50634, respectively.
[34] (Emphasis added).

The Board finds that the merger question involves the policy with respect to how the estimates for the amount of uncompensated care (Factor 3) are calculated. This issue involves "estimates for purposes of determining factors described in paragraph 2,"[35] for which the statute precludes administrative and judicial review. In addition, the regulation, 42 C.F.R. § 412.106(f)(2), precludes review of any estimate of the Secretary for the purpose of determining the factors in paragraph (g)(1). 42 C.F.R. § 106(g)(1)(iii) includes, once again, the calculation of uncompensated care. Since Board review of the issue under dispute is barred, the Board does not have jurisdiction over this appeal. The Board also cannot grant the Provider's request for EJR since jurisdiction is a prerequisite granting such a request. The Board's decision above hereby closes the case.

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.
Charlotte F. Benson

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: Kyle Browning, NGS
Kevin Shanklin, BCBSA

[35] 42 U.S.C. §1395ww(r)(2)

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: 14-1549 and 14-3449

SEP 17 2014

CERTIFIED MAIL
Robert Plaskey
Corporate Director, Reimbursement
Oakwood Healthcare, Inc.
Corporate Services Building
15500 Lundy Parkway
Reimbursement Department
Dearborn, MI 48126

Byron Lamprecht
Wisconsin Physicians Service Ins. Corp.
Cost Report Appeals
P.O. Box 1787
Madison, WI 53701

Re: Oakwood Annapolis Hospital
Provider No. 23-0142
FYE 06/30/2008
PRRB Case Nos. 14-1549 and 14-3449

Dear Mr. Plaskey and Mr. Lamprecht:

The Provider Reimbursement Review Board ("Board") has reviewed Oakwood Annapolis Hospital's ("Provider") request to consolidate case number 14-1549 with case number 14-3449. The decision of the Board is set forth below.

Procedural History

The Provider filed two appeal requests with the Board in response to Wisconsin Physicians Service Insurance Corporation's ("MAC") calculation of direct graduate medical education ("DGME") and indirect medical education ("IME") FTE Cap for fiscal year ending ("FYE") 06/30/2008.

The first appeal request was timely filed on December 18, 2013 (dated December 17, 2013), for FYE 06/30/2008 in response to the Notice of DGME and IME FTE Cap Notification Letter from the MAC dated October 15, 2013. This appeal request was assigned Board case number 14-1549.

The second appeal request was timely filed on May 8, 2014 (dated May 7, 2014), in response to the FYE 12/31/2008 notice of program reimbursement ("NPR") dated December 13, 2013. The Provider appealed the same issue as identified in its appeal request dated December 17, 2013. This appeal request was assigned Board case number 14-3449.

The MAC submitted a Jurisdictional Challenge to the Board on April 21, 2014 (dated April 15, 2014).

The Provider submitted its Response to the Jurisdictional Challenge on May 9, 2014 (dated May 8, 2014).

MAC's Position

The MAC contends that the Board does not have jurisdiction over the DGME and IME cap issue in Board case number 14-1549. The MAC explains that the Provider's appeal must be based on a specific cost report settlement and it is not sufficient for the Provider's appeal to be based on the IME & GME FTE Cap notification letter.

Provider's Position

The Provider contends that the MAC's jurisdictional challenge is moot because the MAC issued a NPR dated December 13, 2013 for FYE 12/31/08 and the Provider filed an appeal within 180 days of the NPR.

In the alternative, the Provider explains that the Board has jurisdiction to grant the Provider's request for a hearing because 1) the Provider filed a timely appeal with the Board, 2) the amount in controversy is over $10,000 and 3) the Provider is dissatisfied with the MAC's final determination of the FTE Cap Determination. The Provider also suggests that the Board combine case number 14-1549 with case number 14-3449.

Decision

In order for the Board to have jurisdiction, a Provider's appeal request must be based on a final determination.[1] This Provider's appeal request in case number 14-1549 is based on the Notice of DGME and IME FTE Caps from the MAC dated October 15, 2013. A Notice of DGME and IME FTE Caps is not a final determination from which a Provider is afforded appeal rights. Accordingly, the Provider cannot demonstrate its dissatisfaction[2] with a final determination. The Board therefore, dismisses the providers appeal in case number 14-1549 as it lacks jurisdiction over the final determination under appeal. The Provider's request to consolidate Board case number 14-1549 into case number 14-3449 is denied. Board case number 14-3449 remains open for the issues identified in its request filed on May 8, 2014.

Case number 14-1549 will be closed as there are no remaining issues. 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

cc: Kevin Shanklin, BCBSA

1 42 C.F.R. § 405.1835(a)
2 42 C.F.R. § 405.1835(a)(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

CERTIFIED MAIL SEP 17 2014

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

RE: **Nyack Hospital**
Provider No.: 33-0104
FYE: 12/31/2004
PRRB Case No.: 07-2519

Dear Mr. Blumberg:

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:

On July 26, 2007, the Provider appealed its original Notice of Program Reimbursement (NPR) dated February 16, 2007. The Provider appealed two issues: Medicare SSI Percentage and Medicare/Medicaid Dual Eligible Patient Days.

In a letter dated September 24, 2007, the Provider withdrew the Medicaid SSI Percentage.

On March 15, 2008, Ms. Kristin DeGroat of CampbellWilson submitted a request to add the DSH/SSI Percentage to this appeal and transfer the issue to Group Case No. 03-1254G.[1] The DSH/SSI issue was transferred to Group Case No. 03-1254G.

On August 6, 2008, the Provider submitted a request to add the Medicare SSI Percentage and the SSI Realignment issues to this appeal.

On October 20, 2008, the Provider requested to add the Rural Floor Budget Neutrality issue and on October 25, 2011, the Provider withdrew this issue.

In a letter dated September 11, 2014, the Board remanded the Dual Eligible Days issue under CMS Ruling CMS-1498-R.

---

[1] Nyack Hospital, Provider Number 33-0104 for FYE 12/31/2004, was included on the final Schedule of Providers for PRRB Case No. 03-1254G; therefore, Nyack Hospital was remanded to the FI as a member of that group appeal. The Fiscal Intermediary did not challenge jurisdiction over the Provider and the Board reviewed the Provider for proper jurisdictional standing with the documentation included in the group appeal. Group Case No. 03-1254G was remanded and closed on August 28, 2013.

Board Determination:

A provider has a right to a hearing before the Board, with respect to costs claimed on a timely filed cost report, if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the Notice of Program Reimbursement (NPR).[2]

DSH/SSI Percentage

The Provider appealed the Medicare DSH/SSI Percentage in its original appeal request; however, it withdrew this issue on September 24, 2007. While CampbellWilson requested to add the DSH/SSI issue to this appeal and transfer it to Group Case No. 03-1254G, that request was not jurisdictionally reviewed and CampbellWilson's add/transfer request was completed. The Provider was included in the Schedule of Providers for Group Case No. 03-1254G for FYE 13/31/2004; therefore, the DSH/SSI issue cannot again be added to this appeal, Case No. 07-2519. The Board denies jurisdiction over the DSH/SSI Percentage issue and dismisses it from this appeal.

DSH/SSI REALIGNMENT

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

> The Provider contends that its Disproportionate Share (DSH) Percentage has not been calculated in accordance with Medicare regulations and Manual provisions as described in 42 CFR Section 412.106. Specifically, the Provider contends that the Federal Fiscal Year SSI percentage used by the Fiscal Intermediary to settle the cost report is understated. *A recalculation of the SSI percentage from the Federal Fiscal Year to the Provider's fiscal year would generate a more accurate SSI Percentage which when employed in the DSH formula would increase the Provider's DSH payments....* (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 DSH/SSI Realignment (Provider Specific) issue. Since there are issues remaining in this appeal, the appeal will remain open and be scheduled for a hearing.

---

[2] 42 U.S.C. §1395oo(a) and 42 C.F.R. §§405.1835-1841.

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

For the Board:

Michael W. Harty
Chairman

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

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

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

Refer to: 09-1706

SEP 23 2014

CERTIFIED MAIL

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

Noridian Healthcare Solutions, LLC
James R. Ward
Appeals Resolution Manager
JF Provider Audit Appeals
P.O. Box 6722
Fargo, ND 58108-6782

RE: Jurisdictional Decision – Community Medical Center
Provider No.: 27-0023
FYE: 06/30/2007
PRRB Case No.: 09-1706

Dear Messrs. Blumberg and Ward,

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 06/30/2007 on December 5, 2008. On May 21, 2009, the Provider submitted an appeal request to the Board where it appealed the following issues: Medicare SSI Percentage and Medicare SSI Realignment. On August 3, 2009, the Provider added the Rural Floor Budget Neutrality Adjustment (RFBNA) issue to its appeal request.

On December 17, 2009, the Board received the Provider's request to transfer the Medicare SSI Percentage and RFBNA issues into optional group appeals, case numbers 10-0222G and 10-0225G, respectively. Upon transfer, the sole issue remaining in case number 09-1706 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 Medicare SSI Realignment issue in this appeal on its own motion and finds that it lacks jurisdiction as the appeal is premature.

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.

Realignment is a remedy the Provider may pursue if it is dissatisfied with MEDPAR SSI data. The regulation found at 42 C.F.R. § 412.106(b)(3) provides, in relevant part, that:

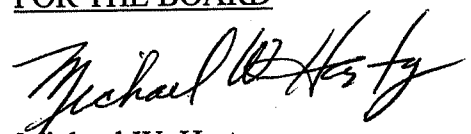
> If a hospital prefers that CMS use its cost reporting period instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request including the hospital's name, provider number, and cost reporting period end date.

In this case, there was no final determination made by the Intermediary and the Provider has not yet decided whether it will request realignment. Therefore, the SSI Realignment issue is premature and is dismissed from this case. Since the Medicare SSI Realignment issue was the sole remaining issue in the appeal, case number 09-1706 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

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

Refer to:

04-1300GC, 04-1303GC, 04-1311GC, 04-1314GC, 05-1652GC, 05-1375GC, and 06-0739GC

SEP 24 2014

CERTIFIED MAIL

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

National Government Services, Inc.
Danene L. Hartley, Appeals Lead
MP INA101-AF42
P.O. Box 6474
Indianapolis, IN 46206 - 6474

Re: Request for Expedited Judicial Review
Allina Health System 02 DSH SSI Days
Allina 2001 DSH SSI Days
Allina 00 DSH SSI Days
Allina Health 99 Medicare DSH SSI Ratio
Allina Health 98 Medicare DSH SSI Ratio
Allina Health 97 Medicare DSH SSI Ratio
Allina Health 96 Medicare DSH SSI Ratio

Dear Ms. Webster and Ms. Hartley:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' August 28, 2014 Request for Expedited Judicial Review (EJR) (received August 29, 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 these appeals of the disproportionate share adjustment (DSH) supplemental security income (SSI) issue?

MEDICARE STATUTORY AND REGULATORY BACKGROUND

The Medicare program was established to provide health insurance to the aged and disabled, 42 U.S.C. §§ 1395-1395cc. CMS, formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (HHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries and Medicare

administrative contractors. Fiscal intermediaries determine payment amounts due the providers under Medicare law and interpretive guidelines published by CMS. 42 U.S.C. § 1395h; 42 C.F.R. §§ 413.20 and 413.24.

Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. Those cost reports show the costs incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. § 413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. § 405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Board if it meets the following conditions: (1) The provider must be dissatisfied with the final determination of the intermediary; (2) the amount in controversy must exceed $10,000 for an individual appeal (or $50,000 for groups); and (3) the appeal must be filed with the Board within 180 days of the receipt of the final determination. 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835-405.1837.

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

Medicare Disproportionate Share Hospital (DSH) Payment

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

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

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

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

> (I) the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were **entitled to benefits under Part A** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were **entitled to benefits under Part A** of this subchapter.

42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) (emphasis added).

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

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

> (II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX of this chapter, but who were **not entitled to benefits under Part A** of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.

42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) (emphasis added).

According to CMS' regulation, "[t]he fiscal intermediary determines … the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period." 42 C.F.R. § 412.106(b)(4).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY

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

---

[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

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]

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

---

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.

[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).

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 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]

---

[10] Providers' EJR Request at 3-4.
[11] *Id.* at 5.
[12] *Id.* at 5-9.
[13] *Id.* at 7-8.
[14] *Id.* at 8-9, citing *Presbyterian Med. Ctr. of Philadelphia v. Aetna Life Ins. Co.*, CMS Adm'r Dec., MEDICARE & MEDICAID GUIDE (CCH) ¶ 45,032 (Nov. 29, 1996).

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.

Issues under Appeal

The Providers in these group appeals appealed the SSI "data matching process" issue in their group appeal requests.[16] The Providers identified the issue under appeal in their group appeal requests as whether the Disproportionate Share Hospital data included in the SSI ratio was accurate. The Providers contend the SSI ratio is understated.

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 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

[15] *Id.* at 9.
[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.

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.[17] 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.[18]

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 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

---

[17] 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.
[18] Providers' EJR request at 3.

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.[19]

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

[19] 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.[20] The D.C. Circuit in *CHI* found that an earlier administrative decision in *Edgewater Medical Center*[21] 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.

---

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

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 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.
Charlotte S. Benson

For the Board:

Michael W. Harty
Chairman

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

cc: Bruce Snyder, Novitas Solutions, 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

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

Refer to:

05-1865GC and 05-1868GC

SEP 24 2014

CERTIFIED MAIL

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

Novitas Solutions, Inc.
Bruce Snyder, JL Provider Audit Mngr.
Union Trust Bldg.
501 Grant Street, Suite 600
Pittsburg, PA 15219

Re: Request for Expedited Judicial Review
CHE 00 DSH SSI
CHE 01 DSH SSI

Dear Ms. Webster and Mr. Snyder:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' August 28, 2014 Request for Expedited Judicial Review (EJR) (received August 29, 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 these appeals of the disproportionate share adjustment (DSH) supplemental security income (SSI) issue?

MEDICARE STATUTORY AND REGULATORY BACKGROUND

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

Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. Those cost reports show the costs incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. § 413.20. The fiscal

intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. § 405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Board if it meets the following conditions: (1) The provider must be dissatisfied with the final determination of the intermediary; (2) the amount in controversy must exceed $10,000 for an individual appeal (or $50,000 for groups); and (3) the appeal must be filed with the Board within 180 days of the receipt of the final determination. 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835-405.1837.

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

Medicare Disproportionate Share Hospital (DSH) Payment

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

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

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

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

> (I) the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were **entitled to benefits under Part A** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were **entitled to benefits under Part A** of this subchapter.

42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) (emphasis added).

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

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

> (II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX of this chapter, but who were **not entitled to benefits under Part A** of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.

42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) (emphasis added).

According to CMS' regulation, "[t]he fiscal intermediary determines … the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period." 42 C.F.R. § 412.106(b)(4).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY

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

---

[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.

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]

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

---

[4] 545 F. Supp. 2d at 55 n. 37.
[5] Providers' EJR request at 3.
[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.

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 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

---

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

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.

Issues under Appeal

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

The Providers identified the issue under appeal in both group appeal requests as "[t]he 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."[17] The Providers contend in both group appeals "that CMS' computation of the Medicare fraction is systemically flawed, as recently found by the Board in *Baystate Medical Center v. Mutual of Omaha*, PRRB Dec. No. 2006-D20, *slip op.* (Mar. 17, 2006), and that the Medicare fraction is therefore understated."[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 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

---

[15] *Id.* at 9.
[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' Group Appeal Request for Case No. 05-1865GC at 1, and Providers' Group Appeal Request for Case No. 05-1868GC at 1.
[18] Providers' Final Position Paper for Case No. 05-1865GC at 5, and Providers' Final Position Paper for Case No. 05-1868GC at 5.

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 of the Ruling would require or permit CMS or the Medicare contractors to add Medicare Part A

---

[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.

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]

[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.

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 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

---

[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).

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 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.
Charlotte S. Benson

For the Board:

Michael W. Harty
Chairman

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

cc: Danene L. Hartley, National Government 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: 02-0779

SEP 29 2014

Certified Mail

Jason M. Healy, Esq.
The Law Offices of Jason M. Healy, LLC
1750 Tysons Blvd.
Suite 1500
McLean, VA 22102

RE: Specialty Hospital-California
Provider No. 05-2038
FYE 10/31/1998
PRRB Case No. 02-0779

Dear Mr. Healy:

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

Background

The issue under appeal in this case involves whether the Provider should receive reimbursement for costs for San Gabriel Valley Hospital (SGV, formerly known as West Covina) for the period from November 1, 1997 through August 26, 1998. During this period of time the SGV was found not to have provider-based status. The requested reimbursement was entered as a protest amount on the cost report and adjusted through audit adjustments 4 and 24. The Provider described the issue(s) under dispute in three documents: its hearing request, position paper and jurisdictional brief. Set forth below is the factual background and the various iterations of the issues presented by the Provider.

Provider-Based Status Background

Prior to the implementation of the prospective payment system (PPS) in 1983, there was little incentive for hospitals to affiliate with one another to increase Medicare revenues because they were paid on a retrospective, cost-based system. This changed after 1983 as a result of integrated delivery systems and the pressure to enhance revenue under PPS. HCFA formalized its recognition of provider-based entities with the issuance of Program Memorandum A-96-7, issued on August 1, 1996. This Program Memorandum was subsequently reissued, without substantive change, as Program Memorandums A-98-5 and A-99-24 and, in October of 1999, was added to the Provider Reimbursement Manual (PRM) (HCFA Pub. 15-1) § 2446.

The proposed provider-based status regulations were not published in the Federal Register until September 8, 1998[1] and the final rule was subsequently issued on April 7, 2000.[2] In the final rule

[1] *See* 63 Fed. Reg. 47552, 47587 (September 8, 1998).

regarding provider-based status, the Secretary said that she would continue to follow those policies set forth in the Program Memorandum A-96-7, the Provider Reimbursement Manual and the State Operations Manual § 2004 until October 10, 2000. This case involves the determination of provider-based status prior to the implementation of the new regulations in October of 2000.

For purposes of this appeal, it is important to note that prior to the implementation of the new provider-based regulations in 2000, there was no administrative appeals process for entities that had been denied provider-based status. In the April 7, 2000 final rule, the Secretary announced that:

> To provide an administrative appeals process for entities that have been denied provider-based status, we proposed to revise the regulations on provider appeals at [42 C.F.R.] § 498.3. As revised, these rules would specify that a provider seeking a determination that a facility or an organization is a department of the provider or a provider-based entity under proposed § 413.65 would be included in the definition of "prospective provider" for purposes of part 498, and would be afforded the same appeal rights as a prospective provider, such as a hospital or SNF, that we have found not to qualify for participation as a provider.[3]

Factual Background

Specialty Hospital of Southern California is a long-term acute care hospital (LTACH), with its primary campus located in La Mirada, California. It operated two other facilities located in Santa Ana and West Covina, California. The La Mirada facility was certified as a LTACH in 1996. Also, in 1996, HCFA approved the retroactive consolidation of the Provider's sites located in La Mirada and Santa Ana as a single Medicare provider.

La Mirada acquired Covina Valley Community Hospital, located in West Covina, California on June 13, 1997. Covina Valley is located 14 miles from the La Mirada facility. Covina Valley was acquired in order to transition it from a short term acute care hospital to a LTACH and consolidate it with the La Mirada operation. Covina Valley Community Hospital's name has changed to Specialty Hospital of Southern California-San Gabriel Valley Campus (SGV).

In connection with the acquisition of SGV, La Mirada requested the State of California revise SGV's license to reflect the change of ownership and consolidate the license with La Mirada. During the period May 15, 1997 (prior to the acquisition) and October 16, 1997, State Employees visited SGV to determine if the request for change of ownership and consolidation met the requirements of Section 2024 of the Medicare State Operations Manual (SOM) (HCFA-Pub. 7) entitled "Certification of hospitals with Multiple Components as a Single Hospital." The State approved the change of ownership and licensure consolidation on October 7, 1997.[4]

Subsequent to the State approval, a new Medicare provider enrollment form seeking consolidation of the SGV facility with the La Mirada facility was submitted to HCFA's San Francisco Regional Office. General information related to the consolidation was submitted in November of 1997 and February of 1998. The Providers' request was denied on February 12, 1998, for failure to satisfy 5 of the 17

---

[2] 65 Fed. Reg. 18434, 18505 (April 7, 2000).
[3] 65 Fed. Reg. at 18505.
[4] Provider's September 30, 2002 Position Paper at 2.

provider-based requirements in Medicare Program Memorandum A-96-7 issued in August of 1996.[5] On February 26, 1998, the Providers requested reconsideration of the decision which was denied on April 10, 1998. Through additional work with HCFA, the requested "certify[ing] . . . Specialty Hospital of Southern California-San Gabriel Valley . . . as a component of Specialty Hospital of Southern California-LaMirada" was granted on November 20, 1998. The approval was deemed effective as of August 27, 1998. SGV's provider agreement terminated on August 26, 1998, at midnight.[6] The Provider's consolidated status was denied for the first 10 months of the period following its initial October 1997 request for consolidation (the point at which the State of California had approved the change of ownership and consolidated licensure).

Prior to filing this appeal with the Board, the Provider filed an appeal of this determination with the Departmental Appeals Board (DAB). The Administrative Law Judge and the Appellate Division of the DAB both concluded that this was a reimbursement classification decision not a certification determination and they lacked jurisdiction to hear reimbursement classification decisions. In the DAB case, the Provider relied on the Board's denial of jurisdiction in *Johns Hopkins Hospital System*[7] in which the question presented was whether a outpatient facility should be considered part of the hospital. The Board had found that it lack jurisdiction over this question and the case was appealed to DAB. The ALJ determined that the oncology center satisfied HCFA's criteria for participation as part of the hospital. Unlike *Johns Hopkins,* the DAB found that the Provider in the current case had to seek relief from the Board before it could be considered to have exhausted its administrative remedies and dismissed the appeal.[8] The Federal Court concurred with the DAB decisions, finding that HCFA's decision denying the request for consolidation of the SGV and La Mirada was not a decision regarding certification or participation. Rather, the Court concluded, any status determination is subsumed by the effect it will have on reimbursement.

Initial Hearing Request and the Issue(s) in Dispute

This appeal was filed on February 15, 2002, from a Notice of Program Reimbursement (NPR) dated August 21, 2001 for the fiscal year (FY) October 31, 1998. The amount in controversy is estimated to be $6,948,216.[9] The Provider stated that it was appealing audit adjustments 4 and 24 which involved protested TEFRA amounts for the disallowance of a hospital consolidation involving San Gabriel. The hearing request contained the following statement of the issue:

> In June 1997 Specialty Healthcare purchased a 76 bed acute [care] hospital located in West Covina[,] Calif[.] Effective October 7, 1997[,] the State of California issued a license consolidating the new facility with the two owned facilities which had been [previously] consolidated. For Medicare purposes[,] HCFA only allowed the West Covina facility to be consolidated effective Aug[.] 27, 1998. It is our contention that the facility met all the consolidation criteria on Oct[.] 7, [1997] as evidenced by the State's ruling. Further[,] that there was no change in operation, location or anything between Oct[.] 7, 1997 and Aug[.] 27, 1998. Thus[,] the consolidation should have been effective in conjunction with the States [sic] ruling as is the case in 99.9% of

[5] *Id. Ex. P-4,* attachment to 2/12/1998 letter.
[6] Provider's Position Paper at 4 and August 27, 2004 Jurisdictional Brief Ex. P-8.
[7] 1999 WL 596463 (HHS 1999).
[8] Provider's August 27, 2004 Jurisdictional Brief Ex. P-9 at 14-19.
[9] Provider's Juris. Br. at 8.

all cases. The cost report was file [sic] with West Covina data for the periods Aug[.]1, 1998 thru Oct[.] 31, 1998. The protested item then estimates the reimbursement impact of the cost from Nov[.] 1, 1997 thru Aug[.] 26, 1998.

Provider's Position Paper

In the Provider's September 30, 2002 position paper, the following issues were identified as the subject of the adjudication:

A. Whether adjustments 4 and 24 to the Provider's FY 1998 Medicare cost report should be reversed because HCFA's decision to deny the Provider's request for consolidation of its hospitals and certification effective on a date earlier than August 27, 1998 is arbitrary and capricious, constitutes an abuse of discretion, or is otherwise contrary to law.

B. Whether adjustments 4 and 24 to the Provider's FY 1998 Medicare cost report should be reversed because HCFA erroneously applied the provider-based requirements contained in the Program Memorandum to the decision to consolidate and certify Provider SVG and La Mirada hospitals.

C. Whether adjustments 4 and 24 to the Provider's FY 1998 Medicare cost report should be reversed because HCFA, prior to August 26, 1998, possessed sufficient information to establish the relationship between SGV and La Mirada hospitals to approve their consolidation under the same Medicare provider number.[10]

Jurisdictional Brief

In its August 27, 2004 jurisdictional brief, the Provider identified both factual and legal issues as the subject of the dispute. The legal issues are:

(1) Whether the appropriate standard for HCFA to apply to the Provider's request to reclassify the San Gabriel Valley facility as a component of the Provider for reimbursement purposes should have been the Medicare State Operations Manual section 2024, rather than Medicare Program Memorandum A-97-6.

(2) Whether HCFA's decision to deny Provider's request to classify the San Gabriel Valley facility as a component of the Provider for reimbursement purposes effective on a date earlier than August 27, 1998 is arbitrary and capricious,

[10] Provider's September 30, 2002 Position Paper at 7.

constitutes an abuse of discretion or is otherwise contrary to law.

The factual issues are:

(1) Whether adjustments 4 and 24 to the Provider's FY 1998 Medicare cost report should be reversed and the Provider paid the protested amount of reimbursement.

(2) Whether HCFA had sufficient documentation to classify the San Gabriel Valley facility as a component of the Provider for reimbursement purposes as of June 13, 1997 or October 7, 1997, or some other date prior to August 27, 1998.

(3) Whether HCFA was inconsistent in its treatment of the Provider's request to consolidate its Santa Ana facility as compared to the Provider's request to consolidate its San Gabriel Valley facility.[11]

Provider's Position with Respect to Jurisdiction

The Provider asserts that the Board has the authority to consider the issue of provider-based status as it relates to adjustments to its FY 1998 cost report and HCFA's decision to consolidate the Medicare certification of SGV with the Provider's La Mirada and Santa Ana campuses.[12] The Provider points out that the ALJ, DAB and District Court have all determined that the "consolidation" was a reimbursement classification for the Board to decide.

The Provider points out that it was denied "consolidation status" for the first 10 months following its initial October 1997 request for consolidation, after the State of California had completed its review for change of ownership and licensure. The Provider contends that HCFA's decision to make the effective date of the certification August 27, 1998 is inconsistent with its prior practice of making certification decisions retroactive to the change of ownership (here, June 13, 1997), the survey, or the issuance of the appropriate license (in this case, October 7, 1997) for the hospitals involved the transaction. In the earlier 1996 certification of the Provider's La Mirada and Santa Ana facilities, HCFA granted consolidation retroactive to the date the State survey agency surveyed the Santa Ana facility. The disallowed costs represents the difference between SGV's former payment rates under PPS prior to February 1, 1998 and its TEFRA rate after it was excluded from PPS on February 1, 1998, and the Provider's TEFRA rate for La Mirada.[13]

The Provider contends that Medicare providers have the right to include disputed costs on their cost reports as protested items and then appeal them to the Board after the intermediary adjusts the costs. In this case, the reimbursement issue was included on the Provider's cost report as a protested[14] and disallowed based on Provider Reimbursement Manual (PRM) § 115. This section of the PRM provides

---

[11] August 27, 2004 Cover Letter to Provider's Jurisdictional Brief at 2.
[12] Provider's August 27, 2004 Jurisdictional Brief at 2.
[13] *Id.* at 6-7.
[14] Prov. Juris Ex. P-1, Adjustment 4 (Protested Amounts TEFRA: to remove the protested amounts that is subject to audit); Adjustment 24 (Memo Adjustment made to remove the cost for San Gabriel since the provider was not able to get the stats need for the facility in the required time).

providers the ability to dispute regulatory or policy interpretations through appeals including nonallowable items.

The Provider defines the primary issue under appeal as whether the Provider is entitled to the protested amount of reimbursement and the Provider believes the Board has jurisdiction over this issue. The Provider believes that the questions below are secondary questions which the Board can address because they are ancillary to the main issue. Those questions are:

(1) Whether § 2024 of the State Operations Manual, rather than Program Memorandum A-97-6 should have been used to make the determination;

(2) Whether HCFA's use of August 27, 1998 as the effective date of the reclassification of SGV as a component of the provider is arbitrary and capricious and constitutes and abuse of discretion;

(3) Whether HCFA had sufficient information to classify SGV as a component of the Provider as of a date prior to August 27, 1998; and

(4) Whether HCFA was inconsistent in its treatment of the Provider's request to consolidate its Santa Ana facility compared to the request to consolidate SGV.

The Provider notes that the ALJ, DAB and the Federal court conclude that the issue was a reimbursement classification issue, not a certification issue; therefore, the Board could hear the case. The Provider also contends that the Board can decide the secondary issue of status which it has done in other cases involving reasonable compensation equivalents, sole community hospital status, qualification as a new hospital or home health agency. The Provider noted that the ALJ or DAB have issued other decisions in which they declined jurisdiction on the same basis that it did for this Provider, concluding it was a reimbursement matter, but also noting that CMS had not made review under 42 C.F.R. § 498.3 retroactive. The Provider believes that the ALJ and DAB would have taken jurisdiction if the regulation had been made retroactive.[15]

Decision of the Board

The Board concludes that it lacks jurisdiction over the appeal because the question of the date that provider-based status was effective must first be determined under the provisions of 42 C.F.R. § 498.3 (2000). Until that question is determined by an ALJ, the second question regarding the amount of reimbursement to which the Provider is entitled is premature until the question of the effective state of the provider-based status is determined. Since the Board lacks jurisdiction over the appeal, it hereby dismisses the case.

Based on the Supreme Courts statement in *Landgraf v. USI Film Products*[16] and Justice Thomas' explanation regarding laws that expand or eliminate jurisdiction in pending cases in *Republic National Bank of Miami v. U.S.*[17] (*New Republic*) the Court stated that it regularly applied intervening statutes

---

[15] *Id. at 18-19.*
[16] 511 U.S. 244 (1994)
[17] 506 U.S. 80 (1982)

conferring or eliminating jurisdiction to any pending litigation. As a result a court could dismiss a case for lack of jurisdiction or accept jurisdiction if there was an expansion during the pendency of litigation.

Overview of the Retroactive Application of New Regulations

The most well-known case with respect to Board appeals and retroactive rule-making is *Bowen v. Georgetown University Hospital (Georgetown)*.[18] The issue in that case was whether the Secretary may exercise rule-making authority to promulgate cost limit rules that are retroactive.[19] The Court held that Medicare Act compels the conclusion that the Secretary has no authority to promulgate retroactive cost-limit rules.[20] The Court stated that retroactivity is not favored in the law and will not be construed to have retroactive effect unless their language requires the result and conveyed by Congress in express terms. Unless there was an express statutory grant, courts should be reluctant to find such authority.[21]

In a later case discussing retroactive application of new regulations, where such retroactive application would have been potentially beneficially to the petitioner, the Court again declined to apply a regulation retroactively. In the *Landgraf,*[22] the Petitioner filed a complaint asserting that she had been the victim of sexual harassment. While the petitioners appeal was pending the Civil Rights Act of 1991 was enacted. This legislation permitted the award of damages to successful litigants. The controlling question in the case was whether the court should have applied the law in effect at the time of the discriminatory conduct occurred or at the time of the decision in 1992, after a change in the law. In this case, the Supreme Court concluded that it would not apply the change in the law to this case because of the presumption against retroactive rule-making and because the rules of fairness dictate that individuals should have an opportunity to know the law and conform their conduct accordingly.[23] In civil matters, courts have declined to give retroactive effect to statutes that burden private rights unless Congress has made clear its intent to do so.[24]

In the same decision, the Court noted that it regularly applied intervening statutes conferring or ousting jurisdiction whether or not jurisdiction lay when the underlying conduct occurred or when the suit was filed. This includes cases dismissed because the jurisdictional statute under which it had been properly filed was subsequently repealed or where the opposite occurs. For example, while a case is pending the $10,000 amount in controversy threshold for Federal court jurisdiction requirement is eliminated and the plaintiff failed to allege the amount in dispute. Such an application takes away no substantive right, but simply changes the tribunal that will hear the case. Such laws "speak to the power of the court rather than the rights and obligations of the parties."[25]

The clearest explanation regarding the enactment of laws dealing with jurisdiction and their application to pending appeals is found in Justice Thomas' dissent in *New Republic.*[26] In that case, Justice Thomas explained that:

> In the case of newly enacted laws restricting or enlarging jurisdiction, one would think that the "determinative event" for retroactivity purposes

---

[18] 488 U.S. 204 (1988)
[19] *Id.* at 206.
[20] *Id.* at 215.
[21] *Id.* at 208-209.
[22] 511 U.S. 244 (1994).
[23] *Id.* at 265.
[24] *Id.* at 270.
[25] *Id.* at 274.
[26] 506 U.S. 80 (1992).

> would be the final termination of the litigation, since statutes affecting jurisdiction speak to the power of the court rather than to the rights or obligations of the parties. That conclusion is supported by longstanding precedent. We have always recognized that when jurisdiction is conferred by an Act of Congress and that Act is repealed, "the power to exercise such jurisdiction [is] withdrawn, and . . . all pending actions f[a]ll, as the jurisdiction depend[s] entirely upon the act of Congress." *Assessors v. Osbornes*, 76 U.S. (9 Wall.) 567 , 575, 19 L.Ed. 748 (1870). "This rule—that, when a law conferring jurisdiction is repealed without any reservation as to pending cases, all cases fall with the law—has been adhered to consistently by this Court." **566 *Bruner v. United States*, 343 U.S. 112, 116-117 . . . (1952) . . . Moreover, we have specifically noted that "[t]his jurisdictional rule does not affect the general principle that a statute is not be given retroactive effect unless such construction is required by explicit language or by necessary implications." *Ibid.*
>
> The same rule ordinarily mandates the application to pending cases of new laws *enlarging* jurisdiction. We so held in *United States v. Alabama*, 362 U.S. 602 . . . (1960) (*per curiam*). There, the District Court had concluded that it was without jurisdiction to entertain a civil rights action brought by the United States against a State, and the Court of Appeal had affirmed . . . . While the case was pending before this Court, the President signed the Civil Rights Act of 1960, which authorized such actions. Relying on "familiar principles," we held that "the case *must* be decided on the basis of the law now controlling, and the provisions of [the new statute] are applicable to this litigation." [citations omitted]. We therefore held that "the District Court has jurisdiction to entertain this action against the State," and we remanded for further proceedings.[27]

The Board has consistently found in the past that it lacked jurisdiction over appeals of provider-based status because such a determination is not a final determination of the amount of program reimbursement,[28] and does so here. The threshold consideration of jurisdiction over an appeal of provider-based status has now been defined by 42 C.F.R. § 498.3. This regulation provides an appeal process through ALJs, not the Board. Since the appeal and jurisdiction over provider-based status has been determined to lay with another tribune during the pendency of this proceeding, the Board concludes it lacks jurisdiction over the threshold question presented: the effective date of provider-based status. Until the question is determined, the amount of reimbursement that the Provider is entitled is premature.[29] Since the Board has dismissed the appeal, the case is hereby closed.

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

---

[27] *Id.* at 100-102 (emphasis in the original).
[28] *See* 42 U.S.C. § 1395oo(a).
[29] If the ALJ would affirm HCFA's finding with respect to the effective date of provider based status, the amount of reimbursement to which the Provider was entitled would not change. If the ALJ alters the effective date, the amount of reimbursement to which the Provider would be entitled would need to be recalculated and a final determination issued.

CN: 02-0779

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: Donna Kalafut, Noridian Healthcare Solutions
Kevin 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

CERTIFIED MAIL SEP 30 2014

Huntington Memorial Hospital
Venus Marin-Bautista
Director of Reimbursement
100 West California Blvd
Pasadena, CA 91105-3010

RE: **Huntington Memorial Hospital**
Provider Number: 05-0438
FYE: 12/31/2002
Case Number: 07-1144

Dear Venus Marin-Bautista:

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 12, 2007, and filed from an original Notice of Program Reimbursement (RNPR) dated September 26, 2006. The Provider appealed the following issues:

1. Whether or not the intermediary properly determined the SSI%.
2. Whether or not the intermediary properly excluded Medicare/Medicaid dual eligible patients days for DSH % calculation.
3. Whether or not the intermediary properly disallowed Medicare Bad Debts.

On March 21, 2008, the Provider submitted a request to add the Inpatient/Outpatient Medicare/Medi-Cal Crossover Bad Debt issues and transfer the issues to Group Case No. 98-0212G (Inpatient) and 97-2983G (Outpatient).[1]

On October 15, 2008, the Provider submitted a request to add the SSI Realignment issue to this appeal.

In a letter dated April 30, 2009, the Provider transferred the SSI Percentage issue to Group Case No. 08-1711G. That group was remanded back to the Intermediary on September 12, 2013, for the new SSI%.

On January 3, 2011, the Provider transferred the Dual Eligible Days issue to Group Case No. 11-0105G.

---

[1] While the Provider appealed the Medicare Bad Debt issue in its original appeal request, it did not provide a detailed issue statement outlining what they were appealing regarding the Bad Debt issue. The Provider withdrew the Bad Debt issue in its Final Position Paper, which was dated December 10, 2007. (See page 2 of the Provider's Final Position Paper.)

Board Determination:

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

> The Disproportionate Share Adjustment is calculated according to a formula that includes the determination of a hospital's "disproportionate share percentage." 42 U.S.C. § 1395ww(d)(5)(F)(vi). This percentage is defined as the sum of the Medicaid fraction and the Medicare fraction. The Provider contends that its Medicare fraction has not been calculated in accordance with Medicare regulations and Manual provisions as described in 42 CFR § 412.106. Specifically, the Provider contends that the Federal Fiscal Year SSI percentage is used by the Fiscal Intermediary to settle the cost report is understated. *Finally, the Provider is requesting the MEDPAR data underlying its SSI Percentage and after reviewing this data will decide whether to request a realignment of its SSI Percentage*. Estimated Impact: $63,000. (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 Participating:
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esp.
L. Sue Andersen
Charlotte F. Benson

For the Board:

Michael W. Harty
Chairman

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

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

Refer to: 13-0375

CERTIFIED MAIL

SEP 30 2014

Healthcare Reimbursement Services, Inc.
Corinna Goron
President
17101 Preston Road, Suite 220
Dallas, TX 75248-1372

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

RE: Provider Name: Shannon Medical Center
Provider No.: 45-0571
FYE: 09/30/2007
PRRB Case No.: 13-0375

Dear Ms. Goron and Mr. LeJeune,

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

Pertinent Facts

On October 12, 2012, Shannon Medical Center (Provider) was issued its Notice of Program Reimbursement (NPR) for FYE 09/30/2007. On January 3, 2013, the Board received the Provider's appeal request, which disputed the improper:

(1) Inclusion of Exhausted Benefit and Medicare Secondary Payer Days in the Supplemental Security Income fraction (SSI%);
(2) Inclusion of Medicare Advantage Days in the SSI%;
(3) Matching methodology used in computing the SSI%;
(4) Notice and comment rulemaking procedures by the Secretary in adopting Exhausted Benefit and Medicare Advantage Days policy; and,
(5) Computation of the Rural Floor Budget Neutrality Adjustment (RFBNA).[1]

In a letter dated August 30, 2013, the Provider submitted its Preliminary Position Paper to the

[1] *See* Provider's Statement of Issues, R. of Administrator's Decision, 2295-2303.

Medicare Administrative Contractor (MAC), which identified and briefed the following issues:

(1) Calculation of Medicaid Eligible Days;
(2) Calculation of the SSI% ("Provider Specific" and "Systemic Errors");
(3) Calculation of Medicare Advantage Days;
(4) Calculation of Exhausted Benefit and Medicare Secondary Payer Days; and,
(5) Calculation of the RFBNA.[2]

The MAC filed a Jurisdictional Challenge on the Medicaid Eligible Days issue in a letter dated November 8, 2013. The Provider filed its Jurisdictional Response on April 24, 2014.

MAC's Position

The MAC contends that the Board lacks jurisdiction over the Medicaid Eligible Days issue because the issue was not timely added to the Provider's individual appeal request. The MAC claims that the Medicaid Eligible Days issue was not included in the original appeal request filed on January 3, 2013. The MAC was unable to locate the issue as part of the Provider's original appeal request or as an added issue in any subsequent communication. The MAC further contends that the Medicaid Eligible Days issue appeared for the first time on August 30, 2013, when it was briefed in the Provider's Preliminary Position Paper. The MAC concludes that the Provider failed to meet the statutory time requirements when it effectively attempted to add the issue to the appeal on August 30, 2013; therefore, the Board lacks jurisdiction over the Medicaid Eligible Days issue.

Provider's Position

The Provider contends that the Medicaid Eligible Days issue was included in its original appeal request. While the Provider concedes that the "issue language" was "inadvertently omitted" from its appeal request, it argues that its intention to appeal the issue was evidenced by the inclusion of the issue's impact calculation in the total estimated reimbursement amount which was provided with the original appeal request. Absent the issue language, the Provider concludes that the MAC was put on notice that the issue was being appealed and that the MAC was incorrect in concluding that the issue was not timely added to the appeal.

Board's Determination

The Board finds that it does not have jurisdiction over the Medicaid Eligible Days issue in the Provider's appeal because the Provider did not properly appeal the issue in its original appeal request, and it did not timely add the issue to the appeal.

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 (1) it is dissatisfied with the final determination of the MAC, (2) the amount in controversy is $10,000 or more (or $50,000 for a group), and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

---

[2] *See* Ex. 3 of MAC's Jurisdictional Response, 11-41.

Further guidance and requirements for filing an appeal with the Board are outlined in the PRRB Rules (July 1, 2009). PRRB Rule 7 states: "For each issue under appeal, give a brief summary of the determination being appealed and the basis for dissatisfaction."[3] If filing an appeal of a NPR, Rule 7.1 requires a provider to give a concise statement describing the adjustment, including the adjustment number, why the adjustment is incorrect, and how the payment should be determined differently. Rule 8.1 (Framing Issues for Adjustments Involving Multiple Components, General) further provides that in order to "comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible using the applicable format outlined in Rule 7."

Here, the Provider did not comply with the rules requiring specificity. The Provider failed to identify the Medicaid Eligible Days as a separate issue in its appeal. In particular, the Provider did not give a brief summary of the issue, described as narrowly as possible, or explain why it was dissatisfied with the MAC's determination.[4]

The Provider argues that the impact calculation attached to its appeal is sufficient. While Medicaid Eligible Days were included in the total estimated reimbursement submitted by the Provider, neither Model Form A nor the Issue Statement mentioned the Medicaid Eligible Days issue. The Provider failed to include the elements required pursuant to Board Rules to properly preserve the issue in its original appeal request. The Provider cannot circumvent the Rules by asserting that the MAC was put on notice regarding the issue.

Moreover, the Provider failed to timely add the issue subsequent to its original appeal request. Regulation 42 C.F.R. § 405.1835(c) provides that an issue may be added to the original appeal request "no later than 60 days after the expiration of the 180-day period" following the Provider's receipt of its NPR. The Provider first raised the Medicaid Eligible Days issue months after the deadline expired (the expiration period ended on June 14, 2013; the issue was first raised on or about August 30, 2013). Consequently, because the addition exceeded the 60-day window provided by regulation, the Board finds that the provider did not timely add the issue.

Therefore, for the reasons mentioned above, the Medicaid Eligible Days issue was not appealed timely and is hereby dismissed for lack of jurisdiction. As the other issues in this appeal have either been transferred to group appeals[5] or granted expedited judicial review (EJR),[6] the case is now closed.

---

[3] PRRB Rule 7 (emphasis in original).
[4] *See* PRRB Rules 7, 8.1.
[5] Five Form D Transfer Requests were received on July 31, 2014, which requested the following transfers: SSI Fraction Dual Eligible Days to Case No. 14-3519G; DSH/SSI Percentage to Case No. 14-0356G; DSH SSI Fraction Medicare Managed Care Part C Days to Case No. 14-3518G; DSH Medicaid Fraction Dual Eligible Days to Case No. 14-0366G; and, DSH Medicaid Fraction Medicare Managed Care Part C Days to Case No. 14-0369G.
[6] The Board issued a decision on September 30, 2013 that determined that the Board lacked jurisdiction over the RFBNA issue, but further provided that if its decision was later reversed by the Administrator, then EJR would be appropriate. *See* RFBNA Jurisdictional Decision Letter, September 30, 2013. On December 13, 2013, the Administrator reversed the Board's denial of jurisdiction over the RFBNA issue. By the Administrator ruling that the Board has jurisdiction, EJR was effectively granted. Pursuant to § 1878(f) of the Social Security Act and 42 C.F.R. § 405.1877, the Provider may obtain judicial review from the Administrator's decision.

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

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: 14-3759

CERTIFIED MAIL SEP 30 2014

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

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

RE: Jurisdictional Challenge – Pemiscot County Memorial Hospital
Provider No.: 26-0070
FYE: 12/31/2011
PRRB Case No.: 14-3759

Dear Mr. Ravindran and Mr. 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 Provider's original Notice of Program Reimbursement (NPR) was issued on January 17, 2014 for fiscal year end (FYE) 12/31/2011. The Provider timely appealed one issue on July 9, 2014, which was whether the rural floor budget neutrality adjustments (RFBNA) as implemented by CMS violated the law's requirement of budget neutrality. On August 14, 2014, the Medicare Administrative Contractor (MAC) filed a Jurisdictional Challenge. The Provider filed a response on August 19, 2014.

MAC's Position

The MAC challenged the Board's jurisdiction over the RFBNA issue because the Provider failed to meet the requirements under 42 C.F.R. § 405.1835(a)(1). First, the MAC made no adjustment to the RFBNA and the Provider made no claim for it on its cost report. Second, the Provider did not preserve its right to claim dissatisfaction with the amount of Medicare payment by self-disallowing the specific items and following the applicable procedures for filing a cost report under protest. The MAC maintained that the Board lacks jurisdiction since the Provider failed to follow this procedure.

Provider's Position

In its response, the Provider argued that it could not claim an erroneously computed RFBNA on its cost report is because those factors were not cost items. The Provider explained in its Jurisdictional Response that its appeal had two basic components:

(1) Prior to 2008, the Secretary improperly adjusted the "average standardized amount" per discharge for differences in hospital wage levels; and,
(2) In 2008 and after, the Secretary improperly adjusted the "area wage index" reflecting the relative wage levels in the hospital's geographic location.[1]

The Provider stated that neither the "average standardized amount" nor the "area wage index" factors are cost items which can be claimed on a hospital's cost report. As such, the Provider argued that the requirement contained in 42 C.F.R. § 405.1835(a)(1)(i), that specific cost items be claimed in the cost report to preserve appeal rights, was not applicable to its case.

The Provider also argued that the provisions of 42 C.F.R. § 405.1835(a)(1)(ii), which state that a provider may self-disallow specific items by filing them under protest, do not apply because "these regulations are inconsistent with the plain language of the governing statute."[2] The Provider conceded that it "did not expressly self-disallow any costs,"[3] but argued that the Board's jurisdiction is not contingent upon a provider claiming each disputed item in the cost report. In other words, there is no exhaustion requirement before the MAC. The Provider's view is that the Supreme Court's analysis in *Bethesda* would not change notwithstanding the amendment to 42 C.F.R. § 405.1835(a)(1) because the Court will still look to the plain language of 42 U.S.C. § 1395oo. The Provider claimed that the presentment requirement would not change the Court's analysis. The Provider maintained that the holding in *Bethesda* and other related cases apply to the instant case and that a provider may appeal a self-disallowed cost even if it failed to protest its claim on the cost report.

Further, the Provider argued that the inclusion of the Diagnostic Related Group (DRG) payments in the cost report is equivalent to the inclusion of RFBNA in its cost report. The Provider stated that the DRG payments are understated due to the error in CMS's calculation of the RFBNA factor. Therefore, any claim for or action regarding DRG payments is equivalent to a claim for RFBNA. Since the DRG payments were specifically adjusted, the Provider contended, any protest requirement for RFBNA is obviated by the appeal of adjustments to its DRG payments.

PRRB's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2010), 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.

---

[1] *See* Provider's Jurisdictional Response Letter, August 15, 2014, 2.
[2] Provider's Jurisdictional Resp. 2.
[3] *See* Provider's Jurisdictional Resp. 2.

Similarly, 42 C.F.R. § 405.1835(a)(1) provides, in relevant part:

> (a) A provider . . . has a right to a Board hearing . . . for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination, only if --
>
> (1) The provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue, by either –
>
> (i) Including a claim for specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or
>
> (ii) Effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item(s) by following the applicable procedures for filing a cost report under protest, where the provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy (for example, if the intermediary lacks discretion to award the reimbursement the provider seeks for the item(s)).

This confirms that the general right to hearing at the beginning of 42 C.F.R. § 405.1835(a) necessarily encompasses claims for both reasonable cost reimbursement and reimbursement under inpatient prospective payment system (IPPS). The general right to a hearing in the new subsection (a) relates to "an intermediary or Secretary *determination.*"[4] The definition of "determination" as used therein is defined in 42 C.F.R. § 405.1801. Significantly, the § 405.1801 definition of "determination" has included determinations for both reasonable cost reimbursement and reimbursement under IPPS since September 1983 when the Centers for Medicare & Medicaid Services (CMS) revised its regulations to implement IPPS.[5] Indeed, the Board's review of the regulatory history of § 405.1835 suggests that the May 23, 2008 changes simply update and expand the § 405.1835 right to hearing to include any IPPS reimbursement issues that are part of the normal cost report audit, settlement and appeals process as reflected by the historical application of such process.

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

---

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

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

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

Here, the Provider did not claim RFBNA on its cost report; therefore, the Provider must meet the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) in order for the Board to have jurisdiction.

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

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

[6] (Emphasis added).

Effective with cost report periods that end on or after December 31, 2008, CMS amended the regulations governing cost report appeals to incorporate PRM 15-2 § 115 *et seq.* into the regulations at 42 C.F.R. § 405.1835(a)(1)(ii) (2008) by specifying that, where a provider seeks payments that it believes may not be allowable or may not be in accordance with Medicare policy, the provider must claim the items as self-disallowed costs "by following the applicable procedures for filing a cost report under protest."

In the preamble to the final rule published on May 23, 2008 ("2008 Final Rule"),[7] the Secretary explained that he believed that the requirement to follow procedures for filing cost reports under protest was appropriate under the decision in *Bethesda Hospital Association v. Bowen.*[8] In *Bethesda*, the providers were dissatisfied with malpractice reimbursement and did not file a claim for the additional reimbursement on their cost report, nor did they file a statement with the cost report challenging the validity of the regulation. Hence, there was no final determination with respect to malpractice costs. The Court rejected the Secretary's argument that 42 U.S.C. § 1395oo(a)(1)(A)(i), which requires dissatisfaction with a final determination of the intermediary, "necessarily incorporates an exhaustion requirement." The Court found that this "strained interpretation" of the statutory dissatisfaction requirement was inconsistent with the express language of the statute.[9] However, the Court agreed, that under § 1395oo(a)(1)(A)(i), a provider's dissatisfaction with the amount of its total reimbursement is a condition of the Board's jurisdiction, but held that "it is clear, however, that the submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations. No statute or regulation expressly mandates that a challenge to the validity of a regulation be submitted first to the intermediary. . . . Thus, [the providers in *Bethesda]* stand on different ground than do providers who bypass clearly prescribed exhaustion requirements or who fail to request from the intermediary reimbursement for costs to which they are entitled under the applicable rules. While such defaults might well establish that a provider was satisfied with the amounts requested in its cost report and awarded by the intermediary, those circumstances are not presented here."[10] The Secretary noted that the Court recognized that an exhaustion requirement could be imposed by regulation, and that a provider who fails to claim all costs to which it is entitled may fail to meet the jurisdictional prerequisite of dissatisfaction.[11] In light of the ability to enact such regulations, 42 C.F.R. § 405.1835(a)(1)(ii) was promulgated, requiring providers to claim all items for which they seek additional reimbursement.

The Secretary went on to state that "[a]lthough there may be nothing in the statute indicating that dissatisfaction must be expressed with respect to 'each claim,' there also is nothing in the statute indicating that the Secretary cannot interpret the dissatisfaction requirement in this manner."[12]

The final determination, which here is the NPR, is not just the total amount of program reimbursement. Rather, it is composed of many individual calculations representing the various

---

[7] 73 Fed. Reg. 30190 (May 23, 2008).
[8] 485 U.S. 399 (1988).
[9] 73 Fed. Reg. at 30196 citing *Bethesda* at 404.
[10] *Id.* at 404-405.
[11] *Id.*
[12] 73 Fed. Reg. at 30197.

items for which a provider seeks payment. Providers generally challenge discrete reimbursement items. Thus, dissatisfaction with total reimbursement is based on dissatisfaction with items that result in total reimbursement. Consequently, the Secretary believes it is reasonable under 42 U.S.C. § 1395oo(a) to require dissatisfaction be shown with respect to each issue being appealed.[13] In light of this and the requirements of the regulation, the challenge to the RFNBA must be claimed as a protested item and the Provider failed to comply with this requirement.

In the preamble, the Secretary also confirmed that this regulation codified the PRM rules governing cost reports filed under protest:

> **Comment**: One commenter recommended that the text of section 115 *et seq.* of the PRM, Part II, be placed in the regulations. The commenter noted that these sections of the PRM have not changed since 1980. . . .
>
> **Response**: We are adopting the proposal, which is essentially a codification of the protested amount line procedures set forth in section 115 *et seq.* of the PRM, Part II.[14]

For purposes of IPPS providers, filing a cost report under protest is achieved by entering such costs on Worksheet E, Part A, Line 75 of the cost report. In this regard, PRM 15-2 § 3630.1 requires IPPS providers:

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

The Board notes that 42 C.F.R. § 405.1803(d) (2008) provides further evidence that the "rules and regulations governing [cost] reports" are, in part, located in 42 C.F.R. Part 405, Subpart R. This regulation governs implementation of decisions to award, in part or in full, self-disallowed items filed under protest:

> (d) **Effect of certain final agency decisions and final court**

---

[13] *Id.*

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

> **judgments: audits of self-disallowed and other items. . . .**
>
> (3) CMS may require the intermediary to audit any item, including any self-disallowed item, at issue in an appeal or a civil action, before any revised intermediary determination or additional Medicare payment, recoupment, or offset may be determined for an item under paragraph (d)(2) of this section.

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

> The final decision awarding reimbursement for a self-disallowed item may come from the Board, the Administrator, or a court. Although we believe that, in most instances, the administrative or judicial body that issues a decision would not specify a dollar figure for reimbursement, the proposal was intended to ensure that intermediaries, in fact, have the opportunity to determine the correct amount of reimbursement after an award is made. We believe that it would be inappropriate for the administrative or judicial body to award a specific amount for reimbursement without the benefit of an audit by the intermediary.[15]

Thus, the procedures and documentation required for filing an item under protest and the audit of such items when they are awarded (in part or in full) following a successful appeal as codified at 42 C.F.R. §§ 405.1835(a)(1)(ii) and 405.1803(d) respectively, are an integral part of the cost reporting process established under 42 U.S.C. § 1395g(a) that the provider must "furnish[ ] such information as the Secretary may request in order to determine the amounts due such provider."

It should be mentioned that the Provider cited several cases with similar holdings to *Bethesda* in its Jurisdictional Response.[16] These cases were decided prior to the implementation of the 2008 regulations and are not applicable here. Further, the Board is bound by the regulations as described by the Secretary. The Board finds that the Provider must comply with 42 C.F.R. § 405.1835(a)(1) to prove the dissatisfaction prong for jurisdictional purposes, as outlined above.

Additionally, the Provider also argued that since the DRG payment was adjusted, the RFBNA was also adjusted and therefore any requirement to claim RFBNA is obviated. That is incorrect. A provider preserves its right to claim dissatisfaction by following the procedures for filing under protest, including "specifically identif[ying]" the disputed item.[17] The provisions require a provider to state with specificity what issue is being appealed (i.e. protested). The Provider is not appealing DRG specifically; therefore, this argument fails.

The Provider did not enter a protested amount on its cost report as required to protest the amount

---

[15] 73 Fed. Reg. at 30199.
[16] *See generally* Provider's Jurisdictional Resp.
[17] *See* PRM 15-2 § 115.1 (the disputed item and amount for each issue must be specifically identified).

of RFBNA pursuant to § 405.1835(a)(1)(ii).[18] As this cost report involves a fiscal year (2011) that ends on or after December 31, 2008, self-disallowed items such as the RFBNA at issue must have been filed under protest in order to have "complied with the rules and regulations of the Secretary relating to such [cost] report" and, thereby, established one of the elements for Board jurisdiction under 42 U.S.C. § 1395oo(a)(1). Thus, as the Providers failed to protest the RFBNA at issue and that is the sole issue involved in this appeal, the Board lacks jurisdiction over the appeal and hereby dismisses the case. Since there are no remaining issues in the appeal, the case is hereby closed.

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

Board Members Participating
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Anderson, Esq.
Charlotte F. Benson

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

[18] *See* Provider's Jurisdictional Resp. 2 (the Provider concedes it did not expressly self-disallow any costs).