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CERTIFIED MAIL

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RE: Rome Memorial Hospital
Provider No.: 33-0215
FYE: 12/31/2001
PRRB Case No.: 05-1390

Dear Mr. McKay and Mr. Browning,

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

Background

The Provider filed a timely appeal request on April 12, 2005 containing two issues, including DSH Medicaid eligible patient days and DSH Medicaid paid patient days.

On July 19, 2005, the Provider submitted a request to add the SSI Ratio to the appeal and simultaneously transfer the issue to the Northeast Region 93-97 SSI Group Appeal, PRRB Case No. 01-1347G.

On July 28, 2005, the Provider submitted a request to add the DSH Medicare/Medicaid dual eligible patient days issue to the appeal. On November 15, 2005, the Provider submitted a request to transfer the issue to the McKay 2001 DSH Dual Eligible Group Appeal II, PRRB Case No. 05-2173G.

The Provider filed its final position paper and a supplemental position paper on November 25, 2005 and November 1, 2012, respectively. In both papers, the Provider identified the transfers of the SSI percentage and dual eligible days issues to group appeals and briefed the issue of 261 additional unpaid eligible days.[1]

The Intermediary filed a jurisdictional challenge on the Medicaid eligible days issue on January 24, 2013. The Provider responded to the Intermediary's jurisdictional challenge on February 21, 2013.

[1] In 2005, the Provider initially identified a patient day count of 396 days, but in 2012 clarified that 261 additional days were specific to eligible days and the other 135 days were dually eligible days transferred to Case No. 05-2173G.

Intermediary's Contentions

The Intermediary contends that the Provider's right to a Board hearing derives from a MAC determination, which is defined at 42 CFR § 405.1801(a)(1) as:

> ...a determination of the amount of total reimbursement due the provider, pursuant to § 405.1803 following the close of the provider's cost reporting period...

The Intermediary's position is that §§ 405.1801 and 405.1803 imply that an identifiable adverse finding, with a corresponding reduction in reimbursement, is necessary to request a Board hearing under § 405.1841(a). The Intermediary asserts that an issue is rooted in "an identifiable adverse finding" indicated in the Notice of Program Reimbursement.[2]

The Intermediary argues that since it accepted the Medicaid eligible unpaid days submitted by the Provider on its as-filed cost report, i.e., made no adjustment to Medicaid eligible unpaid days, the Board lacks jurisdiction over this matter in accordance with 42 C.F.R. § 405.1811. The only adjustment made was to Medicaid paid days. The Intermediary notes that HCFA Ruling 97-2 stated that Medicaid eligible unpaid, as well as Medicaid eligible paid days, may be included in the DSH calculation effective February 27, 1997. The Provider has had ample time since the issuance of HCFA Ruling 97-2 to either establish a method for accumulating its own Medicaid eligible paid and unpaid days, or to timely make a request to its state agency for a Medicaid eligible paid and unpaid days listing, prior to submission of its Medicare cost report.[3]

The Intermediary contends that in New York, for all cost reporting periods beginning on or after January 1, 2000, hospital specific Medicaid paid and eligible claim information has been available through the New York State Department of Health (NYSDOH) Datamart Reports. Utilizing the available information, the Provider had the opportunity to include Medicaid unpaid eligible days in the as-filed cost report for FYE 12/31/01 or submit an amended cost report to include eligible Title XIX days paid and processed after the Provider's cutoff date for the initial report filing.[4]

The Intermediary notes that the DSH information received through the Medicare cost report is used to determine a more accurate DSH payment than that received by the Provider through its claims payment. The DSH payment calculation is based on the Provider's cost report information and the SSI percentage. The Provider has the responsibility to submit complete and accurate data on its filed cost report. The submission of the number of allowable Medicaid days to be used in the DSH reimbursement at final settlement is, therefore, the responsibility of the Provider. The Intermediary does not accumulate cost report data for the Provider, but rather is responsible for the review of the data submitted by the Provider and verification that this data meets regulatory requirements.[5]

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[2] Intermediary's Jurisdictional Brief at 2.
[3] *Id.*
[4] *Id.*
[5] *Id.* at 3.

Provider's Contentions

The Provider contends that the Board has jurisdiction to review the Intermediary's determination of, and adjustment to, the Provider's number of Medicaid patient days. The Provider notes that the Intermediary's audit adjustment # 203 removed 505 Medicaid patient days from Worksheet S-3, column 5, thus, the Provider argues, jurisdiction over the Medicaid patient day count in this appeal is proper. The Provider contends that the Intermediary's attempt to distinguish between Medicaid patient days that were paid and those that were not paid by the State is a semantic distinction without a difference. It notes that the DSH payment calculation does not separately tabulate Medicaid patient days that are paid and Medicaid patient days that are unpaid, nor does it calculate separate Medicaid fractions for "paid" and "unpaid" Medicaid patient days. There is just one fraction, with one numerator, and the numerator is defined by statute, in § 1886(d)(5)(F)(vi) to include all Medicaid patient days. That is a singular issue and singular determination for Medicare DSH payment purposes.[6]

The Provider further contends that the Board and the Administrator have long ruled that when any component of a determination or issue is adjusted, there is jurisdiction over the entire issue including any component of the calculation not adjusted. This is consistent with the position that CMS has taken in CMS Ruling 1498-R. In the Ruling, CMS took the position that the agency can recalculate one aspect of a hospital's DSH payment even if that aspect is not contested in an appeal on other aspects of the DSH payment. CMS's position under the Ruling is that if a Provider has appealed the exclusion of certain Medicaid-eligible days from the Medicaid fraction (e.g., dual eligible days), then the MAC can reopen the Medicare/SSI fraction on remand and recalculate it to correct the errors and omissions that were the subject of the *Baystate* litigation, and also to add dual eligible days to that fraction. In other words, the Ruling established CMS's position that the DSH payment constitutes one issue, regardless of whether the Provider appealed the Medicare/SSI fraction or the Medicaid fraction, or some component of those fractions. The Provider cites *Southwest Consulting 1997 MA Uncompensated Care Days Group*, Case No. 06-0314G and *Beverly Hospital*, Case No. 04-1083 as prior jurisdictional decisions where the Board has viewed the DSH payment calculation as a single issue.[7]

The Provider also cites another Board precedent in *Blessing/St. Mary GME Group Appeal v. Blue Cross and Blue Shield Association*, PRRB Dec. No. 97-D57 where the Board held that the hospitals were entitled to a hearing on the classification of the clinic costs as non-reimbursable GME costs, notwithstanding the absence of an audit adjustment on that particular aspect of the Intermediary's determination. The Provider notes that the Board concluded, and the Administrator affirmed, that the hospitals had timely and properly appealed from the Intermediary's determination of allowable GME costs that were included in the average per resident amount calculation, that the hospitals were entitled to include an additional issue relating to the Intermediary's determination of their allowable GME costs, and that the Board's "jurisdiction extends over the *entire issue* relating to the determination of GME costs."[8]

The Provider contends that the Board also has jurisdiction under *Bethesda*.[9] The Provider argues that it could not have submitted a complete and accurate listing of its Medicaid patient days at the time it filed

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[6] Provider's Jurisdictional Brief at 12.
[7] *Id.* at 12-14.
[8] *Id.* at 15-16. (Emphasis added in Provider's Brief).
[9] *Bethesda Hosp. Ass'n. v. Bowen*, 485 U.S. 399 (1988).

its cost report, because of eligibility determinations made after the filing of the cost report and because of deficiencies in the information received from the State. After the cost report was filed, more accurate data became available from the State. The Provider appropriately appealed to express dissatisfaction with the number of Medicaid patient days allowed in the NPR. These actions do not and cannot bar jurisdiction in this case. By filing its cost report in compliance with the rules, the Provider did not relinquish its right to be dissatisfied with the Intermediary's determination of its number of Medicaid patient days and the exclusion of days that had not been identified and could not reasonably have been identified by the Provider as of the filing of the cost report.[10]

The Provider offers several reasons as to why it was difficult to submit a complete and accurate listing of Medicaid eligible patients at the time it filed its cost report, through no fault of its own. First it was impossible to identify Medicaid patient days for patients whose eligibility had not yet been determined at the time the cost report was filed. Second, the Provider was not able to identify other Medicaid patient days because of deficiencies in the State's eligibility verification system. States such as New York that had determined that they would provide eligibility data to hospitals were still in the process of implementing a system and process for making that data available, and as a result, the data provided by the state was often inaccurate and incomplete. As an example, the verification process did not provide all of the information, such as aid categories and coverage codes, which hospitals needed to ensure that any particular day could be included in the Medicaid fraction. Additionally, the batch verification process relied upon an insufficient number of search variables which may not be known by the hospital at the time the cost report is filed.[11]

The Provider further contends that the Board has jurisdiction under § 1878(d) of the Act. It notes that in *Bethesda*, the Supreme Court, in its consideration of the language and design of Section 1878 of the Act as a whole, concluded that once the Board has jurisdiction over one issue pursuant to 1878(a), it has further power to review and revise the cost report even with respect to issues that were not considered by the Intermediary, so long as the issue was covered by the cost report. In this appeal, the Intermediary does not dispute that the Board has jurisdiction over the Medicaid paid days. Because the Provider has properly invoked the Board's jurisdiction over various aspects of the DSH payment calculation, the Board also has the power to review and revise the calculation of the Provider's unpaid Medicaid patient days in accordance with § 1878(d) of the Act even if it would not otherwise have jurisdiction under Section 1878(a), which it does.[12]

Lastly, the Provider argues that the reporting requirement under Ruling 97-2 is invalid under the Paperwork Reduction Act. To the extent that HCFA Ruling 97-2 imposed a burden on hospitals to verify patients' eligibility for medical assistance with the appropriate Medicaid State agencies, the Ruling imposed a new information collection obligation on hospitals for which CMS failed to obtain the requisite approval from the Office of Management and Budget ("OMB"), as required in the Paperwork Reduction Act ("PRA"). Thus, under the PRA, the Provider may not be penalized, through a denial of or decrease in reimbursement, for failing to comply with CMS' requirement. Additionally, the Provider argues that CMS did not invoke the PRA's statutory exception provision either in Ruling 97-2 or in the subsequent 1998 rulemaking.[13]

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[10] Provider's Jurisdictional Brief at 16.
[11] *Id.* at 17-18.
[12] *Id.* at 19.
[13] *Id.* at 20-21 and 23.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) (2004) and 42 C.F.R. §§ 405.1835-405.1841 (2004), a provider has a right to a hearing before the Board with respect to a timely filed cost report if it is dissatisfied with the final determination of the Intermediary, the amount in controversy is $10,000 or more, and the request for hearing is received by the Board within 180 days of the date the notice of the intermediary's determination was mailed to the provider. The Board has *discretionary power* under 42 U.S.C. § 1395oo(d), after jurisdiction is established under 42 U.S.C. § 1395oo(a), to make a determination over all matters covered by the cost report. The Board can affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and make any other revisions on matters covered by the cost report even though such matters were not considered by the intermediary in making its final determination.

At the outset, the Board recognizes that CMS' computation of DSH payment has been shaped by decisions from the Supreme Court and administrative tribunals. In particular, the Board recognizes that the following decisions are relevant to this case in connection with whether the Board has jurisdiction to conduct a hearing on it: (1) the Supreme Court's decision in *Bethesda*; and (2) the Board's recent decision in *Danbury Hospital v. BlueCross BlueShield Ass'n* ("*Danbury*").[14]

Similar to its decision in *Danbury*, the Board finds that: (1) a provider does have an obligation to submit Medicaid eligible days information as part of the cost reporting process; and (2) this obligation is separate and distinct from the DSH adjustment determination process handled by its intermediary.

In support of these findings, the Board notes that the preambles to the May 1986 Interim Final Rule and the September 1986 Final Rule confirm that providers have been required (both prior to and following 1986 when the DSH adjustment payment was added) to submit the Medicaid days data as part of the normal cost reporting process and that this information has been and continues to be subject to the normal cost report audit and settlement process.[15]

Second, the Board notes that the addition of the DSH adjustment in 1986 did not alter the scope of the providers' obligation to submit Medicaid days data. Specifically, in implementing the DSH adjustment in 1986, CMS did not substantively change the scope of providers' then-existing obligation to report Medicaid *paid* days on the cost report. In the preamble to the September 1986 Final Rule, CMS stated that its interpretation of the Medicaid days as used in the Medicaid percentage of the DSH calculation was "consistent with the way we require Medicaid days to be reported on the Medicare cost report."[16] CMS explained that its initial interpretation was based, in part, on CMS' belief that Congress did not intend that "an additional reporting mechanism, possibly tied to State eligibility records, be developed to obtain Medicaid statistics on noncovered patient days."[17] As a result, the Board concludes that the then-

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[14] PRRB Dec. No. 2014-D3 (Feb. 11, 2014).
[15] The Board notes that 42 C.F.R. § 413.24(f) describes a provider's cost report as a "report[] of its operations", which necessarily would include not only a report of costs but also certain occupancy and volume statistics such as Medicaid eligible days. *See also* Provider Reimbursement Manual, CMS Pub. No. 15-2 ("PRM 15-2"), § 3600.
[16] 51 Fed. Reg. at 31460. *See also* 56 Fed. Reg. 43358, 43379 (Aug. 30, 1991) (cross-referencing the September 1986 Final Rule discussion of CMS' interpretation of Medicaid days being based, in part, on how Medicaid days was then-currently being reported as part of the normal cost reporting process).
[17] 51 Fed. Reg. at 31460.

existing obligation to report Medicaid *paid* days data was not subsumed into the DSH adjustment decision process (*i.e.*, that obligation remained separate and distinct from the DSH adjustment decision process).

Third, the preamble to the May 1986 Interim Final Rule confirms that, if a provider is dissatisfied with the intermediary's "determination of its Medicaid days" (whether for purposes of interim DSH adjustment determination or for the final DSH adjustment determination), the provider as part of the "year-end settlement on a cost reporting period basis" has "the ... responsibility to demonstrate to the intermediary that the Medicaid statistics reported on its cost report are incorrect or were improperly applied."[18] This discussion confirms that CMS viewed decisions on Medicaid days as separate and distinct from the DSH adjustment determination itself. The separate and distinct nature of Medicaid days is supported by the facts that it is reported on a separate line and in a separate worksheet from where the DSH adjustment is claimed. Specifically, a provider claims Medicaid eligible days in Worksheet S-3 and claims a DSH adjustment in Worksheet E, Part A.

The DSH regulations have undergone numerous changes since the creation of the adjustment. Certain of these revisions came in the wake of circuit court decisions that invalidated HCFA's[19] computation of DSH payment, specifically its practices concerning the Medicaid fraction. In issuing HCFA Ruling 97-2, the agency acquiesced to these rulings, noting that:

> HCFA will count in the Medicaid fraction the number of days of inpatient hospital services for patients eligible for Medicaid on that day, whether or not the hospital received payment for those inpatient hospital services.[20]

Ruling 97-2 reiterated that the responsibility for verifying Medicaid eligibility fell on the provider community, noting:

> Pursuant to this ruling, Medicare fiscal intermediaries will determine the amounts due and make appropriate payments through normal procedures. Claims must, of course, meet all other applicable requirements. This includes the requirement for data that are adequate to document the claimed days. *The hospitals bear the burden of proof and must verify with the State that a patient was eligible for Medicaid (for some covered services) during each day of the patient's inpatient hospital stay. As the intermediaries may require, hospitals are responsible for and must furnish appropriate documentation to substantiate the number of patient days claimed.* Days for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid cannot be counted.[21]

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[18] 51 Fed. Reg. at 16777 (emphasis added) (discussing the DSH adjustment process as being "similar to the process we use to make the additional payment for indirect medical education costs").
[19] CMS was formerly known as the Health Care Financing Administration ("HCFA").
[20] HCFA Ruling 97-2 at 3 (February 27, 1997), *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/Downloads/HCFAR972.pdf (last visited December 28, 2012).
[21] *Id.* (emphasis added).

In the final rule published on July 31, 1998, CMS conformed the DSH regulations located in 42 C.F.R. § 412.106 "to the new statutory construction issued in HCFA Ruling 97-2."[22] In particular, as part of this final rule, CMS incorporated the hospital's obligation to provide Medicaid eligible days data into regulation at § 412.106(b)(4)(iii).[23] As a result of this revision (as well as other subsequent revisions), § 412.106(b)(4) read as follows during the time at issue:

> (4) *Second computation.* The fiscal intermediary determines, for the same cost reporting period used for the first computation [*i.e.*, the Medicare fraction], 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. For purposes of this second computation [*i.e.*, the Medicaid fraction], the following requirements apply:
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> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
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> (ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.
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> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.[24]

In 2003, Congress addressed a provider's access to information needed to calculate the DSH Medicare and Medicaid fractions, as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA").[25] Specifically, MMA § 951 requires CMS to "*arrange to furnish* to subsection (d) hospitals ... the data necessary for such hospitals to compute the number of patient days used in computing the disproportionate patient percentage under such section for that hospital for the current cost reporting year."[26]

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[22] *See* 63 Fed. Reg. 40954, 40985 (July 31, 1998).
[23] *Id. See also* Program Memorandum, CMS Pub. No. 60A, Transmittal No. A-01-13 (Jan. 25, 2001) (reissuing Program Memorandum, CMS Pub. No. 60A, Transmittal No. A-99-62 (Dec. 1, 1999)). This memorandum specifies that: "Regardless of the type of allowable Medicaid day, *the hospital bears the burden of proof and must verify with the State* that the patient was eligible under one of the allowable categories during each day of the patient's stay. The Hospital is *responsible for* and must provide adequate *documentation to substantiate the number of Medicaid days claimed. Days for patients that cannot be verified by State* records to have fallen within a period wherein the patient was eligible for Medicare as described in this memorandum *cannot be counted.*" *Id.* (emphasis added).
[24] 42 C.F.R. § 412.106(b)(4) (2005) (emphasis in original).
[25] Pub. L. No. 108-173, 117 Stat. 2066 (2003).
[26] *Id.* at 2427 (emphasis added.)

In the preamble to the final rule published on August 12, 2005,[27] CMS discussed its implementation of MMA § 951. CMS stated that "we interpret section 951 to require CMS to arrange to furnish the personally identifiable information that would enable a hospital to compare and verify its records ..., in the case of the Medicaid fraction, against the State-Medicaid agency's records."[28] CMS maintained that it has satisfied its § 951 obligation under this interpretation because the "established mechanisms" in place at the States allow providers to obtain access to this Medicaid days data and these mechanisms are sufficient.[29] Moreover, CMS reiterated the idea that providers bear ultimate responsibility for verifying the Medicaid eligibility of patients claimed on their cost reports since they furnished inpatient care to the patients underlying any claimed days and, thereby, should be in possession of much of the information needed to verify the days:

> In addition, we believe it is reasonable to continue to place the burden of furnishing the data adequate to prove eligibility for each Medicaid patient day claimed for DSH percentage calculation purposes on hospitals because, *since they have provided inpatient care to these patients for which they billed the relevant payers, including the State Medicaid plan, they will necessarily already be in possession of much of this information. We continue to believe hospitals are best situated to provide and verify Medicaid eligibility information.* Although we believe the mechanisms are currently in place to enable hospitals to obtain the data necessary to calculate their Medicaid fraction of the DSH patient percentage, there is currently no mandatory requirement imposed upon State Medicaid agencies to verify eligibility for hospitals. At this point, we continue to believe there is no need to modify the Medicaid State plan regulations to require that State plans verify Medicaid eligibility for hospitals. However, should we find that States are not voluntarily providing or verifying Medicaid eligibility information for hospitals, we will consider amending the State plan regulations to add a requirement that State plans provide certain eligibility information to hospitals.[30]

All providers are required to file cost reports annually, with reporting periods based on the provider's fiscal or accounting year. A cost report shows the costs incurred during the relevant fiscal year and the portion of those costs allocated to Medicare.[31] Each 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").[32] As noted in HCFA Ruling 97-2, under the "normal procedures," intermediaries determine DSH adjustment payments under the IPPS for a cost reporting period based, in part, on the Medicaid eligible days that providers claim on the relevant cost report forms. An intermediary's determination of a provider's eligibility for a DSH adjustment during a cost reporting period and, if eligible, the amount of that adjustment, is issued as part of the relevant NPR.

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[27] 70 Fed. Reg. 47278 (Aug. 12, 2005).
[28] *Id.* at 47438.
[29] *Id.* at 47442.
[30] *Id.* (emphasis added). *See also* 63 Fed. Reg. at 40985 (July 31, 1998) (stating that "[o]ur proposed revisions to §412.106(b)(4), like the Ruling [97-2], would continue to place on the hospital *the burdens of production, proof, and verification* as to each claimed Medicaid patient day" (emphasis added)).
[31] *See* 42 C.F.R. §§ 413.20, 413.24.
[32] *See* 42 C.F.R. § 405.1803.

Based on the above, the Board concludes that: (1) the provider has an obligation to submit Medicaid days information as part of the cost reporting process; and (2) this obligation is separate and distinct from the DSH adjustment determination process. If a provider is dissatisfied with the intermediary's determination of its Medicaid days, the provider can exercise appeal rights in accordance with the regulations set forth in 42 C.F.R. Part 405, Subpart R.[33]

As previously discussed, HCFA Ruling 97-2 expanded the days included in the numerator of the Medicaid fraction from Medicaid paid days to Medicaid paid and unpaid days (*i.e.*, Medicaid eligible days). Further, as part of HCFA Ruling 97-2 and the subsequent promulgation of 42 C.F.R. § 412.106(b)(4)(iii), CMS codified the provider's obligation to claim only those Medicaid eligible days that have been verified by State records. In this regard, that Ruling states that "[c]laims [for Medicaid eligible days] must, of course, meet other applicable requirements" such as "the requirement for data adequate to document the claimed [Medicaid eligible] days" and that "[d]ays for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid cannot be counted." Similarly, the preamble to the July 1998 Final Rule that promulgated § 412.106(b)(4)(iii) states "[o]ur proposed revisions to § 412.106(b)(4), like the Ruling, would continue to place on the provider the burdens of production, proof, and verification *as to each **claimed** Medicaid patient day*."[34] Thus, CMS made clear that, following the expansion of Medicaid days to include paid and unpaid days, providers continued to have the responsibility of claiming the relevant Medicaid days on the cost report (*i.e.*, "production") and proving and verifying with the State each of those claimed days.

This expansion of the types of days included in the numerator of the Medicaid fraction to include State-verified Medicaid eligible days that were unpaid created challenges for providers. Historically, the data needed by providers from the State to verify Medicaid eligibility during a specific fiscal year often had not been available for months or even years after the cost report filing deadline for that fiscal year had tolled. This lack of availability and/or access to State data created a practical impediment to reporting all Medicaid eligible days (both paid and unpaid) for a given fiscal year at the time of the relevant cost report filing deadline. Specifically, it created situations where none (or only a portion) of the relevant Medicaid eligible days data for a fiscal year was available from the State prior to the cost report filing deadline for that fiscal year. In those situations, as required by HCFA Ruling 97-2, providers were to claim only those Medicaid eligible days that were verified by State records.

Notwithstanding the increased complexity associated with reporting Medicaid eligible days data, CMS did not identify and adjust for that complexity when it implemented HCFA Ruling 97-2 as well as CMS' obligation under MMA § 951 to "arrange to furnish the personally identifiable information that would enable a hospital to compare and verify its records, … in the case of the Medicaid fraction, against the

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[33] *See* 51 Fed. Reg. at 31458-31459. *See also* Board Rule 8.2; *see generally* Board Rule 8. Board Rule 8.0 addresses how to frame issues for adjustments involving multiple components and Board Rule 8.2 describes a DSH adjustment as the type of adjustment that may involve multiple issue components. Board Rule 8.1 specifies that "[t]o 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 [Board] Rule 7." Similarly, the Board Rules in effect from March 1, 2002 to August 21, 2008 specified the following in Part I.B.II.a: "You must clearly and specifically identify your position in regard to the issue in dispute. For instance, if you are appealing an aspect of the disproportionate share (DSH) adjustment factor or calculation, do not define the issue as 'DSH.' You must precisely identify the component of the DSH issue that is in dispute."

[34] 63 Fed. Reg. at 40985 (emphasis added).

State-Medicaid agency's records."[35] In particular, CMS has not addressed how the practical impediment described above (*i.e.*, the fact that only Medicaid eligible days verified by the State can be claimed and that the data needed to verify Medicaid eligibility may not be available through no fault of the provider) may affect a provider's appeal rights under 42 U.S.C. § 1395oo(a).[36] As described below, the Board concludes that this practical impediment is similar to the legal impediment in *Bethesda*.

In *Bethesda*, the Supreme Court was presented a situation where regulations prohibited a provider from claiming certain items on its cost report. The provider filed its report in compliance with the applicable regulations, but later sought to use the Board appeals mechanism as a means to address the perceived reimbursement shortfall. The Supreme Court held that the "dissatisfaction" requirement could be met absent an adverse adjustment from a fiscal intermediary, stating:

> We agree that under 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.[37]

The Supreme Court concluded that "petitioners could claim dissatisfaction within the meaning of the statute, without incorporating their challenge in the cost report filed with their fiscal intermediaries."[38]

Application of the *Bethesda* holding has resulted in a perception that the "dissatisfaction" demonstration threshold has been lowered. This in turn, had led providers to attempt to apply *Bethesda* reasoning to expand the Board's jurisdiction over a variety of claims that might not have been otherwise appealed. However, the precise contours of the *Bethesda* decision are subject to dispute.

The Board recognizes that CMS promulgated regulatory provisions to address *Bethesda* situations in the final rule published on May 23, 2008 (May 2008 Final Rule).[39] Specifically CMS promulgated new regulatory provisions at 42 C.F.R. § 405.1835(a)(1) describing how a provider can preserve its right to claim dissatisfaction and to pursue a Board hearing:

> (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—
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> (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—

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[35] 70 Fed. Reg. at 47438.
[36] The Board is not aware of CMS ever revisiting its 1986 evaluation of "the need to publish regulations to outline procedures and requirements for hospitals to follow in applying for a disproportionate share adjustment based on the patient revenue criteria under section 1886(d)(5)(F)(i)(II) of the Act." 51 Fed. Reg. at 31457.
[37] *Bethesda Hospital Ass'n v. Bowen*, 485 U.S. 399, 404 (1988).
[38] *Id.* at 405.
[39] 73 Fed. Reg. 30190 (May 23, 2008).

> (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
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> (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)).[40]

Significantly, CMS describes the new § 405.1835(a)(1)(ii) as "more akin simply to a presentment requirement" than "an exhaustion requirement."[41]

Section 405.1835(a)(1)(ii) states that the "presentment requirement" is not applicable to FYs that end prior to December 31, 2008 and, thereby, is not applicable to this case. Nevertheless, the regulatory history indicates that CMS anticipated that a provider may protest self-disallowed claims in compliance with § 405.1835(a)(1)(ii) where the cost is unknown and still have appeal rights. In the preamble to the May 2008 Final Rule, CMS recognized that providers can appeal certain situations where the provider is uncertain about the cost of a protested item and does not have access to the underlying data to verify such costs. Specifically, in connection with "Provider Hearing Rights," CMS states the following in the preamble:

> In § 405.1811(b)(2)(i) and § 405.1835(b)(2)(i), we proposed that a provider would be required to explain its dissatisfaction with the amount of Medicare payment for the specific item(s) at issue by stating why Medicare payment is incorrect for each disputed item. *We acknowledge that there may be instances in which a provider may be uncertain as to whether Medicare payment is incorrect because it does not have access to the underlying data* ***(for example, data from a State agency)***. Accordingly, we have revised § 405.1811(b)(2)(i) and § 405.1835(b)(2)(i) to allow a provider to explain why it is unable to determine whether payment is correct as a result of not having access to underlying information.[42]

This preamble supports the Board's application of *Bethesda* to this case, namely that, prior to the "presentment requirement" specified in § 405.1835(a)(1)(ii) going into effect, a provider was not required to "present" or "claim" Medicaid eligible days which (through no fault of the provider) could not be identified and/or verified with the State because the provider did not have access to the data from the State necessary to identify and/or verify those days.

The Board's application of *Bethesda* is also consistent with Board Rule 7, entitled "Issue Statement and Claim of Dissatisfaction." The portions of Board Rule 7 that apply to this case are only those portions which do not involve the § 405.1835(a)(1)(ii) "presentment requirement" governing self-disallowed

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[40] *Id.* at 30249 (italics in original).
[41] *Id.* at 30196-30197.
[42] *Id* at 30194 (emphasis added) (quoting from Section II.D entitled "Provider Hearing Rights (§ 405.1803(d), § 405.1811, and § 405.1835)").

items.[43] Specifically, Board Rule 7.1 describes what is required for issue statements that are included in appeal requests and address "NPR or Revised NPR Adjustment." It recognizes in Paragraph B that there may situations where a provider may not have access to data:

> **B. No Access to Data**: If the Provider, *through no fault of its own*, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.[44]

Similarly, Board Rule 7.2 describes what is required for issue statements addressing "Self-Disallowed Items" and recognizes in Paragraph B that there may be situations where a provider may not have access to data:

> **B. No Access to Data**
> If the Provider elects to not claim an item on the cost report because, *through no fault of its own*, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon filing the cost report.[45]

Finally, the Board believes that the basis for above preamble discussion and for Board Rules 7.1.B and 7.2.B continues to exist. In particular, the Board believes that, despite recent improvements in the availability of data, some providers may still experience delays in obtaining access to this State data (*e.g.*, some States will not accept requests relating to a fiscal year until the cost report filing deadline for that fiscal year has tolled).

In a February 2014 published decision, the Board ruled that it did not have jurisdiction over a reimbursement appeal filed by Danbury Hospital under circumstances very similar to the present case.[46] In *Danbury*, the provider claimed that it was unable to obtain the State-maintained information necessary to verify the Medicaid eligibility of its patients. The lack of verified information, it was argued, hindered the provider's ability to fully and accurately claim Medicaid eligible days on its cost report. Therefore, the provider filed a cost report that included only those days that were verified prior to the reporting deadline. The provider subsequently pursued a Board appeal in which it sought additional DSH reimbursement based on the inclusion of newly-verified Medicaid eligible days.

The provider argued that Board jurisdiction over its appeal was proper based upon *Bethesda*, claiming that *Bethesda* stands for the idea that a provider may appeal costs which it excludes from its cost report, if the inclusion of such items would be futile. The Provider asserted that the Medicaid eligible days are often not available from the State in time for the Provider to include them on the cost report prior to the filing deadline. In support of its position, the Provider asserted that prior Board jurisdiction decisions have suggested that the "practical difficulties in getting [State] information combined with the Secretary's statement that it is not necessary for hospitals to formally apply for a DSH adjustment create circumstances in which a provider may demonstrate that it is dissatisfied with the Intermediary's

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[43] Subsection C of Board Rule 7.2 addressing the protest of self-disallowed items applies to cost reporting periods ending on or after December 31, 2008. As the cost reporting year in this case ended December 31, 2001, subsection C is not applicable.
[44] (Bold emphasis in original and italics added.)
[45] (Bold emphasis in original and italics added.)
[46] *Danbury Hospital v. BlueCross BlueShield Ass'n/Nat'l Govt. Serv. Inc.* PRRB Decision No. 2014-D3 (February 11, 2014).

determination of reimbursement despite not having made a claim on the cost report." The Provider essentially asserted that the preambles to the May 1986 Interim Final Rule and the September 1986 Final Rule confirm that providers do not need to make a formal claim for a DSH adjustment and that providers can later submit additional Medicaid eligible days data if they believe their cost report is not accurate.[47]

As discussed above, the Board has interpreted and applied *Bethesda* such that, prior to the "presentment requirement" specified in § 405.1835(a)(1)(ii) going into effect, a provider was not required to "present" or "claim" Medicaid eligible days that (through no fault of the provider) could not be identified and/or verified with the State because the provider did not have access to the data from the State necessary for such identification and/or verification. However, a provider does have an obligation to establish that a practical impediment did exist preventing it from obtaining required verification from the State. In this regard, if the practical impediment theory were allowed to proceed, the provider would have a high burden of proof to establish the existence of such a practical difficulty.[48]

As a consequence, in the *Danbury* case, the Board asked the Provider to bolster the record on two separate occasions. However, despite the Board requests, the Provider failed to demonstrate the existence of a practical impediment that prevented it from claiming the additional days on the as-filed cost report. Therefore, the Board concluded that it did not have jurisdiction under 42 U.S.C. § 1395oo(a) to hear the Provider's claim for additional Medicaid eligible days pursuant to *Bethesda* because the Provider failed to establish that there was a practical impediment, through no fault of the Provider, preventing the Provider from identifying and/or verifying the additional days with the State prior to the filing of the cost report.

In light of *Danbury,* the Board issued Alert 10 on May 23, 2014. This Alert allowed parties to an appeal currently pending before the Board that included the Disproportionate Share Payment ("DSH") paid/unpaid Medicaid eligible days issue an opportunity to supplement the record based on the *Danbury* decision. Specifically, the parties were given 60 days from the date of the Alert to supplement the record with additional arguments and/or documentation that would be relevant to the Board making a jurisdictional decision on the issue.

In particular, the Board was interested in receiving the following provider-specific information or documentation to the extent it was not already in the record:

- A detailed description of the process that the provider used to identify and accumulate the actual paid and unpaid eligible days that were reported and filed on the Medicare cost report at issue.

- The number of additional paid and unpaid eligible days that the provider is requesting to be included in the DSH calculation.

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[47] *Id.* at 12.

[48] *See also* Administrator Dec. (May 21, 2012), reversing, PRRB Dec. No. 2012-D14 (Mar. 19, 2012). The *Norwalk* provider appealed to federal district court and the case was later dismissed. The record suggests that the parties settled the case and that the provider requested dismissal of its appeal. *See* Joint Status Rep. at ¶ 1 (Sept. 16, 2013) and Stipulation of Dismissal (Nov. 5, 2013), *Norwalk Hosp. Ass'n v. Sebelius*, Case No. 3:12-cv-01065-JBA (D. CT. filed July 20, 2012 and dismissed Nov. 5, 2013) (stating in the Joint Status Report that "[o]n or about July 23, 2013, the parties reached an agreement in principle with respect to settlement of the...appeal").

- A detailed explanation why the additional Medicaid paid and unpaid eligible days at issue could not be verified by the state at the time the cost report was filed. If there is more than one explanation/reason, identify how many of these days are associated with each explanation reason.

In the instant appeal, the Provider did not submit any additional arguments and/or documentation in response to the specific information/documentation requested in Alert 10. No detailed description of the process that the Provider used to identify and accumulate the actual paid and unpaid eligible days was supplied. Likewise, no detailed explanation why the additional days at issue could not be verified by the State at the time the cost report was filed was provided.

The Board finds that the Provider has not presented any evidence of the internal process it followed to gather State information for reporting DSH Medicaid eligible days on the cost report. Although the Provider explained general reasons why it was difficult to submit a complete and accurate listing of Medicaid eligible days at the time it filed its cost report, it did not explain which, if any, of those reasons were an impediment to the reporting of the days at issue in this appeal.

Therefore, the Board concludes that it does not have jurisdiction under 42 U.S.C. § 1395oo(a) to hear the claim for the 261 additional Medicaid eligible days pursuant to *Bethesda,* because the Provider failed to establish that there was a practical impediment, through no fault of the Provider, preventing the Provider from identifying and/or verifying the days with the State prior to the filing of the cost report.

Notwithstanding the Board's denial of jurisdiction under 42 U.S.C. § 1395oo(a) to hear the Medicaid eligible days claim, the Board recognizes that the Provider did include in its original appeal other issues which establish the Board's jurisdiction under 42 U.S.C. § 1395oo(a) to hold a hearing (*e.g.*, whether the Intermediary used the correct Medicaid paid days in the DSH calculation) and that the Board could exercise discretion under 42 U.S.C. § 1395oo(d) to hear the Medicaid eligible days claim.[49] However, the Board declines to exercise its discretion under subsection (d). In this regard, the Board notes that it decides whether to exercise discretion on a case-by-case basis and that the record for this case contains little if anything for the Board to consider as the Provider has neither presented any evidence supporting its claim that a practical impediment existed, nor asked and explained why the Board should exercise jurisdiction under subsection (d).

The Board hereby dismisses the Medicaid eligible patient days issue from the case for lack of jurisdiction. Because the Provider did not brief the Medicaid paid days issue in its position papers, this issue is deemed to be abandoned and is also dismissed from the appeal. As there are no issues remaining, Case No. 05-1390 is closed.

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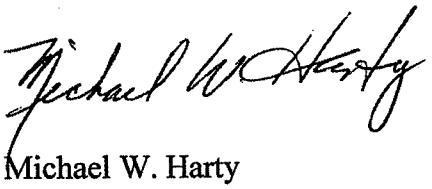
[49] *See St. Vincent Hosp. & Health Ctr. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2013-D39 at 13, 15 (Sept. 13, 2013) (stating that "the Board has generally interpreted [42 U.S.C.] § 1395oo(a) as: (1) the gateway to establishing Board jurisdiction to hear an appeal; and (2) ... requiring that dissatisfaction be expressed with respect to total reimbursement for 'each claim' ... because the Board has viewed 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" (citations omitted) and "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)"). *See also MaineGeneral Med. Ctr. v. Shalala*, 205 F.3d 493 (1st Cir. 2000).

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: Kevin D. Shanklin, Executive Director, Blue Cross Blue Shield Association

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Refer to: 08-2928G

NOV 03 2014

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Kyle Browning
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MP: INA102 – AF42
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RE: Jurisdictional Decision
QRS 2003 DSH/SSI Proxy Group 3
Provider No.: Various
FYE: Various (2003)
PRRB Case No.: 08-2928G

Dear Mr. Ravindran and Mr. Browning,

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

Memorial Regional Hospital, provider no. 10-0038, FYE 4/30/2003

Memorial Regional Hospital, listed as participant 8 on the Schedule of Providers, was issued an original Notice of Program Reimbursement (NPR) for FYE 4/30/2003 on September 21, 2006. The Provider requested to transfer the SSI percentage issue to this group appeal on April 11, 2014, however the Provider was remanded pursuant to CMS Ruling 1498-R as part of case number 05-1966G on December 7, 2012.

University Medical Center, provider no. 45-0686, FYE 12/31/2003

University Medical Center, listed as participant 17 on the Schedule of Providers, was issued an original NPR for FYE 12/31/20023 on October 12, 2006. The Provider requested to transfer the SSI percentage issue to this group on April 7, 2010; the Board denied this request on April 28, 2010.

University Medical Center, provider no. 45-0686, FYE 12/31/2003

University Medical Center, listed as participant 18 on the Schedule of Providers, was issued a revised NPR for FYE 12/31/2003 on July 28, 2010. The Provider requested to be directly added to this group appeal on November 15, 2010.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1841, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date the notice of the intermediary's determination was mailed to the provider. However, before the Board can make a determination over all matters covered by the cost report, it must first determine that the Provider has filed a jurisdictionally valid appeal.

Although the Intermediary did not file a jurisdictional challenge, the Board nonetheless finds that it does not have jurisdiction over University Medical Center's revised NPR appeal for FYE 12/31/2003 because the Provider appealed from a revised NPR in which the issue on appeal, the SSI percentage, was not specifically revised. The Provider was issued a revised NPR on July 28, 2010. The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 provides, in relevant part:

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

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

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

The Board finds that it does not have jurisdiction over University Medical Center's revised NPR appeal because the documentation submitted does not establish that the SSI percentage was specifically revised. The Provider was issued a revised NPR in response to an administrative resolution in case number 07-1790. The Notice of Reopening issued by the Intermediary

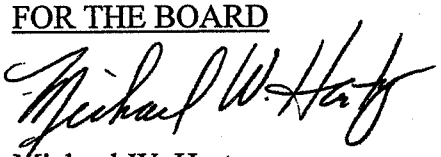
explained that the Provider's cost report was being reopened in order to adjust Medicaid Eligible Days. Adjustment number R2-004 shows that there was an adjustment to DSH, but from the other documents submitted, the SSI percentage was not adjusted. The Provider did not establish that the SSI percentage was specifically revised as required by the regulations and is hereby dismissed from this appeal.

The Board also hereby confirms that Memorial Regional Hospital and University Medical Center (original NPR appeal) are not proper participants in case number 08-2928G. Memorial Regional Hospital was remanded as a participant in another group appeal prior to requesting to transfer to this group, therefore the Board denies that transfer request. The Board has already denied University Medical Center's transfer request, because its individual appeal was closed on April 6, 2010 pursuant to an Administrative Resolution, prior to the April 7, 2010 transfer request. Therefore, Memorial Regional Hospital and University Medical Center (original NPR appeal) are not participants in case number 08-2928G.

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 upon final disposition of the appeal.

Board Members
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: Kevin D. Shanklin, BCBSA

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Refer to:

07-2748GC

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NOV 06 2014

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RE: Group Name: GNP Adventist Health 2000-09/30/2004 DSH Dual Eligible Days CIRP Group
Provider No.: Various
FYE: 2000 – 09/30/2004
PRRB Case No.: 07-2748GC

Dear Ms. Gong and Ms. Kalafut,

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.

Background

The Board received the request to establish this Common Issue Related Party (CIRP) group appeal on September 10, 2007. The appeal included a challenge to the treatment of Dual Eligible (DE) days in the calculation of the Disproportionate Share Payment adjustment for Fiscal Year Ends (FYEs) 2000 – 2006. The Board bifurcated this case in the beginning of 2014 in order to transfer out any FYEs that did not fall under CMS Ruling CMS-1498-R.

The treatment of DE days was one of the issues covered by CMS-1498-R. Pursuant to CMS-1498-R, "CMS and the Medicare contractors will resolve each properly pending DSH appeal, for cost reports with patient discharges before October 1, 2004, in which the hospital seeks inclusion in the [Disproportionate Patient Percentage (DPP)] of inpatient days where the patient was entitled to Part A benefits but the inpatient hospital stay was not covered under Part A or the patient's Part A hospital benefits were exhausted."[1] Therefore, only those periods prior to October 1, 2004 remain in Case No. 07-2748GC.[2]

[1] CMS Ruling CMS-1498-R 10-11, Apr. 28, 2010.
[2] Participants 18, 20-23 on the Schedule of Providers were transferred in their entirety to other group appeals based on FYEs, specifically Case Nos. 14-2862GC [GNP Adventist Health 10/1/2004-2005 Post 1498R DSH Dual Eligible Days CIRP Group]; 14-2880GC [GNP Adventist Health 2006 DSH Medicaid Fraction Dual Eligible Days

Board's Determination

The Board finds that it has jurisdiction over all of the Providers in the Group except for St. Helena Hospital, Provider No. 05-0013 (Participant 14), which appealed from a revised Notice of Program Reimbursement (RNPR) that did not adjust DE days.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2006), 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 Contractor, (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.

The Code of Federal Regulations provides an opportunity for a provider to obtain a revised Notice of Program Reimbursement (RNPR) through a reopening of its cost report. 42 C.F.R. § 405.1885 provides, in relevant part:

> (a) A determination of an intermediary, a decision by a hearing officer or panel of hearing officers, a decision by the Board, or a decision of the Secretary may be reopened with respect to findings on matters at issue in such determination or decision, by such intermediary officer or panel of hearing officers, Board, or Secretary, or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings. Any such request to reopen must be made within 3 years of the date of notice of the intermediary determination. No such determination or decision may be reopened after such 3-year period except as provided in paragraphs (d) and (e) of this section.

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

> Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in § 405.1885, such revision shall be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1835, 405.1837, 405.1875 and 405.1877 are applicable.

Here, Participant 14 appealed from a RNPR dated September 24, 2007. The Medicare Administrative Contractor (Contractor) reopened the cost report to adjust Medicaid Eligible Days. Participant 14 failed to submit any documentation indicating that DE days were reviewed

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CIRP Group]; and, 14-2881GC [GNP Adventist Health 2007 DSH Medicaid Fraction Dual Eligible Days CIRP Group]. Further, the cost reporting periods for Participants 15, 16, and 19 were amended to reflect only the period covered under CMS-1498-R; e.g., 01/01/2004 – 09/30/2004. The remaining portion of the fiscal year from 10/1/2004 – 12/31/2004 was also transferred to Case No. 14-2862GC [GNP Adventist Health 10/1/2004-2005 Post 1498R DSH Dual Eligible Days CIRP Group].

or revised by the Contractor. Thus, pursuant to 42 C.F.R. § 405.1889, the DE days are beyond the scope of any appeal of the revised determination.[3] The Board finds that it lacks jurisdiction over Participant 14 and therefore St. Helena Hospital is dismissed from this case.

The Board has found that it has jurisdiction over the remaining Providers and will issue a remand under separate cover.

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.
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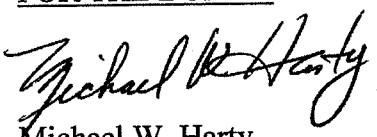
FOR THE BOARD



Michael W. Harty
Chairman

cc: Kevin Shanklin, BCBSA

[3] *See also HCA Health Services of Oklahoma, Inc. v. Shalala*, 27 F.3d 614, 615 (D.C. Cir. 1994) (holding that a provider's appeal of that reopening is limited to the specific issues revisited on reopening).

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NOV 14 2014

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RE: Charleston Area Medical Center
Provider No: 51-0022
FYE: 12/31/2006
PRRB Case No.: 12-0521

Dear Mr. Nash:

The Provider Reimbursement Review Board (Board) has reviewed the August 14, 2012 (received August 15, 2012) and September 28, 2012 (received October 1, 2012) hearing requests and Motions for Good Cause Extension of Time or Request for Equitable Tolling and the October 4, 2013 (received October 17, 2013) Motion for Reconsideration in the above referenced case. The Board's decision is set forth below.

Background

On February 24, 2010, a Notice of Program Reimbursement (NPR) was issued to the Provider, Charleston Area Medical Center, Provider No. 51-0022, for the cost reporting period ending December 31, 2006. On August 15, 2012, the Provider filed an appeal of the NPR challenging Medicare outlier payments and filed a Motion for a Good Cause Extension of Time for requesting the individual appeal, or in the alternative, a Request for Equitable Tolling. The Board assigned case number 12-0521 to the case. On October 1, 2012, the Provider filed another individual appeal request challenging the rural floor budget neutrality adjustment (RFBNA) and filed a Motion for a Good Cause Extension of Time for requesting the individual appeal, or in the alternative, a Request for Equitable Tolling. The Board added the RFBNA issue to case number 12-0521.

On July 31, 2013, the Board issued a decision denying the Provider's Request for a Good Cause Extension of Time and for Equitable Tolling as to the RFBNA issue. The Board dismissed the appeal, case number 12-0521, and closed the case as the Board believed that the RFBNA issue was the sole issue in the appeal. On August 5, 2013, the Medicare Administrative Contractor (MAC) filed a jurisdictional challenge contending that the Provider's appeal of the Medicare outlier payments and the RFBNA issues were untimely. On August 30, 2013, the Provider submitted a response to the Intermediary's jurisdictional challenge. On October 17, 2013, the Provider submitted a Motion for Reconsideration of the Board's July 31, 2013 decision dismissing the appeal.

MAC's Position

The MAC contends that the Provider's appeal of its Medicare outlier reimbursement and its appeal of the RFBNA was untimely. The MAC argues that the Provider's NPR is dated February 24, 2010, and the appeal requests were filed well beyond the 180 day deadline established at 42 C.F.R. § 405.1835(a)(3). The MAC maintains the Provider acknowledges its appeals are beyond the 180 day deadline and has requested a good cause exception for the appeal of each issue. Alternatively, the Provider has requested equitable tolling of the applicable 180 day filing period. The MAC contends in the Supreme Court case of *Sebelius v. Auburn Regional Medical Center*, 133 S.Ct. 817 (2013), the Court found that equitable tolling did not apply to appeals filed after the 180 day required deadline. If a provider has not timely filed an appeal the jurisdictional requirement has not been met. As such, the MAC requests that the Board dismiss the appeal of both the RFBNA and outliers issues.[1]

Provider's Position

The Provider contends that the good cause extension is separate from and in addition to the right to equitable relief. The Provider argues the *Auburn* opinion distinguishes these two rights by holding that the Secretary's good cause extension regulation is a permissible interpretation of the Medicare statute, but equitable tolling should not apply to the 180 day deadline. The Provider maintains the MAC misplaces its reliance on the portions of the *Auburn* decision relating to equitable tolling. The ability to request good cause extension is a separate and distinct right and cannot be so summarily dismissed.[2]

Motion for Reconsideration

The Provider contends justice requires that the Board reconsider its July 31, 2013 dismissal of case number 12-0521, because the Board only ruled on one of two separate pending issues and there have been significant changes in the law and facts since the submission of the issue. The Provider maintains that it has challenged two separate payment issues in PRRB case number 12-0521. First, it claims that it was not paid the full amount of the supplemental Medicare outlier payments to which it is entitled. Second, the Provider challenges the validity of the RFBNA factor and the underpayment that resulted for fiscal year ending (FYE) 2006. The Provider argues the Board's July 31, 2013 dismissal, however, addressed only the Provider's RFBNA challenge and did not mention the outliers challenge. The Board dismissed case number 12-0521 under the mistaken notion that the RFBNA challenge was the sole issue in the case. The Provider contends the Board's dismissal is inconsistent with the Board's prior actions in this case because the Board acknowledged case number 12-0521 in connection with the outliers challenge, but did not rule on the good cause extension for the outliers challenge.[3]

The Provider maintains the Board's dismissal was based on misstatements of procedural facts. In addition to misstating that the RFBNA issue was the sole issue in the case, the Board mistakenly stated in its dismissal letter that the Provider's claims were filed more than three years after

[1] MAC's Jurisdictional Challenge at 2-3.
[2] Provider's Response to MAC's Jurisdictional Challenge at 5.
[3] Provider's Motion for Reconsideration at 3-4.

issuance of the final determination. The Provider argues this is a material misstatement of procedural facts because the Provider filed the claims within 31 and 33 months, respective to each Motion for Good Cause Extension, of receiving the NPR. Further, The Provider contends that the Board erroneously applied the post-2008 good cause extension regulation in the dismissal. The Provider maintains that it treated patients in FYE 2006 and the right to appeal these claims accrued before the 2008 amendments to the PRRB regulations. Therefore, the Provider argues the regulations as they existed prior to the 2008 amendments[4] apply to its motion.

The Provider contends reconsideration is also necessary because the Board failed to consider controlling or significant changes in the law or facts since the submission of the issues. The Provider argues since the time when the two Motions for Good Cause extensions were filed, there have been two significant factual and legal developments, one relating to the scope of the Secretary's good cause extension regulation and the other relating to the facts surrounding the agency's FLT regulations in the outliers challenge.[5] The Provider maintains the *Auburn*[6] decision provided guidance as to the proper scope of the good cause extension. Justice Sotomayor's concurring opinion is instructive on this point. Discussing the majority opinion, Justice Sotomayor stated:

> While the providers in this case allege that the agency's failure to disclose information about how it calculated the Supplemental Security Income fraction prevented them from bringing timely challenges to reimbursement determinations, I am satisfied that the Secretary's 3-year good-cause exception is a reasonable accommodation of the competing interests in administrative efficiency and fairness. We would face a different case if the Secretary's regulation did not recognize an exception for good cause or defined good cause so narrowly as to exclude cases of fraudulent concealment and equitable estoppel. *See* ante, at 3, n.2 (explaining that the Secretary's amended regulation limiting the scope of "good cause," 73 Fed.Reg. 30250 (2008) (codified in 42 C.F.R. § 405.1836(b) (2012)), is not before us).[7]

The Provider argues the dismissal described the standards for good cause as "[t]he Board may find good cause to extend a time limit in extraordinary circumstances beyond the Provider's control, such as natural catastrophes, fire or strike." Reading this in conjunction with Justice Sotomayor's concurring opinion, "extraordinary circumstances beyond the Provider's control" must necessarily also include "cases of fraudulent concealment and equitable estoppel." The Provider contends each of the Provider's two Motions for Good Cause Extension explained that extraordinary circumstances exist because the agency failed to disclose key information. The Provider maintains the Board erred in dismissing the Provider's Motion for Good Cause Extension without taking into account Justice Sotomayor's guidance in *Auburn*. The Provider

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[4] 42 CFR § 405.1841(b) (2006)
[5] *Id.* at 5-6.
[6] *Sebelius v. Auburn Regional Medical Center*, 133 S.Ct. 817 (2013).
[7] *Id.* at 830.

argues reconsideration is necessary for a Board finding of whether the allegations surrounding the RFBNA and outliers challenges constitute a case of "fraudulent concealment and equitable estoppel."[8]

The Provider contends that on May 16, 2013, Judge Colleen Kollar-Kotelley issued a memorandum opinion in *Banner Good Samaritan v. Sebelius*[9] which confirmed the role of the IFR in HHS' rulemaking. The court stated in reference to the IFR:

> In summary, there can be little doubt that the Interim Final Rule reflects views adverse to those finally adopted by the Secretary and that the Secretary considered—and indeed proposed to OMB—the Interim Final Rule as an alternative to its path to promulgation of the 2003 amended Outlier Payment Regulations now challenged by Plaintiffs.[10]

The Provider argues the *Banner Good Samaritan* court's holding confirms that HHS withheld the IFR's key information from the regulated industry. The Provider contends this decision is a significant change in the law and/or facts since the submission of the Medicare outlier issue last spring. The Board's determination of whether good cause exists should take the opinion into consideration. The Provider requests the reconsideration and reversal of the Board's dismissal.[11]

Motion for Good Cause Extension or Request for Equitable Tolling – Medicare Outlier Issue

The Provider concedes that it filed its hearing request more than 180 days after, but within three years of the date of its NPR for FYE 2006. The Provider maintains that although the Medicare Act does not provide an exception to the 180 day filing deadline, the Secretary's regulations at 42 C.F.R. § 405.1836 allow the Board to extend the deadline up to three years "for good cause shown."[12] The Provider contends "good cause" comprises extraordinary circumstances beyond the Provider's control that existed prior to the expiration of the 180 day appeal period. The Provider argues the Department of Health and Human Services (HHS), knowing decision not to disclose key information regarding its fixed loss thresholds (FLTs) relevant for FYE 2006, and its provision of misleading statements instead, constitute good cause.

The Provider cites to two documents which provided it with notice of HHS's failure to disclose key information: (1) HHS's initial Executive Order 12866 Submission of an "Interim Final Rule" (the IFR) to the Office of Management and Budget (OMB), relating to its 2003 revisions to the Outlier Payment Regulations; and (2) the HHS OIG Report, dated June 28, 2012, summarizing its review of the reconciliation process for outlier payments under the Medicare Part A prospective payment system (the OIG Report).

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[8] Provider's Motion for Reconsideration at 6-7.
[9] *Banner Good Samaritan v. Sebelius*, CA No. 10-01638 (CKK), 2013 U.S. Dist. LEXIS 69889 (D.D.C. May 16, 2013).
[10] *Id.* at *66.
[11] Provider's Motion for Reconsideration at 7-8.
[12] The Provider believes because it treated patients in FYE 2006 and the right to appeal these claims accrued before the 2008 amendments to the PRRB Regulation, the pre-2008 good cause regulations should apply.

The Provider maintains that the post-2008 regulation at 42 C.F.R. § 405.1836(b) requires that the Motion for Good Cause be filed within a reasonable time after the expiration of the 180 day period. The Provider argues that it discovered the IFR and first learned of key information confirming the basis of an appeal of its Medicare outlier case payments on February 17, 2012. It filed its appeal within 180 days of said discovery. Accordingly, good cause exists to permit its appeal of the Centers for Medicare and Medicaid Services' (CMS) underpayment of its FYE 2006 outlier case payments. Further, the OIG Report was published in June of 2012. Thus, the Motion was promptly filed after it discovered the key information that the Secretary knowingly kept from the PPS hospitals.

The Provider contends the "extraordinary circumstances" that serves as the basis of this Motion is the fact that HHS knowingly and deliberately concealed information that the FLTs for federal fiscal year (FFY) 2003-2007, used to calculate the Provider's supplemental Medicare outlier payments, were based upon data that was both inflated and otherwise flawed. The Secretary's decision not to use the best available data resulted in the Provider receiving smaller and fewer outlier case payments than the Provider was entitled to receive. The Provider argues that it could not reasonably have been expected to appeal the underpayments on the basis of this key information, which was withheld by the Secretary, regarding the process and data considered for the FLTs, and of which the Provider has only recently been made aware. The Provider maintains that the statements published in the Federal Register misled the Provider into believing that the Secretary had selected the best data, considered all important aspects of the problem regarding reconciliation, and administered the outlier program in a manner consistent with Congressional intent. The Secretary's deliberate concealment of her decisions not to do so prevented the Provider from timely appealing the underpayments for FYE 2006. These extraordinary circumstances require a good cause extension for requesting a Board hearing.[13]

The Provider contends that the Secretary's proposed regulation published on February 28, 2003 (March 5, 2003, in the Federal Register) omitted key data, facts, analysis and conclusions that the Secretary had set forth in the IFR, with the result that the Provider was unaware (until obtaining the IFR) that the Secretary had knowingly decided to use bad data and disregard analysis and conclusions favorable to the Provider when setting the FLTs for FFYs 2003-2007, thus resulting in the Provider receiving the underpayments. The Provider maintains that the IFR shows that the Secretary was aware of the problematic hyper-inflated charge data that resulted from her flawed pre-2003 Outlier Payment Regulations. The Secretary concluded that the agency was required, mid-year, to significantly lower the 2003 FLT down to $20,760 (from $33,560) in order to comply with the outlier payment statute's mandates and the intent of Congress. HHS failed to mention in the proposed regulation, among other key information, the agency's considered analysis quantifying the impact of the turbo-charging hospitals; the need and method to remove the turbo-charged data; and what HHS believed to be its statutory obligation to lower the FLT. Instead, HHS announced that it would leave the threshold at $33,560. The Provider contends by FFY 2006, HHS still had not accounted for the impact of the turbo charging data, still relied on hyper-inflated data in projecting the FLT, and had not returned the FLT to the level

[13] Provider's August 15, 2012 Motion for Good Cause or Request for Equitable Tolling at 1-2.

calculated and set forth in the IFR. As a result, the Provider continued to receive underpayments throughout FYE 2006. [14]

The Provider contends that in 2003, HHS changed the Outlier Payment Regulations to require audit and reconciliation of outlier case payments. However, since 2003, and in the face of consistent criticism in public comments received, HHS has consistently refused to consider the impact of any reconciliation when it sets the annual FLTs. HHS' stated reason for the refusal is as follows:

> [D]ue to the policy implemented in the June 9, 2003 outlier final rule, cost-to-charge ratios will no longer fluctuate significantly and, therefore, few hospitals, if any, will actually have these ratios reconciled upon cost report settlement. In addition, it is difficult to predict which specific hospitals will have cost-to-charge ratios and outlier payments reconciled in their cost reports in any given year. We also note that reconciliation occurs because hospital's actual cost-to charge ratios for the cost reporting period are different than the interim cost-to-charge ratio used to calculate outlier payments when a bill is processed. Our simulations assume that cost-to-charge ratios accurately measure hospital costs and, therefore, are more indicative of post-reconciliation than pre-reconciliation outlier payments. As a result, we omitted any assumptions about the effects of reconciliation from the outlier threshold calculation.[15]

The Provider maintains on June 28, 2012, the HHS OIG issued a report with results from its review of CMS' outlier reconciliation process. The OIG report demonstrated the inaccuracy of (and the key information omitted from) HHS' stated reasons for not considering the impact of reconciliation, in establishing the FLTs for FFYS 2004-2007. The Provider argues most compelling is the OIG's finding that seven years after CMS published its regulation requiring reconciliation, CMS has not reconciled any of the cost reports screened and reported up by its contractors. According to the OIG, the reason for this extraordinary delay was that CMS claimed it had not yet been able to develop a methodology for effecting those reconciliations. The Provider contends this claim—that CMS had not performed the required reconciliation because it could not—is not compatible with the reasons given, year after year, for not taking the effect of reconciliation into account when setting the annual FLTs.

The Provider argues accordingly, it was not until the OIG report came to light that it knew that CMS' published explanations in the Federal Register were misleadingly inaccurate. Prior to the OIG Report, the Provider did not know HHS' explanation was facially inaccurate, and thus could not have filed the instant appeal on this basis. The Provider contends this fact constitutes good cause to permit the late filing of the Provider's appeal.[16]

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[14] *Id.* at 3, 5.
[15] 70 Fed. Reg. 47278, 47495 (August 12, 2005).
[16] Provider's August 15, 2012 Motion for Good Cause or Request for Equitable Tolling at 6-7.

The Provider maintains should the Board not find good cause to grant the requested extension, the Board should hear this appeal on the basis of equitable tolling.[17] The Provider argues equitable tolling is especially appropriate in the instant case because the Secretary's statements published to the PPS hospitals have misrepresented key data, other facts, analysis, and conclusions supporting, and the reasons for adopting, the annual FLTs. The Provider contends equitable tolling is especially appropriate as it would be patently unfair to deny the Provider its right to contest its underpayments on the basis of information purposely hidden from the public and thus unavailable to the Provider.[18]

Decision of the Board

Motion for Reconsideration

Pursuant to 42 C.F.R. § 405.1885(a)(1) (2010), a decision by a reviewing entity may be reopened, for findings on matters at issue in a decision. A reopening made upon request is timely only if the request to reopen is received by the reviewing entity no later than three years after the date of the decision that is the subject of the requested reopening.[27]

In the instant case, the Provider timely filed a Motion for Reconsideration of the Board's July 31, 2013 decision dismissing case number 12-0521. The Provider offers as a reason for its request that the Board only ruled on one of two issues pending before the Board, the RFBNA issue, but failed to rule on the Medicare outlier payments issue prior to dismissing the appeal; the Board's dismissal was based on misstatements of procedural facts; and the dismissal failed to consider controlling or significant changes in the law or facts since the submission of the issues.

The Provider is correct in its allegation that the Board only addressed the Motion for Good Cause Extension or Request for Equitable Tolling as to the RFBNA issue but did not address the Motion for Good Cause Extension or Request for Equitable Tolling as to the Medicare outlier issue in its July 31, 2013 dismissal of case number 12-0521. The Board grants the Provider's Motion for Reconsideration and reopens case number 12-0521 for the sole purpose of ruling on the Provider's Motion for Good Cause Extension or Request for Equitable Tolling as to the Medicare outlier issue.

The Board's decision denying the Provider's Motion for Good Cause Extension or Request for Equitable Tolling as to the RFBNA issue remains unchanged. Although the Board inadvertently misstated the fact that the RFBNA issue was the sole issue in the case and that the Provider's claims were filed more than three years after issuance of the final determination in its dismissal decision, the rationale for the denial of the Motion for Good Extension or Request for Equitable Tolling as to the RFBNA issue has not changed.

In its July 31, 2013 decision, the Board denied the Request for a Good Cause Extension because the RFBNA errors were known as early as December 22, 2009, when the district court issued its

[17] The Provider acknowledges later in its response to the MAC's Jurisdictional Challenge that equitable tolling should not apply to the 180 day deadline. *See* Provider's Response to Mac's Jurisdictional Challenge at 5.
[18] Provider's August 15, 2012 Motion for Good Cause or Request for Equitable Tolling at 7.
[27] § 405.1885(b)(2).

decision in *Cape Cod Hosp. v. Sebelius*, 630 F.3d 203 (D.C. Cir. 2011). This was before the February 24, 2010 Notice of Program Reimbursement and well before the Provider filed its appeal on October 1, 2012. Therefore, there were no extraordinary circumstances beyond the Provider's control preventing it from filing its appeal timely. The Board also denied the Provider's Request for Equitable Tolling as the Board cannot consider equitable tolling to extend the time for filing.[28]

The Board also finds that Provider's right to appeal its claims did not accrue before the 2008 amendments to the regulations as the Provider contests. The Provider was not issued its NPR until February 24, 2010, after the 2008 regulations were issued, and as such did not have a right to file an appeal of its claims until this time.[29] The Board properly utilized the post-2008 good cause extension regulation.

Motion for Good Cause Extension or Request for Equitable Tolling – Medicare Outlier Issue"

Pursuant to 42 U.S.C. § 1395oo(a) (2010) and 42 C.F.R. § 405.1835-1840(a)(1) (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 and the request for a hearing is received by the Board within 180 days of the date of receipt of the final determination.

The Board may find good cause to extend the time limit only if the provider demonstrates in writing it could not reasonably be expected to file timely due to extraordinary circumstances beyond its control (such as a natural or other catastrophe, fire, or strike), and the provider's written request for an extension is received by the Board within a reasonable time (as determined by the Board under the circumstances) after the expiration of the applicable 180-day limit.[30]

In the instant case, the Provider concedes that it filed its appeal of the Medicare outlier issue more than 180 days after the date of receipt of its NPR. The Provider requests a good cause extension or in the alternative, requests equitable tolling of the 180 day filing deadline. The Provider's proffered reason for requesting a good cause extension, HHS' decision not to disclose key information regarding its fixed loss thresholds relevant for FYE 2006 and its provision of misleading statements, does not rise to the level required for good cause.

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 in turn 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 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.

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[28] *See Sebelius v. Auburn Regional Medical Center*, 133 S.Ct. 817 (2013).
[29] 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. 42 U.S.C § 1395oo(a) (2010).
[30] 42 C.F.R. § 405.1836(b) (2010).

In 2002, the Secretary disclosed that HHS was aware of "turbo-charging" and would be amending the outlier regulations to fix "vulnerabilities" in the regulations. In the March 5, 2003[31] and June 9, 2003[32] Federal Registers, the Secretary acknowledged three flaws in the outlier payment regulations and stated that the vulnerabilities would be fixed. CMS went on to state "[t]he steps we are proposing in this proposed rule to direct fiscal intermediaries to update cost-to-charge ratios using the most recent tentative settled cost reports (and in some case, even later data) and using actual rather than statewide average ratios for hospitals that have cost-to-charge ratios that are more than 3.0 standard deviations below the geometric mean cost-to-charge ratio, would greatly reduce the opportunity for hospitals to manipulate the system to maximize outlier payments. However, they would not completely eliminate all such opportunity."[33]

The Provider was given notice of the issue involving the turbo charging hospitals and was made aware of the potential of receiving underpayments due to turbo charging as early as March 5, 2003, in the proposed rule. This was well before the February 24, 2010 NPR was issued and before the Provider filed its appeal of the outlier payments issue on August 15, 2012. There were no extraordinary circumstances beyond the Provider's control preventing it from filing a timely appeal for outlier payments. The Board also finds the Provider's argument related to the extension of a good-cause exception due to fraudulent concealment or equitable estoppel, pursuant to the concurring decision in *Auburn,* is unpersuasive. The provider here, as in *Auburn*, alleges that the agency's failure to disclose information about how it calculated provider payments prevented it from bringing timely challenges, but the record does not support a finding of fraudulent concealment. As such, the Board denies the Provider's request for a good cause extension. Also, the Supreme Court held that the Board cannot consider equitable tolling to extend the time for filing.[34] Therefore, the Board denies the Provider's request for equitable tolling of the filing deadline for the outlier payments issue.

In Summary

The Board grants the Provider's Motion for Reconsideration and reopens case number 12-0521 to rule on the Motion for Good Cause Extension or Request for Equitable Tolling as to the Medicare outlier issue. The Board denies the Provider's Motion for Good Cause Extension or Request for Equitable Tolling as to the Medicare outlier issue. The Board affirms its decision

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[31] 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.)

[32] 68 Fed. Reg. 34,494,34,501 (June 9, 2003) ([3] even though final payment would reflect a hospital's true cost experience, there would still be the opportunity for a hospital to manipulate its outlier payments by dramatically increasing charges during the year in the discharge occurs. Here, the hospital would receive excessive outlier payments, which, although the hospital would incur an overpayment and have to refund the money when the cost report is settled, this would allow the hospital to obtain excess payments from the Medicare Trust fund on a short-term basis.)

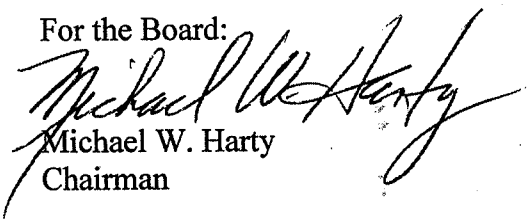
[33] 68 Fed. Reg. at 10425.

[34] *See Sebelius v. Auburn Regional Medical Center*, 133 S.Ct. 817 (2013).

denying the Motion for Good Cause Extension or Request for Equitable Tolling as to the RFBNA issue. The Board dismisses the appeal and closes the case as no further issues remain in the appeal.

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

Board Members Participating:
Michael W. Harty
John Gary Bowers, CPA
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 D. Shanklin
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Refer to: 08-1974

CERTIFIED MAIL

NOV 19 2014

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Beverly Hills, CA 90212

Bruce Snyder
Novitas Solutions, Inc.
Union Trust Building
501 Grant Street, Suite 600
Pittsburgh, PA 15219

RE: Jurisdictional Challenge
Moses Taylor Hospital
Provider No.: 39-0119
FYE: 6/30/2006
Case No.: 08-1974

Dear Mr. Blumberg and Mr. Snyder:

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

Background

The Provider was issued a Notice of Program Reimbursement (NPR) for FYE June 30, 2006 on December 3, 2007. On May 16, 2008, the Provider filed an appeal of the NPR challenging Medicare/ Medicaid dual eligible days. On October 7, 2008, the Provider requested to add the following issues to the appeal: SSI percentage and SSI realignment. On March 3, 2009, the provider was issued a revised NPR. On August 24, 2009, the Provider added to its appeal the appeal of Medicare SSI percentage issue from its revised NPR. On September 24, 2009, the Provider requested transfer of the Medicare SSI Percentage, from the original and revised NPRs to optional group appeal case number 09-0918G, and the dual eligible days issue to optional group appeal case number 09-1122G. These transfers left the SSI realignment issue as the sole issue in the appeal.

Board's Decision

The Board has reviewed jurisdiction over this appeal on its own motion and finds that it does not have jurisdiction over the SSI realignment issue because the MAC has not issued a final determination which the provider can appeal from. 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."

Under 42 C.F.R. § 142.106(b)(3) a hospital can, if it prefers, use its cost reporting period data instead of the federal fiscal year data in determining the DSH Medicare fraction. The decision to use its own cost reporting period is the hospitals alone, which then must submit a written request to the MAC.

In this case, there is no indication that the Provider has submitted a written request to the MAC to use the cost reporting period instead of the federal fiscal year. Without this request it is not possible for the MAC to have made a final determination. There was no final determination made. Accordingly, the Board finds that it lacks jurisdiction over the SSI realignment issue. Since the SSI realignment issue is the sole issue in the case, case number 08-1974 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
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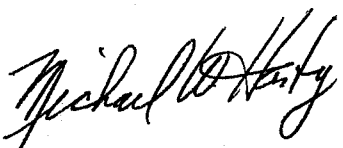
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson

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: Kevin Shanklin, BCBSA

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Refer to:

CERTIFIED MAIL

NOV 19 2014

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

RE: Bellflower Medical Center, Provider No. 05-0531, FYE 8/31/2011, PRRB Case No. 15-0076

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeal. The pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

QRS filed an individual appeal for Bellflower Medical Center on October 9, 2014. The appeal request did not include a copy of the final determination (the Notice of Program Reimbursement (NPR)). The Board established case number 15-0076 and issued an acknowledgement letter on October 17, 2014.

In lieu of the NPR, the Provider submitted a copy of a Freedom of Information Request dated October 3, 2014 directed to the Medicare Administrative Contractor (MAC) and indicated in its cover letter that it "will forward the necessary documents as soon as possible." To date, there is no record that the final determination was submitted.

Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the Notice of Program Reimbursement (NPR).

42 C.F.R § 405.1835(b) specifically requires the Provider to include the final determination it is appealing with the timely request, and authorizes the Board to dismiss with prejudice any appeal that does not include a copy of the determination under appeal with its filing. In the referenced case, QRS is filing an appeal that does not meet the regulatory requirements.

Board Rule 9 also addresses the acknowledgement of an appeal and issuance of critical due dates:

> The Board will send an acknowledgement via email indicating that the appeal request has been received and identifying the case number assigned. If the appeal request does not comply with the filing requirements, the Board may dismiss the appeal or take other remedial action. An acknowledgement does not limit the Board's authority to require more information or dismiss the appeal if it is later found to be jurisdictionally deficient.

Because the appeal request was not filed in conformance with 42 C.F.R § 405.1835 and the Board Rules, the Board hereby dismisses the individual appeal.

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

Board Members Participating:
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
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 .1877

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Refer to: 08-2087GC

CERTIFIED MAIL

NOV 28 2014

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Byron Lamprecht
Wisconsin Physicians Service
Cost Report Appeals
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Omaha, NE 68101

RE: Jurisdictional Decision
Provider No.: Various
FYE: Various (December 1998-December 1999)
PRRB Case No.: 08-2087GC

Dear Mr. Hettich & 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 providers filed an initial request for a group appeal of the SSI percentage issue on June 13, 2008. There are 15 participants in the group.

West Anaheim Medical Center, provider number 05-0426, FYE 8/31/1999

On September 16, 2004, the Provider was issued a revised NPR for FYE 8/31/1999. The Provider filed an appeal request from its revised Notice of Program Reimbursement (NPR) on March 14, 2005; the Board assigned case number 05-0985 to the appeal. The Provider did not include its appeal request with the supporting documentation submitted with the Schedule of Providers. The Provider also did not include any audit adjustment pages associated with its revised NPR appeal. On January 15, 2009, the Provider requested to transfer the SSI percentage issue from case number 05-0985 to this group appeal.

Doctors Hospital of Stark County, provider number 36-0151, FYE 6/30/1999

On May 20, 2005, the Provider was issued a revised NPR for FYE 6/30/1999. The Provider's appeal from its revised NPR was incorporated into an already established appeal, case number 02-1483, on November 15, 2005. The Provider appealed from an audit adjustment report that adjusted DSH, but the Provider did not submit any documentation to establish that the SSI percentage was reviewed or specifically adjusted. The Provider requested to transfer the SSI percentage issue to this group appeal on October 9, 2009.

Carolinas Hospital System, provider number 42-0091, FYE 6/30/1999

On October 21, 2008, the Provider was issued a revised NPR for FYE 6/30/1999. On April 17, 2009, the Provider requested to be directly added to this CIRP group appeal from its revised NPR.

DeTar Hospital, provider number 45-0147, FYE 9/30/1999

This Provider did not submit a copy of its final determination or appeal request to the Board with the Schedule of Providers and jurisdictional documentation. The Provider indicated that it was appealing from a self-disallowed cost, and it included its January 15, 2009 request to transfer the SSI percentage issue from case number 05-0711 to this group appeal.

San Angelo Community Hospital, provider number 45-0340, FYE 8/31/1999

This Provider did not submit a copy of its final determination or appeal request to the Board with the Schedule of Providers and jurisdictional documentation. The Provider indicated that it was appealing from a self-disallowed cost, and it included its October 6, 2009 request to transfer the SSI percentage issue from case number 05-1365 to this group appeal.

Longview Regional Medical Center, provider number 45-0702, FYE 12/31/1999

This Provider did not submit a copy of its final determination or appeal request to the Board with the Schedule of Providers and jurisdictional documentation. The Provider included a copy of its June 22, 2009 request to transfer the SSI percentage issue from case number 07-0164 to this group appeal.

Barberton Citizens Hospital, provider number 36-0019, FYE 12/31/1998

This Provider did not submit a copy of its final determination or appeal request to the Board with the Schedule of Providers and jurisdictional documentation. The Provider indicated that it was appealing from a self-disallowed cost, and it included its January 27, 2011 request to transfer the SSI percentage issue from case number 02-1484 to this group appeal.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841, a provider has a right to a hearing before the Board with respect to 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 hearing is filed within 180 days of the date the notice of the intermediary's final determination was mailed to the provider.

West Anaheim Medical Center, Doctors Hospital of Stark County, and Carolinas Hospital System, have all appealed from revised NPRs. The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 provides in relevant part:

> A determination of an intermediary . . . may be reopened with respect to findings on matters at issue in such determination or decision, by such intermediary . . . either on motion of such intermediary . . . or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings.

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

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

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

West Anaheim Medical Center, provider number 05-0426, FYE 8/31/1999

West Anaheim Medical Center did not establish that the SSI percentage was specifically reviewed in the revised NPR, therefore the Board hereby dismisses the Provider from case number 08-2087GC. The Provider did not include an audit adjustment report associated with the revised NPR; instead, it submitted an explanation that the SSI percentage was a self-disallowed cost, which means that the Intermediary did not review the SSI percentage or make an adjustment to it such to satisfy the statutory and regulatory jurisdictional requirements.

Doctors Hospital of Stark County, provider number 36-0151, FYE 6/30/1999

Doctors Hospital of Stark County did not establish that the SSI percentage was specifically reviewed in the revised NPR, therefore the Board hereby dismisses the Provider from case number 08-2087GC. The Provider's audit adjustment report indicates that DSH was adjusted, however the Provider did not submit any documentation to support a conclusion that the SSI percentage specifically was adjusted.

Carolinas Hospital System, provider number 42-0091, FYE 6/30/1999

Carolinas Hospital System did not establish that the SSI percentage was specifically reviewed in the revised NPR, therefore the Board hereby dismisses the Provider from case number 08-2087GC. The Provider did not include an audit adjustment report associated with the revised NPR; instead, it submitted an explanation that the SSI percentage was a self-disallowed cost, which means that the Intermediary did not review the SSI percentage or make an adjustment to it such to satisfy the statutory and regulatory jurisdictional requirements.

DeTar Hospital, San Angelo Community Hospital, Longview Regional Medical Center, and Barberton Citizens Hospital did not provide sufficient documentation to establish that their respective appeals were timely filed and whether the SSI percentage issue was properly added. Pursuant to 42 C.F.R.§ 405.1835(a)(3)(i) and PRRB rules, an appeal must be filed with the Board no later than 180 days after the provider has received its final determination.

42 C.F.R. § 405.1835(a)(3)(i) states,

> (3) Unless the provider qualifies for a good cause extension[...], the date of the receipt by the Board of the provider's hearing request is-
>
> (i) No later than 180 days after the date of receipt by the provider of the intermediary or Secretary determination.

DeTar Hospital, provider number 45-0147, FYE 9/30/1999

This Provider did not submit a copy of its final determination or appeal request to the Board. Without these two documents, the Board cannot determine several important things that relate to Board jurisdiction. First, the Board does not know whether the Provider has appealed from an original or a revised NPR. Second, the Board cannot determine whether or not the Provider timely appealed from its final determination. Third, the Board cannot determine whether the Provider appealed or timely added the SSI percentage to its appeal prior to its January 15, 2009 transfer request. The Board hereby dismisses this Provider from case number 08-2087GC because the Board cannot determine whether it filed a jurisdictionally valid appeal since the Provider did not submit all of the necessary documents to the Board.

San Angelo Community Hospital, provider number 45-0340, FYE 8/31/1999

This Provider did not submit a copy of its final determination or appeal request to the Board. Without these two documents, the Board cannot determine several important things that relate to Board jurisdiction. First, the Board does not know whether the Provider has appealed from an original or a revised NPR. Second, the Board cannot determine whether or not the Provider timely appealed from its final determination. Third, the Board cannot determine whether the Provider appealed or timely added the SSI percentage to its appeal prior to its October 6, 2009 transfer request. The Board hereby dismisses this Provider from case number 08-2087GC because the Board cannot determine whether it filed a jurisdictionally valid appeal since the Provider did not submit all of the necessary documents to the Board.

Longview Regional Medical Center, provider number 45-0702, FYE 12/31/1999

This Provider did not submit a copy of its final determination or appeal request to the Board. Without these two documents, the Board cannot determine several important things that relate to Board jurisdiction. First, the Board does not know whether the Provider has appealed from an original or a revised NPR. Second, the Board cannot determine whether or not the Provider timely appealed from its final determination. Third, the Board cannot determine whether the

Provider appealed or timely added the SSI percentage to its appeal prior to its June 22, 2009 transfer request. The Board hereby dismisses this Provider from case number 08-2087GC because the Board cannot determine whether it filed a jurisdictionally valid appeal since the Provider did not submit all of the necessary documents to the Board.

Barberton Citizens Hospital, provider number 36-0019, FYE 12/31/1998

This Provider did not submit a copy of its final determination or appeal request to the Board. Without these two documents, the Board cannot determine several important things that relate to Board jurisdiction. First, the Board does not know whether the Provider has appealed from an original or a revised NPR. Second, the Board cannot determine whether or not the Provider timely appealed from its final determination. Third, the Board cannot determine whether the Provider appealed or timely added the SSI percentage to its appeal prior to its January 27, 2011 transfer request. The Board hereby dismisses this Provider from case number 08-2087GC because the Board cannot determine whether it filed a jurisdictionally valid appeal since the Provider did not submit all of the necessary documents to the Board.

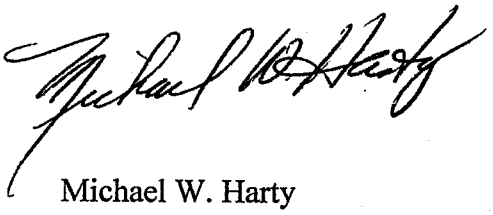
Conclusion

The Board hereby dismisses Providers 3, 7, and 9 (West Anaheim Medical Center, Doctors Hospital of Stark County, and Carolinas Hospital) from this appeal because the Providers appealed from revised NPRs that did not specifically review the SSI percentage. The Board hereby dismisses Providers 10, 11, 14, and 15 (DeTar Hospital, San Angelo Community Hospital, Longview Regional Medical Center, and Barberton Citizens Hospital) from this appeal because the Providers did not submit all of the necessary documentation to establish that they filed jurisdictionally valid appeals. Case number 08-2087GC will remain open as there are other Providers pending in the appeal.

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 upon final disposition of the appeal.

Board Members
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: Kevin D. Shanklin, BCBSA