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

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

Refer to: 13-0697

JAN 13 2015

CERTIFIED MAIL

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

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

RE: Provider Name: Cheyenne Regional Medical Center
Provider No.: 53-0014
FYE: 06/30/2007
PRRB Case No.: 13-0697

Dear Mr. Ravindran and Mr. Ward,

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

**Background**

The Provider, Cheyenne Regional Medical Center ("Provider"), timely appealed from its August 20, 2012 revised Notice of Program Reimbursement (RNPR) on February 14, 2013. The Provider raised two issues in its appeal request: (1) SSI Provider Specific ("SSI") and (2) Rural Floor Budget Neutrality Adjustment (RFBNA). On April 17, 2013, the Provider requested to add the issue of Outlier Payments. The Provider later requested to transfer the Outlier Payments issue to the QRS 2007 Outlier Payments – Fixed Loss Threshold group appeal, Case No. 13-1297G.

On February 6, 2014, the Medicare Administrative Contractor ("Contractor") submitted a Jurisdictional Challenge. The Provider filed its Jurisdictional Response with the Board on March 5, 2014.

**Contractor's Position**

The Contractor contends that the Board should not take jurisdiction over the (1) SSI and

(2) RFBNA issues because they were not adjusted in the RNPR. The Contractor cites to the regulation 42 C.F.R. § 405.1889 (2012), which 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 Contractor argues the sole adjustment in the RNPR was for the Inpatient Rehabilitation Facility Low Income Payment SSI percentage and that since the Provider's SSI and RFBNA were not revised in the Provider's RNPR, those two issues are not appealable. The Contractor did not officially challenge the Outlier Payments issue as that issue was requested to be transferred; however, the Contractor did state there was a jurisdictional problem with that issue as well.

**Provider's Position**

The Provider withdrew the SSI issue, but stated that the RFBNA amounts were understated due to CMS's incorrect adjustment to the standardized amount.

**Board's Determination**

The Board finds that it does not have jurisdiction over the RFBNA and Outlier issues for FYE 6/30/2007 because the Provider appealed from a RNPR in which the issues on appeal were not specifically revised.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841 (2013), 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 contractor, 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 contractor'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 a jurisdictionally valid appeal.

The Provider was issued a RNPR on August 20, 2012. The Code of Federal Regulations provides for an opportunity for a RNPR. The regulation cited above, 42 C.F.R. § 405.1885 provides, in relevant part:

> (a) General. (1) A Secretary determination, a [contractor] 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 [contractor] (with respect to [contractor] 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 RNPR is considered a separate and distinct determination from which the provider may appeal. That regulation (cited in full above) states "[o]nly matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision."[1] Further, "[a]ny 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."[2]

The Board finds that it does not have jurisdiction over the Provider's RNPR appeal because the documentation submitted does not establish that RFBNA or Outlier Payments were specifically revised. As such, the Provider may not appeal those matters as they "may not be considered in any appeal of the revised determination."[3] The only issues revised through the reopening were the SSI ratio used to determine Inpatient Rehabilitation Facility (IRF) Low Income Payment (LIP) and the correction of the allowable disproportionate share hospital (DSH) percentage used to determine the Provider's DSH adjustment.[4] Adjustment number 5 shows there was an adjustment to the SSI percentage used to determine the IRF LIP. This issue is a separate and distinct issue from the RFBNA and Outlier Payments issues remaining in the appeal. The Provider did not establish that the RFBNA or Outlier Payments were specifically revised as required by the regulations.

The SSI issue need not be addressed as that issue was withdrawn by the Provider. However, the Board finds that it lacks jurisdiction over the RFBNA and Outlier Payments issues as those issues were not adjusted in the RNPR. The Provider's transfer request regarding the Outlier Payments is denied, the Provider's appeal of RFBNA and Outlier Payments is dismissed,

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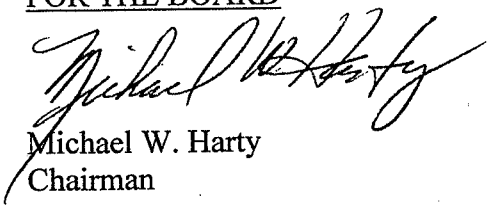
[1] 42 C.F.R. § 405.1889(b)(1).
[2] 42 C.F.R. § 405.1889(b)(2).
[3] *Id.*
[4] Contractor's Jurisdictional Challenge at 2, Feb. 6, 2014.

and the case is hereby closed.

Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 1877.

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 Shanklin, BCBSA (without enclosures)

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CERTIFIED MAIL

JAN 13 2015

Stephen P. Nash
Squire Patton Boggs (US) LLP
1801 California Street
Suite 4900
Denver, CO 80202

RE: Request for Expedited Judicial Review
Patton Boggs 2009 Medicare Outliers – Banner Health CIRP NPR Group
Provider Nos.: Various
FYE: 12/31/2009
PRRB Case No.: 13-0593GC

Dear Mr. Nash:

The Provider Reimbursement Review Board (Board or PRRB) has reviewed the Providers' December 12, 2014 request for expedited judicial review (EJR) (received December 15, 2014) in the above referenced appeal. The Board's decision with respect to the request for EJR and jurisdiction is set forth below.

Background

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

> Whether the specific regulations governing Outlier Case Payments as set forth in the two regulatory sources—the Outlier Payment Regulations[1] and the fixed loss threshold ("FLT") Regulations[2] (collectively, the "Medicare Outlier Regulations")—as promulgated by the Secretary of Health and Human Services ("HHS" or the "Secretary") and the Centers for Medicare and Medicaid Services ("CMS"), and in effect for the appealed years, are contrary to the Outlier Statute[3] and/or are otherwise substantively or procedurally invalid?

[1] The Outlier Payment Regulations are the base regulations that establish the method for calculating a hospital's imputed costs for a patient case, which are set forth at 42 C.F.R. §§ 412.80 through 412.86.
[2] The FLT Regulations are set forth in the Secretary's annual promulgation of "Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal year Rates," which, among other things, establishes the outlier fixed-loss thresholds for the coming fiscal year.
[3] *See*, 18 S.S.A. §§ 1886(d)(5)(A)(i)-(iv) and (d)(3)(B); 42 U.S.C. §§ 1395ww(d)(5)(A)(i)-(iv) and (d)(3)(B).

The Providers assert despite the anticipated virtues of the inpatient prospective payment system (IPPS), Congress recognized that health-care providers would inevitably care for some patients whose hospitalizations would be extraordinarily costly or lengthy. To insulate hospitals from bearing a disproportionate share of these atypical costs, Congress authorized HHS to make supplemental outlier case payments. During the years at issue, the outlier payment provisions were set forth in four clauses of the Medicare statute.[4]

The Providers maintain, traditionally, the Secretary has read paragraph (5)(A)(iv) of the statute to mean that prior to the start of each fiscal year, the Secretary must establish a FLT beyond which hospitals will qualify for outlier case payments, at levels resulting in outlier case payments totaling between 5-6% of projected diagnosis related group (DRG) payments for that year. The Providers contend outlier payments are made from the "outlier pool," which is a regulatory set aside or subset of the Medicare Part A Trust Fund, maintained by the government to pay for outliers (Medicare outlier pool). The Medicare outlier pool is, in effect, funded by all of the acute care hospitals participating in Medicare IPPS, in that each such hospital's ordinary IPPS payments are reduced (between 5% and 6%) and those moneys are credited to the Medicare outlier pool.[5]

The Providers assert that from 1997 until 2003, a relatively small number of hospitals greatly inflated their hospital inpatient charges (as captured in their respective "charge masters"), a practice which the United States Department of Justice (DOJ) calls "turbo-charging."[6] This systematic practice of "turbo-charging", coupled with the Secretary's decision to use cost-to-charge ratios (CCRs) that were typically 3 to 5 years old and thus, artificially high, resulted in the calculation of greatly inflated costs per case (CPC). These inflated CPC were then used as the predicate for greatly inflated claims (inflated both in number and amounts) for payments from the Medicare outlier pool.[7, 8]

The Providers contend, in its later investigations of hospitals it believed had engaged in charge inflation, the DOJ alleged that the practice of "turbo-charging" led directly to inflated claims for payments under the Medicare outlier program, which the DOJ characterized as "false claims." The Providers argue these and other inflated claims led HHS to increase the FLTs at a precipitous rate in an attempt to ensure that the total amount of outlier payments made for discharges in the fiscal years at issue would remain at 5.1 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year.[9]

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[4] 42 U.S.C. § 1395ww(d)(5)(A)(i)-(iv).
[5] 42 U.S.C. § 1395ww(d)(3)(B).
[6] *See, e.g., Amicus Curiae Mem.* of U.S.A in Resp. to Tenet Healthcare Corp's Mot. to Dismiss, *Boca Raton Cmty. Hosp.*, ECF No. [49], at 4 (S.D. Fla. May 17, 2005).
[7] *Id.* at 4-5.
[8] Providers' EJR Req. at 3-4.
[9] *Medicare Outlier Payments to Hospitals: Hearing Before a Subcomm. of the S. Comm. on Appropriations*, 108th Cong. 3-17 (2003) (statement by Thomas A. Scully Administrator, Centers for Medicare and Medicaid Services, Department of Health and Human Services).

The Providers maintain beginning in or around federal fiscal year (FFY) 1998, HHS began making substantial upward adjustments to the FLTs. These adjustments were at a rate far in

excess of the rate of growth of inflationary indices routinely used by HHS, such as the CPI-Medical Index or the Medicare Market Basket. For instance, from 1997 through 2003, HHS increased the FLTs by more than 246%, when by its own admission there was modest cost inflation (of between 22% and 26%) for the same period. The Providers assert although the Secretary purported to calibrate the FLT adjustments to historical inflation data, the actual increase in FLTs bore no discernible relationship to cost inflation; in fact they were more than 10 times higher.

The Providers contend in late 2002, HHS disclosed that it was aware of "turbo charging" and that it would be amending the outlier payment regulations to fix the vulnerabilities in the same.[10] The Providers assert in its previous promulgating and amending the outlier payment regulations, HHS had variously represented there were no critical flaws in its outlier payment regulations, that it had always used the best available data, and that it would not make retroactive corrections to outlier payments. Then in March 2003, in the process of amending the outlier payment regulations, CMS did an about face on all three of these points, admitting that there were three critical flaws in its outlier payment regulations, that other data, which had always been available and was better, should be used and that the outliers case payments would now be subject to reconciliation.[11]

The Providers argue while the agency was in the process of reversing its position on each of these points, HHS had the opportunity (if not the statutory and/or fiduciary obligation) to reset its FLT to correct for what it openly acknowledged had been the improper redistribution of the Medicare funds allocated for outlier case payments—literally billions of dollars of improper payments made to a few "turbo charging" hospitals, at the expense of the many. Instead, after reviewing hundreds of public comments, most urging HHS to lower the FLT, the agency announced that it would leave the threshold where it was, $33,560.

The Providers assert HHS did not disclose that the agency had known six years earlier how to fix the problems engendered by its earlier flawed regulations and believed it was obligated to do so immediately. The Providers contend HHS also did not disclose in that rulemaking that then-HHS Secretary Thompson and then-Administrator Scully had cleared and signed an interim final regulation (the IFR) and submitted the IFR to the Office of Management and Budget (OMB) for presumptive approval on February 12, 2003.[12] The Providers maintain the IFR contained facts and analysis on the basis of which HHS concluded it was required, mid-year, to lower its fiscal year (FY) 2003 FLT to $20,760 (from $33,560) (*i.e.*, that the 2003 FLT was approximately 62% higher than it should have been) in order to comply with the outlier statute's mandates and the

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[10] *See* CMS *Program Memorandum*, Transmittal A-02-122 (Dec. 3, 2002); CMS *Program Memorandum*, Transmittal A-02-126 (Dec. 20, 2002); CMS *Program Memorandum Intermediaries*, Transmittal A-03-058, July 3, 2003; and CMS Manual System, Pub. 100-04 Medicare Claims Processing, Transmittal 707, October 12, 2005, Change Request 3966.

[11] *See* 68 Fed. Reg. 34,494, 34,496 and 34,501 (June 9, 2003).

[12] Providers' EJR Req. at 5-6.

intent of Congress.[13] The Providers contend in stark contrast, HHS' subsequent rulemakings, beginning with the proposed regulation published on February 28, 2003 (March 5, 2003, in the Federal Register),[14] omitted key data, facts, analysis and conclusions. The Providers argue HHS failed to mention, amongst other key information, the agency's considered analysis quantifying the impact of the "turbo-charging" hospitals on its FLT adjustments, the need and method to remove the "turbo-charged" data and what HHS believed to be its statutory obligation to lower the FLT.

The Providers argue contrasting the data, other facts, and analysis set forth in the IFR with HHS' subsequent published rulemakings, it is clear that HHS used corrupted data, and knowingly disregarded its own concurrent provider-favorable conclusions and alternatives in setting the FLTs for fiscal year end (FYEs) 2003-2010. The Providers maintain they did not learn of the IFR until 2012 – and then only through a Freedom of information Act (FOIA) request that through their counsel, submitted to OMB's Office of Information and Regulatory Affairs (OIRA) for various documents related to the Medicare outlier program. The Provider contends as for FYEs 2007-2011, the IFR continued to be relevant because HHS still had not accounted for the impact of the "turbo-charging" data, still relied on hyper-inflated data in projecting the FLTs, and still had not returned the FLTs anywhere close to the levels dictated by analysis set forth in the IFR. Instead, HHS repeatedly set the FLTs at levels which paid out significantly less than the agency's stated target of 5.1% of total IPPS payments. As a result, the Providers argue they did not receive the full amount of the outlier case payments to which they are entitled under the outlier statute.[15]

The Providers allege on June 28, 2012, HHS Office of Inspector General (OIG) issued a report with results from its review of CMS' outlier reconciliation process (the 2012 OIG Report). The 2012 OIG Report reveals the inaccuracy of (and the key information omitted from) HHS' stated reason for not considering the impact of reconciliation, in establishing the FLTs for FYEs 2004-2011. The Providers maintain the Inspector General noted that seven years after the 2003 publication of the regulation requiring reconciliation of outlier payments, CMS had not reconciled any of the cost reports screened and reported by Medicare Administrative Contractors (MACs). The Providers contend in a later 2013 OIG Report, OIG noted that although nearly all hospitals received some outlier payments, a small percentage of hospitals received a significantly higher proportion (almost 6 times higher) of outlier payments than others. These high-outlier hospitals charged Medicare substantially more for the same Medical Severity Diagnostic Related Groups (MS-DRGs), even though their patients had similar lengths of stay as the average in all other hospitals. The Providers argue HHS failed to notice and correct this unusual distribution of outlier payments.[16]

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[13] *Id.* at 7.
[14] *See* 68 Fed. Reg. 10,420 (March 5, 2003).
[15] Providers' EJR Req. at 9-10.
[16] *Id.* at 11-12.

The Providers contend that the FLTs applicable to the claims for which EJR is sought, and as established using the payment regulation and the FLT regulations, are invalid for a number of reasons including but not limited to:

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

2.) CMS has not used the best available data, and in fact, has used faulty data when establishing FLTs even when admonished by hospitals.

3.) The FLTs established by CMS have borne no discernible, much less logical, relationship to CMS' published "inflationary factors."[17]

4.) The FLTs themselves, as calculated pursuant to HHS published criteria, have been (and continue to be) invalid because CMS used data that was not the best available data, used formulas or criteria that CMS knew to be flawed (and did so when CMS knew information was available that would have resulted in a more accurate process), and/or were not supported by substantial evidence (or were contrary to the same).[18]

5.) In disregard of the repeated suggestions of commenters, HHS has refused to make mid-year corrections to the FLTs in order to achieve greater accuracy.

6.) The Medicare outlier regulations (and its companion Program Transmittals) are substantively invalid, as implemented because, in late 2002, when CMS began to realize that its Medicare outlier regulations were flawed, CMS began a process of "selective" administration of the Medicare outlier statute through an effort to correct (and recoup) overpayments but with no corresponding effort to correct underpayments.[19]

7.) The Medicare outlier regulations are both substantively and procedurally invalid because, as written and as implemented, their actual effect has been to frustrate the intent of Congress, and to deprive the Providers of the "catastrophic loss" protection that Congress intended the outlier statute to provide. The agency action described above has consistently violated the outlier statute, and in the absence of adequate explanation, has also violated the Administrative Procedure Act ("APA") as an arbitrary and capricious, and therefore invalid rule-making, and should be set aside.

8.) The Medicare outlier regulations are procedurally invalid because, when HHS amended the outlier payment regulations, it failed to disclose the alternatives set forth in the IFR, alternatives that it had not only considered, but had signed, cleared for

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[17] *Id.* at 14.
[18] *Id.* at 16.
[19] *Id.* at 20.

> distribution outside the agency, and sent to OMB for presumptive approval in the form of an emergency Interim Final Rule. HHS failed to provide any explanation for why it abandoned this alternative. Indeed, it did not even mention the alternative of removing "turbo-charging" data from its future analysis of setting FLTs.[20]

Decision of the Board

The Medicare statute at 42 U.S.C. § 1395oo(f)(1) (2013) and the regulation at 42 C.F.R. § 405.1842(f)(1) (2013) require the Board to grant EJR if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling.

All of the Providers in this appeal were previously participants within PRRB case number 12-0044GC, Patton Boggs 2009 Medicare Outliers-Banner Health CIRP Group, in which the Providers appealed the outlier issue from the lack of the issuance of a Notice of Program Reimbursement (NPR). Each of the Providers subsequently received their NPRs and filed a second appeal for the same issue, which formed this appeal, PRRB case number 13-0593GC. On March 14, 2013, the Board dismissed the three Providers from the initial appeal and reasoned that the Providers' receipt of their NPRs mooted the issue of the MAC's failure to issue a final determination. In addition, Board Rule 4.5 precludes providers from appealing the same issue in more than one appeal. The Board ordered that the Providers be dismissed from case number 12-0044GC and remain in case number 13-0593GC, the current case, based on their appeal filed on February 1, 2013, from the issuance of NPRs.

The Board hereby reverses its prior March 14, 2013 decision to dismiss Banner Heart Hospital (provider number 03-0105, FYE 12/31/09); Banner Baywood Medical Center (provider number 03-0088, FYE 12/31/09); and Banner Estrella Medical Center (provider number 03-0115, FYE 12/31/09), from case number 12-0044GC. The Board reinstates the Providers' appeal into case number 12-0044GC, but merges these participants from case number 12-0044GC into case number 13-0593GC to form a single, consolidated appeal for the outlier issue. The jurisdictional documentation used to pursue the initial appeal from the lack of issuance of an NPR in case number 12-0044GC will be incorporated for these three Providers as part of the record for case number 13-0593GC. Case number 12-0044GC will remain in a closed status based on the merger of appeal requests for the subject Providers.

Pursuant to the Order issued by the United States District Court for the District of Columbia in *Charleston Area Med. Ctr. v. Sebelius*, No. 13-643 (RMC) (D.D.C. filed May 3, 2013),[21] the

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[20] *Id.* at 22-23.

[21] In the Secretary's responses to the Court's May 27, 2014 and June 10, 2014 Orders to Show Cause, the Secretary made a binding concession that 42 C.F.R. § 405.1835(a)(1)'s requirement that a Medicare provider must establish its "dissatisfaction" by claiming reimbursement for the item in question in its Medicare cost report or by listing the items as a "protested amount" in its cost report, should not apply to Board appeals that are based on the provisions of the Medicare statute, 42 U.S.C § 1395oo(a)(1)(B), that provide for appeal to the Board where a Medicare

Board finds that it has jurisdiction over each of the Providers based on their appeals from the lack of the issuance of an NPR.

Specific to the Providers' request for EJR for the outlier reimbursement issue on December 15, 2014, the Board finds that:

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

2) based upon the Providers' assertions regarding the outlier regulations, 42 C.F.R. §§ 412.80-412.86, there are no findings of fact for resolution by the Board;

3) it is bound by the regulations; and

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

Accordingly, the Board finds that the outlier issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the outlier reimbursement issue in case number 13-0593GC. Since this is the only issue under dispute in case number 13-0593GC, the Board hereby closes the case.

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

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

For the Board

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877;
Schedule of Providers for case no. 13-0593GC;
Board's letter dated March 14, 2014

cc: Byron Lamprecht, Wisconsin Physicians Service
Kevin Shanklin, BCBSA

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contractor does not issue a timely NPR. Thus, the United States District Court for the District of Columbia ordered that the Board *et al.* are enjoined from applying 42 C.F.R. § 405.1835(a)(1)'s dissatisfaction requirement for Board jurisdiction to any pending or future Board appeal that, pursuant to 42 U.S.C. § 1395oo(a)(1)(B), is based on the Medicare contractor's failure to issue a timely NPR. *Id.*

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JAN 13 2015

Stephen P. Nash
Squire Patton Boggs (US) LLP
1801 California Street
Suite 4900
Denver, CO 80202

RE: Request for Expedited Judicial Review
Patton Boggs 2009 Medicare Outliers-NPR Optional Group
Provider Nos.: Various
FYEs: Various 2009
PRRB Case No.: 13-3610G

Dear Mr. Nash:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' December 12, 2014 request for expedited judicial review (EJR) (received December 15, 2014) in the above referenced appeal. The Board concludes that it lacks jurisdiction over the appeal and hereby denies the request for EJR.

Background

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

> Whether the specific regulations governing Outlier Case Payments as set forth in the two regulatory sources—the Outlier Payment Regulations[1] and the fixed loss threshold ("FLT") Regulations[2] (collectively, the "Medicare Outlier Regulations")—as promulgated by the Secretary of Health and Human Services ("HHS" or the "Secretary") and the Centers for Medicare and Medicaid Services ("CMS"), and in effect for the appealed years, are contrary to the Outlier Statute[3] and/or are otherwise substantively or procedurally invalid?

[1] The Outlier Payment Regulations are the base regulations that establish the method for calculating a hospital's imputed costs for a patient case, which are set forth at 42 C.F.R. §§ 412.80 through 412.86.
[2] The FLT Regulations are set forth in the Secretary's annual promulgation of "Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal year Rates," which, among other things, establishes the outlier fixed-loss thresholds for the coming fiscal year.
[3] *See*, 18 S.S.A. §§ 1886(d)(5)(A)(i)-(iv) and (d)(3)(B); 42 U.S.C. §§ 1395ww(d)(5)(A)(i)-(iv) and (d)(3)(B).

The Providers assert despite the anticipated virtues of the inpatient prospective payment system (IPPS), Congress recognized that health-care providers would inevitably care for some patients whose hospitalizations would be extraordinarily costly or lengthy. To insulate hospitals from bearing a disproportionate share of these atypical costs, Congress authorized HHS to make supplemental outlier case payments. During the year at issue, the outlier payment provisions were set forth in four clauses of the Medicare statute.[4]

The Providers maintain, traditionally, the Secretary has read paragraph (5)(A)(iv) of the statute to mean that prior to the start of each fiscal year, the Secretary must establish a FLT beyond which hospitals will qualify for outlier case payments, at levels resulting in outlier case payments totaling between 5-6% of projected diagnosis related group (DRG) payments for that year. The Providers contend outlier payments are made from the "outlier pool," which is a regulatory set aside or subset of the Medicare Part A Trust Fund, maintained by the government to pay for outliers (Medicare outlier pool). The Medicare outlier pool is, in effect, funded by all of the acute care hospitals participating in Medicare IPPS, in that each such hospital's ordinary IPPS payments are reduced (between 5% and 6%) and those moneys are credited to the Medicare outlier pool.[5]

The Providers assert that from 1997 until 2003, a relatively small number of hospitals greatly inflated their hospital inpatient charges (as captured in their respective "charge masters"), a practice which the United States Department of Justice (DOJ) calls "turbo-charging."[6] This systematic practice of "turbo-charging," coupled with the Secretary's decision to use cost-to-charge ratios (CCRs) that were typically 3 to 5 years old and thus, artificially high, resulted in the calculation of greatly inflated costs per case (CPC). These inflated CPC were then used as the predicate for greatly inflated claims (inflated both in number and amounts) for payments from the Medicare outlier pool.[7, 8]

The Providers contend, in its later investigations of hospitals it believed had engaged in charge inflation, the DOJ alleged that the practice of "turbo-charging" led directly to inflated claims for payments under the Medicare outlier program, which the DOJ characterized as "false claims." The Providers argue these and other inflated claims led HHS to increase the FLTs at a precipitous rate in an attempt to ensure that the total amount of outlier payments made for discharges in the fiscal years at issue would remain at 5.1 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year.[9]

The Providers maintain beginning in or around federal fiscal year (FFY) 1998, HHS began making substantial upward adjustments to the FLTs. These adjustments were at a rate far in excess of the rate of growth of inflationary indices routinely used by HHS, such as the CPI-

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[4] 42 U.S.C. § 1395ww(d)(5)(A)(i)-(iv).
[5] 42 U.S.C. § 1395ww(d)(3)(B).
[6] *See, e.g., Amicus Curiae Mem.* of U.S.A in Resp. to Tenet Healthcare Corp's Mot. to Dismiss, *Boca Raton Cmty. Hosp.*, ECF No. [49], at 4 (S.D. Fla. May 17, 2005).
[7] *Id.* at 4-5.
[8] Providers' EJR Req. at 3-4.
[9] *Medicare Outlier Payments to Hospitals: Hearing Before a Subcomm. of the S. Comm. on Appropriations*, 108th Cong. 3-17 (2003) (statement by Thomas A. Scully Administrator, Centers for Medicare and Medicaid Services, Department of Health and Human Services).

Medical Index or the Medicare Market Basket. For instance, from 1997 through 2003, HHS increased the FLTs by more than 246%, when by its own admission there was modest cost inflation (of between 22% and 26%) for the same period. The Providers assert although the Secretary purported to calibrate the FLT adjustments to historical inflation data, the actual increase in FLTs bore no discernible relationship to cost inflation; in fact they were more than 10 times higher.

The Providers contend in late 2002, HHS disclosed that it was aware of "turbo charging" and that it would be amending the outlier payment regulations to fix the vulnerabilities in the same.[10] The Providers assert in its previous promulgating and amending the outlier payment regulations, HHS had variously represented there were no critical flaws in its outlier payment regulations, that it had always used the best available data, and that it would not make retroactive corrections to outlier payments. Then in March 2003, in the process of amending the outlier payment regulations, CMS did an about face on all three of these points, admitting that there were three critical flaws in its outlier payment regulations, that other data, which had always been available and was better, should be used and that the outliers case payments would now be subject to reconciliation.[11]

The Providers argue while the agency was in the process of reversing its position on each of these points, HHS had the opportunity (if not the statutory and/or fiduciary obligation) to reset its FLT to correct for what it openly acknowledged had been the improper redistribution of the Medicare funds allocated for outlier case payments—literally billions of dollars of improper payments made to a few "turbo charging" hospitals, at the expense of the many. Instead, after reviewing hundreds of public comments, most urging HHS to lower the FLT, the agency announced that it would leave the threshold where it was, $33,560.

The Providers assert HHS did not disclose that the agency had known six years earlier how to fix the problems engendered by its earlier flawed regulations and believed it was obligated to do so immediately. The Providers contend HHS also did not disclose in that rulemaking that then-HHS Secretary Thompson and then-Administrator Scully had cleared and signed an interim final regulation (the IFR) and submitted the IFR to the Office of Management and Budget (OMB) for presumptive approval on February 12, 2003.[12] The Providers maintain the IFR contained facts and analysis on the basis of which HHS concluded it was required, mid-year, to lower its fiscal year (FY) 2003 FLT to $20,760 (from $33,560) (*i.e.*, that the 2003 FLT was approximately 62% higher than it should have been) in order to comply with the outlier statute's mandates and the intent of Congress.[13] The Providers contend in stark contrast, HHS' subsequent rulemakings, beginning with the proposed regulation published on February 28, 2003 (March 5, 2003, in the Federal Register),[14] omitted key data, facts, analysis and conclusions. The Providers argue HHS failed to mention, amongst other key information, the agency's considered analysis quantifying

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[10] *See* CMS *Program Memorandum*, Transmittal A-02-122 (Dec. 3, 2002); CMS *Program Memorandum*, Transmittal A-02-126 (Dec. 20, 2002); CMS *Program Memorandum Intermediaries*, Transmittal A-03-058, July 3, 2003; and CMS Manual System, Pub. 100-04 Medicare Claims Processing, Transmittal 707, October 12, 2005, Change Request 3966.

[11] *See* 68 Fed. Reg. 34,494, 34,496 and 34,501 (June 9, 2003).

[12] Providers' EJR Req. at 5-6.

[13] *Id.* at 7.

[14] *See* 68 Fed. Reg. 10,420 (March 5, 2003).

the impact of the "turbo-charging" hospitals on its FLT adjustments, the need and method to remove the "turbo-charged" data and what HHS believed to be its statutory obligation to lower the FLT.

The Providers argue contrasting the data, other facts, and analysis set forth in the IFR with HHS' subsequent published rulemakings, it is clear that HHS used corrupted data, and knowingly disregarded its own concurrent provider-favorable conclusions and alternatives in setting the FLTs for fiscal year end (FYEs) 2003-2010. The Providers maintain they did not learn of the IFR until 2012 – and then only through a Freedom of information Act (FOIA) request that through their counsel, submitted to OMB's Office of Information and Regulatory Affairs (OIRA) for various documents related to the Medicare outlier program. The Provider contends as for FYEs 2007-2011, the IFR continued to be relevant because HHS still had not accounted for the impact of the "turbo-charging" data, still relied on hyper-inflated data in projecting the FLTs, and still had not returned the FLTs anywhere close to the levels dictated by analysis set forth in the IFR. Instead, HHS repeatedly set the FLTs at levels which paid out significantly less than the agency's stated target of 5.1% of total IPPS payments. As a result, the Providers argue they did not receive the full amount of the outlier case payments to which they are entitled under the outlier statute.[15]

The Providers allege on June 28, 2012, HHS Office of Inspector General (OIG) issued a report with results from its review of CMS' outlier reconciliation process (the 2012 OIG Report). The 2012 OIG Report reveals the inaccuracy of (and the key information omitted from) HHS' stated reason for not considering the impact of reconciliation, in establishing the FLTs for FYEs 2004-2011. The Providers maintain the Inspector General noted that seven years after the 2003 publication of the regulation requiring reconciliation of outlier payments, CMS had not reconciled any of the cost reports screened and reported by Medicare Administrative Contractors (MACs). The Providers contend in a later 2013 OIG Report, OIG noted that although nearly all hospitals received some outlier payments, a small percentage of hospitals received a significantly higher proportion (almost 6 times higher) of outlier payments than others. These high-outlier hospitals charged Medicare substantially more for the same Medical Severity Diagnostic Related Groups (MS-DRGs), even though their patients had similar lengths of stay as the average in all other hospitals. The Providers argue HHS failed to notice and correct this unusual distribution of outlier payments.[16]

The Providers contend that the FLTs applicable to the claims for which EJR is sought, and as established using the payment regulation and the FLT regulations, are invalid for a number of reasons including but not limited to:

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

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[15] Providers' EJR Req. at 9-10.
[16] *Id.* at 11-12.

2.) CMS has not used the best available data, and in fact, has used faulty data when establishing FLTs even when admonished by hospitals.

3.) The FLTs established by CMS have borne no discernible, much less logical, relationship to CMS' published "inflationary factors."[17]

4.) The FLTs themselves, as calculated pursuant to HHS published criteria, have been (and continue to be) invalid because CMS used data that was not the best available data, used formulas or criteria that CMS knew to be flawed (and did so when CMS knew information was available that would have resulted in a more accurate process), and/or were not supported by substantial evidence (or were contrary to the same).[18]

5.) In disregard of the repeated suggestions of commenters, HHS has refused to make mid-year corrections to the FLTs in order to achieve greater accuracy.

6.) The Medicare outlier regulations (and its companion Program Transmittals) are substantively invalid, as implemented because, in late 2002, when CMS began to realize that its Medicare outlier regulations were flawed, CMS began a process of "selective" administration of the Medicare outlier statute through an effort to correct (and recoup) overpayments but with no corresponding effort to correct underpayments.[19]

7.) The Medicare outlier regulations are both substantively and procedurally invalid because, as written and as implemented, their actual effect has been to frustrate the intent of Congress, and to deprive the Providers of the "catastrophic loss" protection that Congress intended the outlier statute to provide. The agency action described above has consistently violated the outlier statute, and in the absence of adequate explanation, has also violated the Administrative Procedure Act ("APA") as an arbitrary and capricious, and therefore invalid rule-making, and should be set aside.

8.) The Medicare outlier regulations are procedurally invalid because, when HHS amended the outlier payment regulations, it failed to disclose the alternatives set forth in the IFR, alternatives that it had not only considered, but had signed, cleared for distribution outside the agency, and sent to OMB for presumptive approval in the form of an emergency Interim Final Rule. HHS failed to provide any explanation for why it abandoned this alternative. Indeed, it did not even mention the alternative of removing "turbo-charging" data from its future analysis of setting FLTs.[20]

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[17] *Id.* at 14.
[18] *Id.* at 16.
[19] *Id.* at 20.
[20] *Id.* at 22-23.

Decision of the Board

The Board has reviewed the submission of the Providers pertaining to the requests for hearing and expedited judicial review. The Board concludes that it lacks jurisdiction over the appeal and hereby dismisses the case. Since jurisdiction is a prerequisite to granting a request for EJR, the Board hereby denies the request for EJR. *See* 42 C.F.R. § 405.1842(a).

The Medicare statute at 42 U.S.C. §1395oo(f)(1) (2013) and the regulation at 42 C.F.R. §405.1842(f)(1) (2013), require the Board to grant EJR if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling.

42 C.F.R. § 405.1835(a) (2013) sets forth the requirements for a Board hearing. The regulation provides:

> (a) **Criteria.** A provider . . . has a *right to a Board hearing*, as a single provider appeal, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination, *only if*—
>
> (1) *The provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for specific item(s) at issue, by* either—
>
> (i) Including a claim for specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or
>
> (ii) Effective with cost reporting periods that end on or after December 31, 2008, *self-disallowing the specific item(s) by following the applicable procedures for filing a cost report under protest*, where the provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy (for example, if the intermediary lacks discretion to award the reimbursement the provider seeks for the item(s)).
>
> (2) The amount in controversy . . . is $10,000 or more[21]; and
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836 of this subpart, the date of receipt by the Board of the Provider's hearing request is—

[21] $50,000 for group appeals. *See* 42 C.F.R. § 405.1837(a)(3).

> (i) No later than 180 days after the date of receipt by Provider of the intermediary or Secretary determination (emphasis added).

The Provider Reimbursement Manual (CMS Pub. 15-2 § 115 and 3630.1) describes the information that is required to be entered and submitted for protested amounts on Worksheet E, Part A, Line 30 of the as-filed cost report.[22] The Manual requires that providers:

1.) include the non-allowable item in the cost report in order to establish an appeal issue;

2.) estimate the reimbursement effect of the non-allowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process; and

3.) submit with the cost report copies of the working papers used to develop the estimated adjustments.

In this case, all of the Providers, with the exception of Provider #3, Parkview Medical Center (provider number 06-0020), did not claim an amount as a protested item on Worksheet E, Part A, Line 30 of the cost reports as required to protest the amount of outlier reimbursement pursuant to 42 C.F.R. § 405.1835(a)(1)(ii). Provider #3, Parkview Medical Center, claimed an amount on Worksheet E, Part A, Line 30 of the cost report but indicated that the protested amounts did not include the outlier reimbursement issue. As these cost reports involve fiscal years that end after December 31, 2008, self-disallowed items such as the outlier reimbursement at issue must have been filed under protest. As the Providers failed to protest the outlier reimbursement at issue and that is the sole issue involved in the appeal, the Board finds that it lacks jurisdiction over the appeal and hereby dismisses the case. Since there is no jurisdiction over the Providers participating in this appeal as required for Board jurisdiction to grant a request for EJR, the Providers request for EJR is hereby denied. *See* 42 C.F.R. § 405.1842(a). This action closes the case.

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, CPA

For the Board

Michael W. Harty
Chairman

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

[22] For purposes of IPPS providers filing a cost report under protest is achieved by entering such costs on Worksheet E, Part A, Line 30 of the cost report.

cc: James R. Ward, Noridian Healthcare Solutions, LLC
Kevin Shanklin, BCBSA

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

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

CERTIFIED MAIL

JAN 13 2015

Stephen P. Nash
Squire Patton Boggs (US) LLP
1801 California Street
Suite 4900
Denver, CO 80202

RE: Request for Expedited Judicial Review
Patton Boggs 2008 Medicare Outliers Optional Group II
Provider Nos.: Various
FYEs: Various 2008
PRRB Case No.: 13-3296G

Dear Mr. Nash:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' December 12, 2014 request for expedited judicial review (EJR) (received December 15, 2014) in the above referenced appeal. The Board's decision with respect to the request for EJR and jurisdiction is set forth below.

Background

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

> Whether the specific regulations governing Outlier Case Payments as set forth in the two regulatory sources—the Outlier Payment Regulations[1] and the fixed loss threshold ("FLT") Regulations[2] (collectively, the "Medicare Outlier Regulations")—as promulgated by the Secretary of Health and Human Services ("HHS" or the "Secretary") and the Centers for Medicare and Medicaid Services ("CMS"), and in effect for the appealed years, are contrary to the Outlier Statute[3] and/or are otherwise substantively or procedurally invalid?

[1] The Outlier Payment Regulations are the base regulations that establish the method for calculating a hospital's imputed costs for a patient case, which are set forth at 42 C.F.R. §§ 412.80 through 412.86.
[2] The FLT Regulations are set forth in the Secretary's annual promulgation of "Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal year Rates," which, among other things, establishes the outlier fixed-loss thresholds for the coming fiscal year.
[3] *See*, 18 S.S.A. §§ 1886(d)(5)(A)(i)-(iv) and (d)(3)(B); 42 U.S.C. §§ 1395ww(d)(5)(A)(i)-(iv) and (d)(3)(B).

The Providers assert despite the anticipated virtues of the inpatient prospective payment system (IPPS), Congress recognized that health-care providers would inevitably care for some patients whose hospitalizations would be extraordinarily costly or lengthy. To insulate hospitals from bearing a disproportionate share of these atypical costs, Congress authorized HHS to make supplemental outlier case payments. During the years at issue, the outlier payment provisions were set forth in four clauses of the Medicare statute.[4]

The Providers maintain, traditionally, the Secretary has read paragraph (5)(A)(iv) of the statute to mean that prior to the start of each fiscal year, the Secretary must establish a FLT beyond which hospitals will qualify for outlier case payments, at levels resulting in outlier case payments totaling between 5-6% of projected diagnosis related group (DRG) payments for that year. The Providers contend outlier payments are made from the "outlier pool," which is a regulatory set aside or subset of the Medicare Part A Trust Fund, maintained by the government to pay for outliers (Medicare outlier pool). The Medicare outlier pool is, in effect, funded by all of the acute care hospitals participating in Medicare IPPS, in that each such hospital's ordinary IPPS payments are reduced (between 5% and 6%) and those moneys are credited to the Medicare outlier pool.[5]

The Providers assert that from 1997 until 2003, a relatively small number of hospitals greatly inflated their hospital inpatient charges (as captured in their respective "charge masters"), a practice which the United States Department of Justice (DOJ) calls "turbo-charging."[6] This systematic practice of "turbo-charging", coupled with the Secretary's decision to use cost-to-charge ratios (CCRs) that were typically 3 to 5 years old and thus, artificially high, resulted in the calculation of greatly inflated costs per case (CPC). These inflated CPC were then used as the predicate for greatly inflated claims (inflated both in number and amounts) for payments from the Medicare outlier pool.[7, 8]

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The Providers maintain beginning in or around federal fiscal year (FFY) 1998, HHS began making substantial upward adjustments to the FLTs. These adjustments were at a rate far in

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[6] *See, e.g., Amicus Curiae Mem.* of U.S.A in Resp. to Tenet Healthcare Corp's Mot. to Dismiss, *Boca Raton Cmty. Hosp.*, ECF No. [49], at 4 (S.D. Fla. May 17, 2005).
[7] *Id.* at 4-5.
[8] Providers' EJR Req. at 3-4.
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excess of the rate of growth of inflationary indices routinely used by HHS, such as the CPI-Medical Index or the Medicare Market Basket. For instance, from 1997 through 2003, HHS increased the FLTs by more than 246%, when by its own admission there was modest cost inflation (of between 22% and 26%) for the same period. The Providers assert although the Secretary purported to calibrate the FLT adjustments to historical inflation data, the actual increase in FLTs bore no discernible relationship to cost inflation; in fact they were more than 10 times higher.

The Providers contend in late 2002, HHS disclosed that it was aware of "turbo charging" and that it would be amending the outlier payment regulations to fix the vulnerabilities in the same.[10] The Providers assert in its previous promulgating and amending the outlier payment regulations, HHS had variously represented there were no critical flaws in its outlier payment regulations, that it had always used the best available data, and that it would not make retroactive corrections to outlier payments. Then in March 2003, in the process of amending the outlier payment regulations, CMS did an about face on all three of these points, admitting that there were three critical flaws in its outlier payment regulations, that other data, which had always been available and was better, should be used and that the outliers case payments would now be subject to reconciliation.[11]

The Providers argue while the agency was in the process of reversing its position on each of these points, HHS had the opportunity (if not the statutory and/or fiduciary obligation) to reset its FLT to correct for what it openly acknowledged had been the improper redistribution of the Medicare funds allocated for outlier case payments—literally billions of dollars of improper payments made to a few "turbo charging" hospitals, at the expense of the many. Instead, after reviewing hundreds of public comments, most urging HHS to lower the FLT, the agency announced that it would leave the threshold where it was, $33,560.

The Providers assert HHS did not disclose that the agency had known six years earlier how to fix the problems engendered by its earlier flawed regulations and believed it was obligated to do so immediately. The Providers contend HHS also did not disclose in that rulemaking that then-HHS Secretary Thompson and then-Administrator Scully had cleared and signed an interim final regulation (the IFR) and submitted the IFR to the Office of Management and Budget (OMB) for presumptive approval on February 12, 2003.[12] The Providers maintain the IFR contained facts and analysis on the basis of which HHS concluded it was required, mid-year, to lower its fiscal year (FY) 2003 FLT to $20,760 (from $33,560) (*i.e.*, that the 2003 FLT was approximately 62% higher than it should have been) in order to comply with the outlier statute's mandates and the intent of Congress.[13] The Providers contend in stark contrast, HHS' subsequent rulemakings, beginning with the proposed regulation published on February 28, 2003 (March 5, 2003, in the

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[11] *See* 68 Fed. Reg. 34,494, 34,496 and 34,501 (June 9, 2003).

[12] Providers' EJR Req. at 5-6.

[13] *Id.* at 7.

Federal Register),[14] omitted key data, facts, analysis and conclusions. The Providers argue HHS failed to mention, amongst other key information, the agency's considered analysis quantifying the impact of the "turbo-charging" hospitals on its FLT adjustments, the need and method to remove the "turbo-charged" data and what HHS believed to be its statutory obligation to lower the FLT.

The Providers argue contrasting the data, other facts, and analysis set forth in the IFR with HHS' subsequent published rulemakings, it is clear that HHS used corrupted data, and knowingly disregarded its own concurrent provider-favorable conclusions and alternatives in setting the FLTs for fiscal year end (FYEs) 2003-2010. The Providers maintain they did not learn of the IFR until 2012 – and then only through a Freedom of information Act (FOIA) request that through their counsel, submitted to OMB's Office of Information and Regulatory Affairs (OIRA) for various documents related to the Medicare outlier program. The Provider contends as for FYEs 2007-2011, the IFR continued to be relevant because HHS still had not accounted for the impact of the "turbo-charging" data, still relied on hyper-inflated data in projecting the FLTs, and still had not returned the FLTs anywhere close to the levels dictated by analysis set forth in the IFR. Instead, HHS repeatedly set the FLTs at levels which paid out significantly less than the agency's stated target of 5.1% of total IPPS payments. As a result, the Providers argue they did not receive the full amount of the outlier case payments to which they are entitled under the outlier statute.[15]

The Providers allege on June 28, 2012, HHS Office of Inspector General (OIG) issued a report with results from its review of CMS' outlier reconciliation process (the 2012 OIG Report). The 2012 OIG Report reveals the inaccuracy of (and the key information omitted from) HHS' stated reason for not considering the impact of reconciliation, in establishing the FLTs for FYEs 2004-2011. The Providers maintain the Inspector General noted that seven years after the 2003 publication of the regulation requiring reconciliation of outlier payments, CMS had not reconciled any of the cost reports screened and reported by Medicare Administrative Contractors (MACs). The Providers contend in a later 2013 OIG Report, OIG noted that although nearly all hospitals received some outlier payments, a small percentage of hospitals received a significantly higher proportion (almost 6 times higher) of outlier payments than others. These high-outlier hospitals charged Medicare substantially more for the same Medical Severity Diagnostic Related Groups (MS-DRGs), even though their patients had similar lengths of stay as the average in all other hospitals. The Providers argue HHS failed to notice and correct this unusual distribution of outlier payments.[16]

The Providers contend that the FLTs applicable to the claims for which EJR is sought, and as established using the payment regulation and the FLT regulations, are invalid for a number of reasons including but not limited to:

1.) The FLTs established using the payment regulation and the FLT regulations are substantively invalid because, both as written and as implemented, they represent

[14] *See* 68 Fed. Reg. 10,420 (March 5, 2003).
[15] Providers' EJR Req. at 9-10.
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agency action that exceeded statutory authority and frustrated the intent of Congress as reflected in the outlier statute.

2.) CMS has not used the best available data, and in fact, has used faulty data when establishing FLTs even when admonished by hospitals.

3.) The FLTs established by CMS have borne no discernible, much less logical, relationship to CMS' published "inflationary factors."[17]

4.) The FLTs themselves, as calculated pursuant to HHS published criteria, have been (and continue to be) invalid because CMS used data that was not the best available data, used formulas or criteria that CMS knew to be flawed (and did so when CMS knew information was available that would have resulted in a more accurate process), and/or were not supported by substantial evidence (or were contrary to the same).[18]

5.) In disregard of the repeated suggestions of commenters, HHS has refused to make mid-year corrections to the FLTs in order to achieve greater accuracy.

6.) The Medicare outlier regulations (and its companion Program Transmittals) are substantively invalid, as implemented because, in late 2002, when CMS began to realize that its Medicare outlier regulations were flawed, CMS began a process of "selective" administration of the Medicare outlier statute through an effort to correct (and recoup) overpayments but with no corresponding effort to correct underpayments.[19]

7.) The Medicare outlier regulations are both substantively and procedurally invalid because, as written and as implemented, their actual effect has been to frustrate the intent of Congress, and to deprive the Providers of the "catastrophic loss" protection that Congress intended the outlier statute to provide. The agency action described above has consistently violated the outlier statute, and in the absence of adequate explanation, has also violated the Administrative Procedure Act ("APA") as an arbitrary and capricious, and therefore invalid rule-making, and should be set aside.

8.) The Medicare outlier regulations are procedurally invalid because, when HHS amended the outlier payment regulations, it failed to disclose the alternatives set forth in the IFR, alternatives that it had not only considered, but had signed, cleared for distribution outside the agency, and sent to OMB for presumptive approval in the form of an emergency Interim Final Rule. HHS failed to provide any explanation for why it abandoned this alternative. Indeed, it did not even mention the alternative of removing "turbo-charging" data from its future analysis of setting FLTs.[20]

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[17] *Id.* at 14.
[18] *Id.* at 16.
[19] *Id.* at 20.
[20] *Id.* at 22-23.

Decision of the Board

The Medicare statute at 42 U.S.C. § 1395oo(f)(1) (2013) and the regulation at 42 C.F.R. § 405.1842(f)(1) (2013) require the Board to grant EJR if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling.

42 C.F.R. § 405.1835(a) (2013) sets forth the requirements for a Board hearing. The regulation provides:

> (a) **Criteria.** A provider . . . has a *right to a Board hearing*, as a single provider appeal, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination, *only if*—
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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)).
>
> (2) The amount in controversy . . . is $10,000 or more[21]; and
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836 of this subpart, the date of receipt by the Board of the Provider's hearing request is—
>
> (i) No later than 180 days after the date of receipt by Provider of the intermediary or Secretary determination (emphasis added).

[21] $50,000 for a group appeal. *See* 42 C.F.R. § 405.1837(a)(3).

The Provider Reimbursement Manual (CMS Pub. 15-2 § 115 and 3630.1) describes the information that is required to be entered and submitted for protested amounts on Worksheet E, Part A, Line 30 of the as-filed cost report.[22] The Manual requires that providers:

1.) include the non-allowable item in the cost report in order to establish an appeal issue;

2.) estimate the reimbursement effect of the non-allowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process; and

3.) submit with the cost report copies of the working papers used to develop the estimated adjustments.

In the instant case, the following Providers have fiscal years that end on December 31, 2008, and thus were required to file the outlier reimbursement issue under protest on Worksheet E, Part A, Line 30 of the cost report pursuant to 42 C.F.R. § 405.1835(a)(1)(ii):

Provider #1, Boulder Community Hospital (provider number 06-0027, FYE 12/31/08),
Provider #2 Bozeman Deaconess Hospital (provider number 27-0057, FYE 12/31/08),
Provider #4, Charleston Area Medical Center (provider number 51-0022, FYE 12/31/08),
Provider #5 Denver Health (provider number 06-0011, FYE 12/31/08), and
Provider #8 West Virginia University Hospital (provider number 51-0001, FYE 12/31/08).

Provider #1, Boulder Community Hospital, Provider #2, Bozeman Deaconess Hospital, and Provider #5 Denver Health, did not claim any protested items on Worksheet E, Part A, Line 30 of the cost report as required to protest the amount of outlier reimbursement. Provider #4 Charleston Area Medical Center, and Provider #8 West Virginia University Hospital, claimed an amount on Worksheet E, Part A, Line 30 of the cost report. However, Provider #4, Charleston Area Medical Center, protested items specific to bad debts only and not the outlier reimbursement issue. Provider #8, West Virginia University Hospital, indicated that the protested amounts did not include the outlier reimbursement issue.

As these Providers failed to protest the outlier reimbursement at issue, the Board finds that it lacks jurisdiction over Provider #1, Boulder Community Hospital (provider number 06-0027, FYE 12/31/08), Provider #2 Bozeman Deaconess Hospital (provider number 27-0057, FYE 12/31/08), Provider #4, Charleston Area Medical Center (provider number 51-0022, FYE 12/31/08), Provider #5, Denver Health (provider number 06-0011, FYE 12/31/08), and Provider #8, West Virginia University Hospital (provider number 51-0001, FYE 12/31/08) and dismisses these Providers from the appeal. Since jurisdiction is a prerequisite to granting a request for EJR, the Board hereby denies these Providers' request for EJR. *See* 42 C.F.R. § 405.1842(a).

[22] For purposes of IPPS providers filing a cost report under protest is achieved by entering such costs on Worksheet E, Part A, Line 30 of the cost report.

As to the remaining Providers in the case, Provider #3, Cabell Huntington Hospital (provider number 51-0055, FYE 09/30/08), Provider #6, Good Samaritan (provider number 05-0471, FYE 08/31/08), Provider #7, Parkview Medical Center (provider number 06-0020, FYE 06/30/08), and Provider #9, Billings Clinic (provider number 27-0004, FYE 06/30/08), have cost reporting periods that end prior to December 31, 2008. Thus, pursuant to *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988), there is no regulatory requirement to preserve dissatisfaction through a protested claim; the dissatisfaction requirement for Board jurisdiction for these Providers has been satisfied. The documentation shows that in this case the estimated amount in controversy exceeds the $50,000 threshold for Board jurisdiction over group appeals and the appeals were timely filed.

As such, the Board finds that:

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

2.) based upon the Providers' assertions regarding the outlier regulations, 42 C.F.R. §§ 412.80-412.86, there are no findings of fact for resolution by the Board;

3.) it is bound by the regulations; and

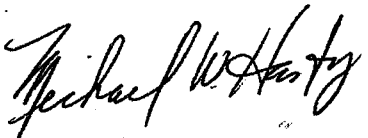
4.) it is without the authority to decide the legal question of whether the outlier regulations, are valid.

Accordingly, the Board finds that the outlier issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the request for EJR for Provider #3, Cabell Huntington Hospital (provider number 51-0055, FYE 9/30/08), Provider #6, Good Samaritan (provider number 05-0471, FYE 08/31/08), Provider #7, Parkview Medical Center (provider number 06-0020, FYE 6/30/08), and Provider #9, Billings Clinic Hospital (provider number, 27-0004, FYE 6/30/08), for the issue and the subject year. These Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

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, CPA

For the Board



Michael W. Harty
Chairman

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

cc: Timothy LeJeune, Novitas Solutions, Inc.
Kevin Shanklin, BCBSA

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

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Certified Mail

JAN 13 2015

Stephen P. Nash
Squire Patton Boggs (US) LLP
1801 California Street
Suite 4900
Denver, CO 80202

RE: Request for Expedited Judicial Review
Patton Boggs 2010 Medicare Outliers-NPR Optional Group
Provider Nos.: 27-0057 and 06-0075
FYE: 12/31/2010
PRRB Case No.: 14-0312G

Dear Mr. Nash:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' December 12, 2014 request for expedited judicial review (EJR) (received December 15, 2014) in the above referenced appeal. The Board concludes that it lacks jurisdiction over the appeal and hereby denies the request for EJR.

Background

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

> Whether the specific regulations governing Outlier Case Payments as set forth in the two regulatory sources—the Outlier Payment Regulations[1] and the fixed loss threshold ("FLT") Regulations[2] (collectively, the "Medicare Outlier Regulations")—as promulgated by the Secretary of Health and Human Services ("HHS" or the "Secretary") and the Centers for Medicare and Medicaid Services ("CMS"), and in effect for the appealed years, are contrary to the Outlier Statute[3] and/or are otherwise substantively or procedurally invalid?

[1] The Outlier Payment Regulations are the base regulations that establish the method for calculating a hospital's imputed costs for a patient case, which are set forth at 42 C.F.R. §§ 412.80 through 412.86.
[2] The FLT Regulations are set forth in the Secretary's annual promulgation of "Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal year Rates," which, among other things, establishes the outlier fixed-loss thresholds for the coming fiscal year.
[3] *See*, 18 S.S.A. §§ 1886(d)(5)(A)(i)-(iv) and (d)(3)(B); 42 U.S.C. §§ 1395ww(d)(5)(A)(i)-(iv) and (d)(3)(B).

The Providers assert despite the anticipated virtues of the inpatient prospective payment system (IPPS), Congress recognized that health-care providers would inevitably care for some patients whose hospitalizations would be extraordinarily costly or lengthy. To insulate hospitals from bearing a disproportionate share of these atypical costs, Congress authorized HHS to make supplemental outlier case payments. During the year at issue, the outlier payment provisions were set forth in four clauses of the Medicare statute.[4]

The Providers maintain, traditionally, the Secretary has read paragraph (5)(A)(iv) of the statute to mean that prior to the start of each fiscal year, the Secretary must establish a FLT beyond which hospitals will qualify for outlier case payments, at levels resulting in outlier case payments totaling between 5-6% of projected diagnosis related group (DRG) payments for that year. The Providers contend outlier payments are made from the "outlier pool," which is a regulatory set aside or subset of the Medicare Part A Trust Fund, maintained by the government to pay for outliers (Medicare outlier pool). The Medicare outlier pool is, in effect, funded by all of the acute care hospitals participating in Medicare IPPS, in that each such hospital's ordinary IPPS payments are reduced (between 5% and 6%) and those moneys are credited to the Medicare outlier pool.[5]

The Providers assert that from 1997 until 2003, a relatively small number of hospitals greatly inflated their hospital inpatient charges (as captured in their respective "charge masters"), a practice which the United States Department of Justice (DOJ) calls "turbo-charging."[6] This systematic practice of "turbo-charging," coupled with the Secretary's decision to use cost-to-charge ratios (CCRs) that were typically 3 to 5 years old and thus, artificially high, resulted in the calculation of greatly inflated costs per case (CPC). These inflated CPC were then used as the predicate for greatly inflated claims (inflated both in number and amounts) for payments from the Medicare outlier pool.[7, 8]

The Providers contend, in its later investigations of hospitals it believed had engaged in charge inflation, the DOJ alleged that the practice of "turbo-charging" led directly to inflated claims for payments under the Medicare outlier program, which the DOJ characterized as "false claims." The Providers argue these and other inflated claims led HHS to increase the FLTs at a precipitous rate in an attempt to ensure that the total amount of outlier payments made for discharges in the fiscal years at issue would remain at 5.1 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year.[9]

The Providers maintain beginning in or around federal fiscal year (FFY) 1998, HHS began making substantial upward adjustments to the FLTs. These adjustments were at a rate far in excess of the rate of growth of inflationary indices routinely used by HHS, such as the CPI-

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[4] 42 U.S.C. § 1395ww(d)(5)(A)(i)-(iv).
[5] 42 U.S.C. § 1395ww(d)(3)(B).
[6] *See, e.g., Amicus Curiae Mem.* of U.S.A in Resp. to Tenet Healthcare Corp's Mot. to Dismiss, *Boca Raton Cmty. Hosp.*, ECF No. [49], at 4 (S.D. Fla. May 17, 2005).
[7] *Id.* at 4-5.
[8] Providers' EJR Req. at 3-4.
[9] *Medicare Outlier Payments to Hospitals: Hearing Before a Subcomm. of the S. Comm. on Appropriations*, 108th Cong. 3-17 (2003) (statement by Thomas A. Scully Administrator, Centers for Medicare and Medicaid Services, Department of Health and Human Services).

Medical Index or the Medicare Market Basket. For instance, from 1997 through 2003, HHS increased the FLTs by more than 246%, when by its own admission there was modest cost inflation (of between 22% and 26%) for the same period. The Providers assert although the Secretary purported to calibrate the FLT adjustments to historical inflation data, the actual increase in FLTs bore no discernible relationship to cost inflation; in fact they were more than 10 times higher.

The Providers contend in late 2002, HHS disclosed that it was aware of "turbo charging" and that it would be amending the outlier payment regulations to fix the vulnerabilities in the same.[10] The Providers assert in its previous promulgating and amending the outlier payment regulations, HHS had variously represented there were no critical flaws in its outlier payment regulations, that it had always used the best available data, and that it would not make retroactive corrections to outlier payments. Then in March 2003, in the process of amending the outlier payment regulations, CMS did an about face on all three of these points, admitting that there were three critical flaws in its outlier payment regulations, that other data, which had always been available and was better, should be used and that the outliers case payments would now be subject to reconciliation.[11]

The Providers argue while the agency was in the process of reversing its position on each of these points, HHS had the opportunity (if not the statutory and/or fiduciary obligation) to reset its FLT to correct for what it openly acknowledged had been the improper redistribution of the Medicare funds allocated for outlier case payments—literally billions of dollars of improper payments made to a few "turbo charging" hospitals, at the expense of the many. Instead, after reviewing hundreds of public comments, most urging HHS to lower the FLT, the agency announced that it would leave the threshold where it was, $33,560.

The Providers assert HHS did not disclose that the agency had known six years earlier how to fix the problems engendered by its earlier flawed regulations and believed it was obligated to do so immediately. The Providers contend HHS also did not disclose in that rulemaking that then-HHS Secretary Thompson and then-Administrator Scully had cleared and signed an interim final regulation (the IFR) and submitted the IFR to the Office of Management and Budget (OMB) for presumptive approval on February 12, 2003.[12] The Providers maintain the IFR contained facts and analysis on the basis of which HHS concluded it was required, mid-year, to lower its fiscal year (FY) 2003 FLT to $20,760 (from $33,560) (*i.e.*, that the 2003 FLT was approximately 62% higher than it should have been) in order to comply with the outlier statute's mandates and the intent of Congress.[13] The Providers contend in stark contrast, HHS' subsequent rulemakings, beginning with the proposed regulation published on February 28, 2003 (March 5, 2003, in the Federal Register),[14] omitted key data, facts, analysis and conclusions. The Providers argue HHS failed to mention, amongst other key information, the agency's considered analysis quantifying

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[10] *See* CMS *Program Memorandum*, Transmittal A-02-122 (Dec. 3, 2002); CMS *Program Memorandum*, Transmittal A-02-126 (Dec. 20, 2002); CMS *Program Memorandum Intermediaries*, Transmittal A-03-058, July 3, 2003; and CMS Manual System, Pub. 100-04 Medicare Claims Processing, Transmittal 707, October 12, 2005, Change Request 3966.

[11] *See* 68 Fed. Reg. 34,494, 34,496 and 34,501 (June 9, 2003).

[12] Providers' EJR Req. at 5-6.

[13] *Id.* at 7.

[14] *See* 68 Fed. Reg. 10,420 (March 5, 2003).

the impact of the "turbo-charging" hospitals on its FLT adjustments, the need and method to remove the "turbo-charged" data and what HHS believed to be its statutory obligation to lower the FLT.

The Providers argue contrasting the data, other facts, and analysis set forth in the IFR with HHS' subsequent published rulemakings, it is clear that HHS used corrupted data, and knowingly disregarded its own concurrent provider-favorable conclusions and alternatives in setting the FLTs for fiscal year end (FYEs) 2003-2010. The Providers maintain they did not learn of the IFR until 2012 – and then only through a Freedom of information Act (FOIA) request that through their counsel, submitted to OMB's Office of Information and Regulatory Affairs (OIRA) for various documents related to the Medicare outlier program. The Provider contends as for FYEs 2007-2011, the IFR continued to be relevant because HHS still had not accounted for the impact of the "turbo-charging" data, still relied on hyper-inflated data in projecting the FLTs, and still had not returned the FLTs anywhere close to the levels dictated by analysis set forth in the IFR. Instead, HHS repeatedly set the FLTs at levels which paid out significantly less than the agency's stated target of 5.1% of total IPPS payments. As a result, the Providers argue they did not receive the full amount of the outlier case payments to which they are entitled under the outlier statute.[15]

The Providers allege on June 28, 2012, HHS Office of Inspector General (OIG) issued a report with results from its review of CMS' outlier reconciliation process (the 2012 OIG Report). The 2012 OIG Report reveals the inaccuracy of (and the key information omitted from) HHS' stated reason for not considering the impact of reconciliation, in establishing the FLTs for FYEs 2004-2011. The Providers maintain the Inspector General noted that seven years after the 2003 publication of the regulation requiring reconciliation of outlier payments, CMS had not reconciled any of the cost reports screened and reported by Medicare Administrative Contractors (MACs). The Providers contend in a later 2013 OIG Report, OIG noted that although nearly all hospitals received some outlier payments, a small percentage of hospitals received a significantly higher proportion (almost 6 times higher) of outlier payments than others. These high-outlier hospitals charged Medicare substantially more for the same Medical Severity Diagnostic Related Groups (MS-DRGs), even though their patients had similar lengths of stay as the average in all other hospitals. The Providers argue HHS failed to notice and correct this unusual distribution of outlier payments.[16]

The Providers contend that the FLTs applicable to the claims for which EJR is sought, and as established using the payment regulation and the FLT regulations, are invalid for a number of reasons including but not limited to:

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

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[15] Providers' EJR Req. at 9-10.
[16] *Id.* at 11-12.

2.) CMS has not used the best available data, and in fact, has used faulty data when establishing FLTs even when admonished by hospitals.

3.) The FLTs established by CMS have borne no discernible, much less logical, relationship to CMS' published "inflationary factors."[17]

4.) The FLTs themselves, as calculated pursuant to HHS published criteria, have been (and continue to be) invalid because CMS used data that was not the best available data, used formulas or criteria that CMS knew to be flawed (and did so when CMS knew information was available that would have resulted in a more accurate process), and/or were not supported by substantial evidence (or were contrary to the same).[18]

5.) In disregard of the repeated suggestions of commenters, HHS has refused to make mid-year corrections to the FLTs in order to achieve greater accuracy.

6.) The Medicare outlier regulations (and its companion Program Transmittals) are substantively invalid, as implemented because, in late 2002, when CMS began to realize that its Medicare outlier regulations were flawed, CMS began a process of "selective" administration of the Medicare outlier statute through an effort to correct (and recoup) overpayments but with no corresponding effort to correct underpayments.[19]

7.) The Medicare outlier regulations are both substantively and procedurally invalid because, as written and as implemented, their actual effect has been to frustrate the intent of Congress, and to deprive the Providers of the "catastrophic loss" protection that Congress intended the outlier statute to provide. The agency action described above has consistently violated the outlier statute, and in the absence of adequate explanation, has also violated the Administrative Procedure Act ("APA") as an arbitrary and capricious, and therefore invalid rule-making, and should be set aside.

8.) The Medicare outlier regulations are procedurally invalid because, when HHS amended the outlier payment regulations, it failed to disclose the alternatives set forth in the IFR, alternatives that it had not only considered, but had signed, cleared for distribution outside the agency, and sent to OMB for presumptive approval in the form of an emergency Interim Final Rule. HHS failed to provide any explanation for why it abandoned this alternative. Indeed, it did not even mention the alternative of removing "turbo-charging" data from its future analysis of setting FLTs.[20]

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[17] *Id.* at 14.
[18] *Id.* at 16.
[19] *Id.* at 20.
[20] *Id.* at 22-23.

Case No. :14-0312G

Decision of the Board

The Board has reviewed the submission of the Providers pertaining to the requests for hearing and expedited judicial review. The Board concludes that it lacks jurisdiction over the appeal and hereby dismisses the case. Since jurisdiction is a prerequisite to granting a request for EJR, the Board hereby denies the request for EJR. *See* 42 C.F.R. § 405.1842(a).

The Medicare statute at 42 U.S.C. §1395oo(f)(1) (2013) and the regulation at 42 C.F.R. §405.1842(f)(1) (2013), require the Board to grant EJR if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling.

42 C.F.R. § 405.1835(a) (2013) sets forth the requirements for a Board hearing. The regulation provides:

> (a) **Criteria.** A provider . . . has a *right to a Board hearing*, as a single provider appeal, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination, *only if*—
>
> (1) *The provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for specific item(s) at issue, by* either—
>
> (i) Including a claim for specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or
>
> (ii) Effective with cost reporting periods that end on or after December 31, 2008, *self-disallowing the specific item(s) by following the applicable procedures for filing a cost report under protest*, where the provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy (for example, if the intermediary lacks discretion to award the reimbursement the provider seeks for the item(s)).
>
> (2) The amount in controversy . . . is $10,000 or more[21]; and
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836 of this subpart, the date of receipt by the Board of the Provider's hearing request is—

[21] $50,000 for group appeals. *See* 42 C.F.R. § 405.1837(a)(3).

(i) No later than 180 days after the date of receipt by Provider of the intermediary or Secretary determination (emphasis added).

The Provider Reimbursement Manual (CMS Pub. 15-2 § 115 and 3630.1) describes the information that is required to be entered and submitted for protested amounts on Worksheet E, Part A, Line 30 of the as-filed cost report.[22] The Manual requires that providers:

1.) include the non-allowable item in the cost report in order to establish an appeal issue;

2.) estimate the reimbursement effect of the non-allowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process; and

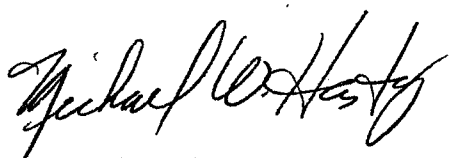
3.) submit with the cost report copies of the working papers used to develop the estimated adjustments.

In this case, there is no amount claimed on Worksheet E, Part A, Line 30 of the cost reports as required to protest the amount of outlier reimbursement pursuant to 42 C.F.R. § 405.1835(a)(1)(ii). As these cost reports involve fiscal years that end after December 31, 2008, self-disallowed items such as the outlier reimbursement at issue must have been filed under protest. As the Providers failed to protest the outlier reimbursement at issue and that is the sole issue involved in the appeal, the Board finds that it lacks jurisdiction over the appeal and hereby dismisses the case. Since there is no jurisdiction over the Providers participating in this appeal as required for Board jurisdiction to grant a request for EJR, the Providers' request for EJR is hereby denied. *See* 42 C.F.R. § 405.1842(a). This action closes the case.

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, CPA

For the Board



Michael W. Harty
Chairman

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

cc: James R. Ward, Noridian Healthcare Solutions, LLC
Kevin Shanklin, BCBSA

[22] For purposes of IPPS providers filing a cost report under protest is achieved by entering such costs on Worksheet E, Part A, Line 30 of the cost report.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to: 15-0750

JAN 14 2015

**CERTIFIED MAIL**

Mr. Isaac Blumberg
Blumberg Ribner, Inc.
315 South Beverly Drive
Suite 505
Beverly Hills, CA 90212

RE: SSM Saint Mary's Health Center
Provider No.: 26-0011
FYE – 12/31/2010
PRRB Case No.: 15-0750

Dear Mr. Blumberg:

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

**Pertinent Facts:**

Blumberg Ribner, Inc. filed an individual appeal for SSM Saint Mary's Medical Center, Provider No.: 26-0011, FYE – 12/31/2010 by letter dated December 5, 2014, received in the Board's office on December 9, 2014. The Board established case number 15-0750 and issued an acknowledgement letter on December 29, 2014. Upon further review, it is noted that the appeal request did not include a copy of the final determination (the Notice of Program Reimbursement ("NPR") dated June 10, 2014).

**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. The Board notes that the subject appeal filed by Blumberg Ribner, Inc. does not meet the regulatory requirements in that a final determination was not included with the initial appeal request.

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 acknowledgment does not limit the Board's authority to require more information or dismiss the appeal if it is later found to be jurisdictionally deficient.

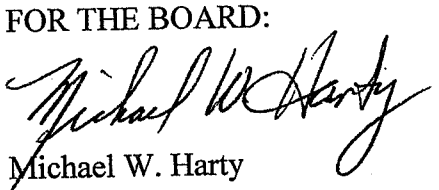
Because the appeal request was not filed in conformance with 42 C.F.R. § 405.1835 and the Board Rules, the Board hereby dismisses case number 15-0750.

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
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA

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: Byron Lamprecht
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**CERTIFIED MAIL**

JAN 15 2015

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

RE: Provider 1, Providence Little Company of Mary Hospital, Provider No. 05-0353, FYE 12/31/03, as a participant in "Providence Health System 2003 SSI Percentage Group" PRRB Case No.: 09-0788GC

Dear Mr. Blumberg:

The Provider Reimbursement Review Board (Board) has reviewed the Schedule of Providers and the associated jurisdictional documents for case number 09-0788GC. The Board finds that it lacks jurisdiction over Provider 1, Providence Little Company of Mary Hospital, Provider No. 05-0353, fiscal year end (FYE) December 31, 2003, as Providence Little Company of Mary Hospital appealed from a revised NPR and the supplemental security income (SSI) percentage was not specifically adjusted.

Background

On September 20, 2007, the Medicare administrative contractor (MAC) issued a notice of program reimbursement (NPR) to Providence Little Company of Mary Hospital, Provider No. 05-0353, for the cost reporting period ending December 31, 2003. On January 21, 2008, Providence Little Company of Mary Hospital filed an appeal of the NPR challenging, amongst other things, the Medicare SSI percentage. The Board assigned case number 08-0669 to the appeal. On July 02, 2008, the MAC issued a revised NPR to Providence Little Company of Mary Hospital. On August 7, 2008, the MAC issued a second revised NPR to Providence Little Company of Mary Hospital. On January 26, 2009, Providence Little Company of Mary Hospital requested to join the current group appeal, case number 09-0788GC, from a direct appeal of the second revised NPR dated August 7, 2008. On December 28, 2009, Providence Little Company of Mary Hospital requested to transfer the SSI percentage issue from its individual appeal, case number 08-0669, to case number 09-1707GC.

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) (2009) and 42 C.F.R. § 405.1835-405.1841 (2009), a Provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the

intermediary, the amount in controversy is $10,000 or more ($50,000 for a group) and the request for a hearing is filed within 180 days of the NPR.

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2009) 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).

A revised NPR is considered a separate and distinct determination from which the provider may appeal. 42 C.F.R. § 405.1889(a) (2009) states:

> [i]f 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 are applicable.
>
> § 405.1889(b)(1) explains the effect of a cost report revision: [o]nly 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.

This regulation has also been addressed and explained in the decision *HCA Health Services of Oklahoma v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994). In this case, the court held that when a fiscal intermediary reopens its original determination regarding the amount of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening and does not extend further to all determinations underlying the original NPR. More recently, this regulation has also been addressed in the decision *Emanuel Med. Ctr., Inc. v. Sebelius*, No. CV 12-1962 (GK), 2014 WL 1557524, at *8 (D.D.C. Apr. 17, 2014), the court held that the Secretary's "issue-specific" interpretation of her NPR reopening regulations is reasonable and entitled to substantial deference.

In this case, Providence Little Company of Mary Hospital is appealing from a revised NPR audit adjustment report (adjustment 4) that adjusted the disproportionate share hospital (DSH) percentage. The adjustment report prepared on July 31, 2008, shows an adjustment to the total DSH percentage as reported on Worksheet E, Part A, Line 4.03, "[t]o include the correct allowable DSH percentage on the cost report" but there is no adjustment specific to the SSI percentage. Worksheet E, Part A, Lime 4.0 (the line the DSH SSI ratio is reported on) prepared on July 31, 2008, lists the SSI ratio for the second revised NPR as 11.45. However, the Provider provided no documentation for the first revised NPR dated July 2, 2008, to show that the SSI percentage was revised from the first revised NPR dated July 2, 2008, to the second revised NPR dated August 7, 2008. The original NPR dated September 20, 2007, SSI percentage was .1119 but it was not documented if the first revised NPR had an SSI percentage revision. As such, the Board finds that it lacks jurisdiction over Provider 1, Providence Little Company of Mary Hospital, Provider No. 05-0353 from the revised NPR dated August 7, 2008, and dismisses the Provider from the group appeal.[1]

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

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), 42 C.F.R. §§ 405.1875 and 405.1877

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

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

[1] The original NPR appeal although included on the Schedule of Providers is not a part of this group appeal as it was transferred to case number 09-1707GC.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to: 15-0825

JAN 15 2015

**CERTIFIED MAIL**

Mr. Isaac Blumberg
Blumberg Ribner, Inc.
315 South Beverly Drive
Suite 505
Beverly Hills, CA 90212

Mr. Daniel Flood
CHS Services c/o Mercy Medical Center
1000 North Village Avenue
Rockville Centre, NY 11570-1098

RE: Mercy Medical Center
Provider No.: 33-0259
FYE – 12/31/2010
PRRB Case No.: 15-0825

Dear Messrs. Blumberg and Flood:

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

**Pertinent Facts:**

Blumberg Ribner, Inc. filed an individual appeal for Mercy Medical Center, Provider No.: 33-0259, FYE – 12/31/2010 by letter dated December 19, 2014, received in the Board's office on December 22, 2014. The Board established case number 15-0825 and issued an acknowledgement letter on January 5, 2015. Upon further review, it is noted that the appeal request did not include a copy of the final determination (the Notice of Program Reimbursement ("NPR") dated June 24, 2014).

**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. The Board notes that the subject appeal filed by Blumberg Ribner, Inc. does not meet the regulatory requirements in that a final determination was not included with the initial appeal request.

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 acknowledgment does not limit the Board's authority to require more information or dismiss the appeal if it is later found to be jurisdictionally deficient.

In addition, 42 C.F.R. § 405.1835(a) clearly states that only a Provider has a right to a hearing before the Board. Without a representation letter signed *prior* to the appeal request, Blumberg Ribner has no authorization to file an appeal on behalf of a provider, nor should the Board be corresponding with them on an appeal for which they are not the authorized representative. If a Provider has not provided Blumberg Ribner with a representation letter, it is acting without authority to file an appeal with the Board.

Because the appeal request was not filed in conformance with 42 C.F.R. § 405.1835 and the Board Rules, the Board hereby dismisses case number 15-0825.

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
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA

FOR THE BOARD:

Michael W. Harty
Chairman

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

cc: Kyle Browning
Appeals Lead
National Government Services
MP: INA102 - AF42
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Refer to:

CERTIFIED MAIL

JAN 15 2015

CHE Trinity Health
Cynthia F. Wisner, Associate Counsel
20555 Victor Parkway
Livonia, MI 48152

RE: Trinity 2000-2001 DSH SSI CIRP Group
Specifically Mercy Medical Center Sioux City (16-0153) FYE 2000 and 2001
Participants 1 and 2 in PRRB Case No.: 12-0242GC

Dear Ms. Wisner:

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced appeal. Background for the two of the participants in question and the jurisdictional decision of the Board are set forth below.

**Background:**

**Mercy Medical Center Sioux City (16-0153) FYE 2000 (Participant 1)**

On June 18, 2008 Mercy Medical Center Sioux City appealed from a revised NPR dated January 3, 2008 to which the Board assigned case number 08-2134. The Notice of Reopening submitted indicates that the cost report was reopened to incorporate the results of a full Administrative Resolution (AR) in the Provider's initial individual appeal, case number 03-0631. The Provider did not supply a copy of the audit adjustment page showing the adjustment to the SSI Percentage. The Provider transferred the SSI Percentage issue from case number 08-2134 to the subject group appeal on August 18, 2012.

**Mercy Medical Center Sioux City (16-0153) FYE 2001 (Participant 2)**

On June 18, 2008 Mercy Medical Center Sioux City appealed from a revised NPR dated April 21, 2008 to which the Board assigned case number 08-2135. The Notice of Reopening submitted indicates that the cost report was reopened to incorporate the results of a full Administrative Resolution (AR) in the Provider's initial individual appeal, case number 04-1358. The Provider did not supply a copy of the audit adjustment page showing the adjustment to the SSI Percentage. The Provider transferred the issue to the subject group appeal on August 18, 2012.

**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 Mercy Medical Center Sioux City's revised NPR appeals for FYE 2000 and 2001.

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).

Further, 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 42 C.F.R. §§ 405.1811, 405.1835, 405.1875 and 405.1877 are applicable.

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

The Board finds that it does not have jurisdiction over Mercy Medical Center Sioux City's revised NPR appeals because the documentation submitted does not establish that the SSI Percentage was specifically revised for FYE 2000 and 2001. The Provider was issued revised NPRs in response to administrative resolutions in case numbers 03-0631 and 04-1358, respectively. The Provider did not supply copies of the adjustment pages for either FYE. Therefore, the Provider did not establish that the SSI Percentage was specifically revised for FYEs 2000 and 2001 as required by the regulations and both years are hereby dismissed from this 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.

The Parties will receive correspondence regarding the applicability of CMS Ruling 1498-R for the remaining participants in the group appeal under separate cover.

Board Members
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA

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: 10-0181

JAN 22 2015

CERTIFIED MAIL

Danny Hutter
Reimbursement Manager
Cox Health
3850 S. National Avenue, Suite 500
Springfield, MO 65807

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

Re: Provider: Cox Health
Provider No.: 26-0040
FYE: 09/30/2004
PRRB Case No.: 10-0181

Dear Mr. Hutter and Mr. Lamprecht:

The Provider, Cox Health ("Cox"), appealed the amount of its Medicare reimbursement calculated by the Medicare Administrative Contractor, Wisconsin Physicians Service ("WPS"). The Provider Reimbursement Review Board ("Board") concludes that it lacks jurisdiction over Cox's appeal because Cox abandoned all of the existing issues in its appeal. The Board hereby dismisses the case.

Background

Cox timely appealed eight issues to the Board:

(1) Disproportionate share hospital ("DSH") supplemental security income percentage ("SSI%") "Provider Specific"
(2) DSH SSI% "Systemic Errors"
(3) Medicaid eligible days
(4) Part C days
(5) Dual eligible days
(6) Exhausted Medicare benefits days
(7) Labor and delivery room days
(8) Missouri charity care days[1]

Upon receipt of Cox's appeal, the Board sent its Acknowledgement and Critical Due Dates letter. The letter provided that Cox's preliminary position paper was due by August 1,

[1] Cox Individual Appeal Request, Nov. 30, 2009.

2010.[2] The Board received proof that Cox submitted its preliminary position paper to WPS on July 29, 2010. Cox only briefed one issue in its preliminary position paper, SSI% "Provider Specific." The Board also received several transfer requests from Cox, requesting the following transfers:

(1) SSI% to Case No. 08-2929G
(2) Part C days to Case No. 07-2388G
(3) Labor and delivery room days to Case No. 07-2324G
(4) Exhausted Medicare benefits days to Case No. 09-0377G
(5) Missouri charity care days to Case No. 07-2274G[3]

Board Determination

Board Rule 16.2 provides that the Board will not acknowledge transfers to an existing group appeal; it is the provider's responsibility to maintain evidence of timely filing.[4] This means that, for this analysis, the Board will presume that Cox's transfer requests are jurisdictionally valid. Cox requested only one transfer for its SSI% issue, but both SSI% "Provider Specific" and SSI% "Systemic Errors" will transfer to Case No. 08-2929G, as discussed more fully below. Therefore, the only issues remaining in Cox's individual appeal are Medicaid eligible days and dual eligible days.

*SSI%*

Board Rule 4.5 states that, "[a] Provider may not appeal an issue from a final determination in more than one appeal."[5] Cox requested "SSI%" to be transferred to a group appeal; however, Cox identified two SSI% issues in its individual appeal request: "Provider Specific" and "Systemic Errors." Cox did not distinguish which issue it requested to transfer, although Cox solely briefed SSI% "Provider Specific" in its preliminary position paper for the instant case. Upon review, the Board finds that SSI% "Provider Specific" and SSI% "Systemic Errors" is one issue for the purposes of this appeal. Therefore, under Board rules, Cox is barred from filing a duplicate SSI% issue.

In describing the issues in its individual appeal request, Cox basically disputes whether WPS used the correct SSI% in computing its DSH calculation.[6] Both issues reference audit adjustment number 20.[7] Cox contends that the "Provider Specific" issue is based on "certain data from the State of Missouri and the Provider that does not support the SSI percentage issued by CMS."[8] Cox states it analyzed Medicare Part A and state records to identify patients believed

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[2] Acknowledgement and Critical Due Dates letter, Dec. 3, 2009.
[3] Model Form D Transfer Requests, Jul. 28, 2010.
[4] Board Rule 16.2 at 13, Mar. 1, 2013.
[5] Board Rule 4.5 at 3.
[6] Cox Individual Appeal Request at Tab 3, 1-4.
[7] *Id.* at 1, 4.
[8] Cox Preliminary Position Paper at 7, Jul. 9, 2010.

to be entitled to both Medicare Part A and SSI that were not accounted for in its SSI% for DSH calculation purposes.[9] However, Cox states that, "in order to confirm [its] findings, [Cox] needs to obtain SSI data from CMS . . . "[10] Cox presents a similar argument for its SSI% "Systemic Errors" issue. Cox contends that the SSI% published by CMS was incorrectly computed for several reasons, and that Cox lacks access to the data.[11]

The SSI data is the underlying issue for both SSI% "Provider Specific" and SSI% "Systemic Errors." The Board finds that SSI% is one issue for appeal purposes. Specifically, the SSI% "Provider Specific" issue that was briefed is a subset of the SSI% "Systemic Errors" issue that was transferred. Therefore, the Board concludes that this issue was previously transferred to a group appeal. The SSI% issue will be handled in Case No. 08-2929G pursuant to CMS Ruling 1498-R.

Thus, the only remaining issues in the individual appeal are Medicaid eligible days and dual eligible days.

*Medicaid Eligible Days and Dual Eligible Days*

Board Rule 23.4 states that a case will be dismissed if a provider fails to file its preliminary position paper by the requisite due date.[12] A provider's preliminary position paper must state the material facts that support its claim for each issue.[13] The issues of Medicaid eligible days and dual eligible days remained in Cox's individual appeal as of the due date for its preliminary position paper. Cox submitted a timely preliminary position paper; however, it did not brief these two issues. Board Rule 41.2 states that the Board may dismiss a case or an issue on its own motion if it has a reasonable basis to believe that the issues have been abandoned.[14] If an issue is not addressed as required by Rules 23.4 and 25.1, the issue is considered abandoned and dismissed from the case. Here, the Board finds that Cox failed to brief both Medicaid eligible days and dual eligible days in its preliminary position paper. Therefore, the Board concludes that these issues are dismissed from the appeal.

*Conclusion*

The Board concludes that six of the eight issues under appeal were transferred to various group appeals, and that the Board lacks jurisdiction over the remaining two issues as they were not briefed in Cox's preliminary position paper (and, therefore, abandoned). Since no other issues remain in this case, the Board hereby closes this case. Review of this jurisdictional decision is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1835(a) and 405.1877.

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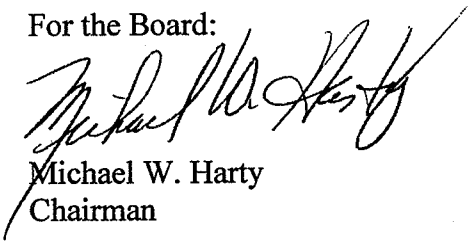
[9] *Id.* at 8.
[10] *Id.*
[11] *See* Cox Individual Appeal Request at Tab 3, 1-4.
[12] Board Rule 23.4 at 22.
[13] Board Rule 25.1 at 25 (emphasis in original).
[14] Board Rule 41.2 at 40.

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 Shanklin, Executive Director, BCBSA (without enclosures)

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**CERTIFIED MAIL**

JAN 29 2015

Daniel Hettich
King & Spalding, LLP
1700 Pennsylvania Ave., NW
Suite 200
Washington, DC 20006-2706

RE: *Paradise Valley Hospital,* Provider No. 03-0083, FYE 10/31/01,
*Mary Black Health Systems*, Provider No. 42-0083, FYE 6/30/01,
*Carolinas Hospital System*, Provider No. 42-0091, FYE 6/30/01,
*Abilene Regional Medical Center*, Provider No. 45-0558, FYE 8/31/01,
*Cleveland Regional Medical Center*, Provider No. 45-0296, FYE 8/31/01
*St. Joseph Medical Center*, Provider No. 15-0047, FYE 5/31/01,
*Barberton Citizens Hospital*, Provider No. 36-0019, FYE 12/31/01 and
*Doctor's Hospital of Stark County,* Provider No. 36-0151, FYE 6/30/01,
as participants in:
"CHS 2001 DSH SSI Ratio - 07 Hospitals CIRP Group"
PRRB Case No.: 08-2817GC

Dear Mr. Hettich:

The Provider Reimbursement Review Board (Board) has reviewed the Schedule of Providers and the associated jurisdictional documents for case number 08-2817GC. The Board's decision regarding jurisdiction for the above referenced Providers is set forth below.

Background

*Provider 1, Paradise Valley Hospital, Provider No. 03-0083*

On September 27, 2004, the Medicare administrative contractor (MAC) issued a notice of program reimbursement (NPR) to Paradise Valley Hospital, Provider No. 03-0083, for the cost reporting period ending October 31, 2001. On March 25, 2005, Paradise Valley Hospital filed an appeal of the NPR challenging Medicaid eligible days, SSI percentage and protested amounts. The Board assigned case number 05-1279 to the appeal. On February 5, 2007, Paradise Valley Hospital requested to transfer the SSI percentage issue from its individual appeal, case number 05-1279, to case number 06-0602G. The Board remanded the SSI percentage issue in case number 06-0602G on August 28, 2014. On July 7, 2008, the MAC issued a revised NPR to Paradise Valley Hospital. On December 30, 2008, Paradise Valley Hospital requested to join the current group appeal, case number 08-2817GC, from a direct appeal of the revised NPR dated July 7, 2008.

*Provider 3, Mary Black Health Systems, Provider No. 42-0083*

On October 2, 2006, the MAC issued a NPR to Mary Black Health Systems, Provider No. 42-0083, for the cost reporting period ending June 30, 2001. On February 28, 2007, Mary Black Health Systems requested to join a group appeal, case number 06-0602G, from a direct appeal of the original NPR dated October 2, 2006. The Board remanded the SSI percentage issue in case number 06-0602G on August 28, 2014. On March 30, 2007, Mary Black Health System filed another appeal from the original NPR challenging labor and delivery days, dual eligible days and tentative settlement payments. On January 22, 2009, the MAC issued a revised NPR to the Provider. On April 15, 2009, Mary Black Health Systems requested to join the current group appeal, case number 08-2817GC, from a direct appeal of the revised NPR dated January 22, 2009.

*Provider 4, Carolinas Hospital System, Provider No. 42-0091*

On October 21, 2008, the MAC issued a revised NPR to Carolinas Hospital System, Provider No. 42-0091, for the cost reporting period ending June 30, 2001. On April 17, 2009, Carolinas Hospital System requested to join the current group appeal, case number 08-2817GC, from a direct appeal of the revised NPR dated October 21, 2008.

*Provider 5, Abilene Regional Medical Center, Provider No. 45-0558*

On October 9, 2007, the MAC issued a revised NPR to Abilene Regional Medical Center, Provider No. 45-0558, for the cost reporting period ending August 31, 2001. On April 4, 2008, Abilene Regional Medical Center filed an appeal of the revised NPR challenging labor and delivery days and the SSI percentage. The Board assigned case number 06-1571 to the case. On March 5, 2009, Abilene Regional Medical Center requested to transfer the SSI percentage issue from case number 06-1571 to the current group appeal, case number 08-2817GC.

*Provider 6, Cleveland Regional Medical Center, Provider No. 45-0296*

On September 20, 2005, the MAC issued a NPR to Cleveland Regional Medical Center, Provider No. 45-0296, for the cost reporting period ending August 31, 2001. On February 23, 2006, Cleveland Regional Medical Center filed an appeal of the NPR challenging the elimination of observation bed days from the available bed count for the purpose of determining DSH eligibility. The Board assigned case number 06-0814 to the appeal.

*Provider 8, St. Joseph Medical Center, Provider No. 15-0047*

On October 21, 2003, the MAC issued a revised NPR to St. Joseph Medical Center, Provider No. 15-0047, for the cost reporting period ending May 31, 2001. On March 26, 2004, St. Joseph Medical Center filed an appeal of the revised NPR challenging Medicaid eligible days and the SSI percentage. The Board assigned case number 04-1390 to the appeal. On February 5, 2007, St. Joseph Medical Center requested to transfer the SSI

percentage issue from case number 04-1390 to case number 06-0602G. Thereafter, on September 27, 2011, St. Joseph Medical Center requested to transfer the same issue, the SSI percentage issue, from the individual appeal, case number 04-1390, to the current group appeal, case number 08-2817GC. On August 28, 2014, the Board dismissed St. Joseph Medical Center from case number 06-0602G as no adjustment was made from a revised NPR.

*Provider 9, Barberton Citizens Hospital, Provider No. 36-0019*

On June 24, 2004, the MAC issued a NPR to Barberton Citizens Hospital, Provider No. 36-0019, for the cost reporting period ending December 31, 2001. On December 20, 2004, Barberton Citizens Hospital filed an appeal of the NPR. The Board assigned case number 05-0398 to the appeal. On February 5, 2007, Barberton Citizens Hospital requested to transfer the SSI percentage issue from case number 05-0398 to case number 06-0602G. Thereafter, on April 25, 2012, Barberton Citizens Hospital requested to transfer the same issue, the SSI percentage issue, from case number 05-0398 to the current group appeal, case number 08-2817GC.

*Provider 10, Doctor's Hospital of Stark County, Provider No. 36-0151*

On September 23, 2003, the MAC issued a NPR to Doctor's Hospital of Stark County, Provider No. 36-0151, for the cost reporting period ending June 30, 2001. On March 19, 2004, Doctor's Hospital of Stark County filed an appeal of the NPR. The Board assigned 04-1447 to the appeal. On February 5, 2007, Doctor's Hospital of Stark County requested to transfer the SSI percentage issue from case number 04-1447 to case number 06-0602G. Thereafter, on May 31, 2012, Doctor's Hospital of Stark County requested to transfer the same issue, the SSI percentage issue, from case number 04-1447 to the current group appeal, case number 08-2817GC.

Decision of the Board

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

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2004) provides in relevant part:

> A determination of an intermediary . . . may be reopened with respect to findings on matters at issue in such determination or decision, by such intermediary . . . 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 (2004) states:

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

In *HCA Health Services of Oklahoma v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994), the court held that when a fiscal intermediary reopens its original determination regarding the amount of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening and does not extend further to all determinations underlying the original NPR. More recently, this regulation has also been addressed in the decision *Emanuel Med. Ctr., Inc. v. Sebelius*, No. CV 12-1962 (GK), 2014 WL 1557524, at *8 (D.D.C. Apr. 17, 2014), the court held that the Secretary's "issue-specific" interpretation of her NPR reopening regulations is reasonable and entitled to substantial deference.

*Provider 1, Paradise Valley Hospital, Provider No. 03-0083*

Paradise Valley Hospital lists on the Schedule of Providers that they are appealing from an original NPR dated September 27, 2004. Paradise Valley Hospital included the original NPR and the March 25, 2005 appeal request from the original NPR in the jurisdictional documents under Tab 1A and 1B. However, Paradise Valley Hospital provided no evidence that the SSI percentage issue was transferred from their original NPR appeal, case number 05-1279, to the current group appeal, case number 08-2817GC. No documents were provided as evidence of the transfer. Paradise Valley Hospital requested to transfer the SSI percentage issue from their original NPR appeal, case number 05-1279, to case number 06-0602G on February 5, 2007. The SSI percentage issue was remanded in case number 06-0602G on August 28, 2014.

Paradise Valley Hospital included a December 30, 2008 request to join the current group appeal, case number 08-2817GC, from a direct appeal of the revised NPR dated July 7, 2008, under Tab 1G. However, Paradise Valley Hospital did not provide a copy of the revised NPR nor include any audit adjustment reports or supporting documentation (such as the request for reopening, reopening notice or the audit work papers) to determine the full scope of the issues reviewed within the revised NPR process. Paradise Valley Hospital cites n/a* as their audit adjustment for their appeal from the original NPR which indicates that they self-disallowed costs. However, Providers cannot self-disallow from revised NPRs as it is a distinct determination from which only issues revised can be

appealed. As Paradise Valley Hospital failed to provide evidence that the SSI percentage issue was specifically revised in the reopening, the Board finds that it lacks jurisdiction over Provider 1, Paradise Valley Hospital, Provider No. 03-0083, fiscal year end (FYE) October 31, 2001, and dismisses the Provider from the appeal.

*Provider 3, Mary Black Health Systems, Provider No. 42-0083*

Mary Black Health Systems lists on the Schedule of Providers that they are appealing from an original NPR dated October 2, 2006. Mary Black Health Systems included the original NPR and a March 30, 2007 appeal request from the original NPR in the jurisdictional documents under Tab 3A and 3B. However, Mary Black Health Systems did not appeal the SSI percentage issue in the March 30, 2007 appeal request. Mary Black Health Systems appealed labor and delivery days, dual eligible days and tentative settlement payments. Mary Black Health Systems filed a direct appeal of the SSI percentage issue from the original NPR dated October 2, 2006, into case number 06-0602G on February 28, 2007. The SSI percentage issue was remanded in case number 06-0602G on August 28, 2014.

Mary Black Health System included a April 15, 2009 request to join the current group appeal, case number 08-2817GC, from a direct appeal of the revised NPR dated January 22, 2009, under Tab 3G. However, Mary Black Health Systems did not provide a copy of the revised NPR nor include any audit adjustment reports or supporting documentation (such as the request for reopening, reopening notice or the audit work papers) to determine the full scope of the issues reviewed within the revised NPR process. Mary Black Health Systems cites n/a* as their audit adjustment for their appeal from the original NPR which indicates that they self-disallowed costs. However, Providers cannot self-disallow from revised NPRs as it is a distinct determination from which only issues revised can be appealed. As Mary Black Health System failed to provide evidence that the SSI percentage issue was specifically revised in the reopening, the Board finds that it lacks jurisdiction over Provider 3, Mary Black Health System, Provider No. 42-0083, FYE June 30, 2001, and dismisses the Provider from the appeal.

*Provider 4, Carolinas Hospital System, Provider No. 42-0091*

Carolinas Hospital System requested to join the current group appeal, case number 08-2817GC, from a direct appeal of a revised NPR dated October 21, 2008. Carolinas Hospital System did not include any audit adjustment reports or provide any supporting documentation (such as the request for reopening, reopening notice or the audit work papers) to determine the full scope of the issues reviewed within the revised NPR process. Carolinas Hospital System cited n/a* as their audit adjustment which indicates that they self-disallowed costs. However, Providers cannot self-disallow from a revised NPR as it is a distinct determination from which only issues revised can be appealed. As Carolinas Hospital System failed to provide evidence that the SSI percentage issue was specifically revised in the reopening, the Board finds that it lacks jurisdiction over

Provider 4, Carolinas Hospital System, Provider No. 42-0091, FYE June 30, 2001, and dismisses the Provider from the appeal.

*Provider 5, Abilene Regional Medical Center, Provider No. 45-0558*

Abilene Regional Medical Center appealed from an audit adjustment report (adjustment 5) that did not specifically adjust the SSI percentage. The adjustment report shows an adjustment to the total disproportionate share percentage as reported on Worksheet E, Part A, Line 4.03, Col. 0, "[t]o reopen the cost report and adjust the allowable DSH percentage per audit" but there is no adjustment specific to the SSI percentage (which is reported on Worksheet E, Part A, Line 4.00). The Provider did not supply supporting documentation (such as request for reopening, reopening notice, or the audit work papers) to determine the full scope of the issues reviewed within the revised NPR process. However, the audit adjustment report shows that although the total DSH calculation was adjusted, the SSI percentage was not specifically revised in the reopening. As the SSI percentage issue was not specifically revised in the reopening, the Board finds that it lacks jurisdiction over Provider 5, Abilene Regional Medical Center, Provider No. 45-0558, FYE August 31, 2001, and dismisses the Provider from the appeal.

*Provider 6, Cleveland Regional Medical Center, Provider No. 45-0296*

Cleveland Regional Medical Center did not appeal the SSI percentage issue in its individual appeal request and did not timely request to add the SSI percentage issue to its individual appeal. There is no evidence that the SSI percentage issue was transferred from its individual appeal, case number 06-0814, to the current group appeal, case number, 08-2817GC. No documentation was provided under Tab 6G as evidence of the transfer and no date was listed on the Schedule of Providers for the transfer. As the SSI percentage issue was not originally appealed nor timely added to the appeal, and was not transferred from the individual appeal to the current group appeal, the Board dismisses, Provider 6, Cleveland Regional Medical Center, Provider No. 45-0296, FYE August 31, 2001, from the appeal.

*Provider 8, St. Joseph Medical Center, Provider No. 15-0047*

St. Joseph Medical Center cited n/a* as their audit adjustment for their appeal from the revised NPR which indicated that that they self-disallowed costs. However, in the jurisdictional documents under Tab 8D the Provider supplied the audit adjustment report from the revised NPR (annotated as "AMENDED" and has a run date of October 8, 2003); this audit adjustment report (adjustment 4) shows an adjustment to the total disproportionate share percentage as reported on Worksheet E, Part A, Line 4.03, Col. 0, "to properly calculate the DSH add-on payment" but there is no adjustment specific to the SSI percentage (which is reported on Worksheet E, Part A, Line 4.00). The Notice of Reopening says the original NPR was issued on September 30, 2003. Therefore, the Board would lack jurisdiction from the revised NPR as no specific adjustment to the SSI percentage was made.

St. Joseph Medical Center, on February 5, 2007, requested to transfer the SSI percentage issue from its individual appeal, case number 04-1390, to case number 06-0602G. Thereafter, on September 27, 2011, requested to transfer the same issue, the SSI percentage issue from its individual appeal, case number 04-1390, to the current group appeal, case number 08-2817GC. As the SSI percentage issue was already transferred from the individual appeal, case number 04-1390, to case number 06-0602G on February 5, 2007, the Provider's subsequent September 27, 2011 request to transfer the SSI percentage issue from its individual appeal, case number 04-1390, to the current group appeal, case number 08-2817GC, is denied (as the issue was no longer pending in the individual appeal). The Board dismisses Provider 8, St. Joseph Medical Center, Provider No. 15-0047, FYE October 21, 2003, from the appeal.

*Provider 9, Barberton Citizens Hospital, Provider No. 36-0019*

Barberton Citizens Hospital, on February 5, 2007, requested to transfer the SSI percentage issued from its individual appeal, case number 05-0398, to a group appeal, case number 06-0602G. Thereafter, on April 25, 2012, Barberton Citizens Hospital requested to transfer the same issue from its individual appeal, case number 05-0398, to the current group appeal, case number 08-2817GC. As the SSI percentage issue was already transferred from the individual appeal, case number 05-0398, to case number 06-0602G on February 5, 2007, Barberton Citizens Hospital's subsequent April 25, 2012 request to transfer the SSI percentage issue from its individual appeal, case number 05-0398, to the current group appeal, case number 08-2817GC, is denied (as the issue was no longer pending in the individual appeal). The Board dismisses Provider 9, Barberton Citizens Hospital, Provider No. 36-0019, FYE 12/31/2001, from the appeal.

*Provider 10, Doctor's Hospital of Stark County, Provider No. 36-0151*

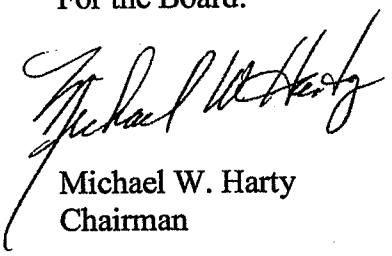
Doctor's Hospital of Stark County, on February 5, 2007, requested to transfer the SSI percentage issue from its individual appeal, case number 04-1447, to a group appeal, case number 06-0602G. Thereafter, on May 31, 2012, Doctor's Hospital of Stark County requested to transfer the same issue from its individual appeal, case number 04-1447, to the current group appeal, case number 08-2817GC. As the SSI percentage issue was already transferred from the individual appeal, case number 04-1447, to case number 06-0602G on February 5, 2007, the Provider's subsequent May 31, 2012 request to transfer the SSI percentage issue from its individual appeal, case number 04-1447, to the current group appeal, case number 08-2817GC, is denied (as the issue was no longer pending in the individual appeal). The Board dismisses Provider 10, Doctor's Hospital of Stark County, Provider No. 36-0151, FYE 6/31/2001, from the appeal.

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

Summary: After participants 1, 3, 4, 5, 6, 8, 9, and 10 are dismissed there are two Providers which remain. The remaining Providers will be reviewed to determine if they should be remanded back to the contractor for payment pursuant to CMS Ruling 1498-R.

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), 42 C.F.R. §§ 405.1875 and 405.1877

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PROVIDER REIMBURSEMENT REVIEW BOARD
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Phone: 410-786-2671
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Refer to:

13-1691

**Certified Mail**

JAN 29 2015

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Re: Provider Name: Parkland Health & Hospital System
Provider No.: 45-0015
FYE: 09/30/2007
PRRB Case No.: 13-1691

Dear Mses. Nystrom and Griffin:

The Provider Reimbursement Review Board (PRRB or Board) has reviewed Parkland Health & Hospital System's (Provider's) requests to transfer the Disproportionate Share Hospital (DSH) Supplemental Security Income (SSI) Data Match issue, the Medicare Fraction Dual Eligible Days issue and the Medicaid Fraction Dual Eligible Days issue from its individual appeal, PRRB Case No. 13-1691, through the establishment of optional group appeals. The Board's determination is set forth below.

On April 12, 2013, the Board received the Provider's hearing request from an original Notice of Program Reimbursement (NPR) dated October 17, 2012, for fiscal year ending (FYE) September 30, 2007. Southeast Reimbursement Group, LLC was named as provider representative of the individual appeal.

Mediation was held on September 16, 2014 for PRRB Case No. 13-1691. In the resulting Mediation Timeline, the parties agreed that certain issues would be transferred to group appeals by December 15, 2014.

On December 1, 2014, the Board received the Provider's request to transfer the issues cited above from the Provider's individual appeal to the following newly established group appeals:

Hall Render 2007 Post 1498R SSI Data Match Optional Group II
Hall Render 2007 Medicare Fraction Dual Eligible Days Group II
Hall Render 2007 Medicaid Fraction Dual Eligible Days Group II

The Provider designated Hall Render Killian Heath & Lyman, P.C. as its representative for each of the group appeals. Upon review of the Provider's requests to form the optional group appeals referenced above, it was noted that the Schedules of Providers appears to list two participating providers. However, the schedule actually contains the provider number for the hospital (45-0015) and the hospital's rehabilitation subunit (45-T015), which collectively forms a single provider.

Pursuant to 42 C.F.R. § 405.1837(b)(2) (2013) and PRRB Rule 12.5.A., at least two different providers that are not under common ownership or control, are required to initially form an optional group. Specifically, 42 C.F.R. § 405.1837(b)(2) states:

> *Optional group appeals.* (i) Two or more providers not under common ownership or control may bring a group appeal before the Board under this section, if the providers wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers. (Emphasis added.)

PRRB Rule 12.5 states:

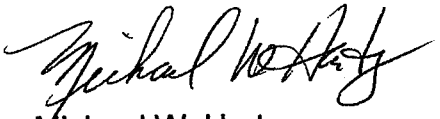
> **A. Optional Group Appeals**
>
> At least two different Providers are required to initially form an optional group. (Emphasis added.)

**Decision of the Board**

The Board hereby denies the Provider's requests to transfer the DSH SSI Data Match issue, the Medicare Fraction Dual Eligible Days issue and the Medicaid Fraction Dual Eligible Days issue into a group appeal. The Board further denies the establishment of the Hall Render 2007 Post 1498R SSI Data Match Optional Group II, the Hall Render 2007 Medicare Fraction Dual Eligible Days Group II and the Hall Render 2007 Medicaid Fraction Dual Eligible Days Group II as the Schedules of Providers does not contain two separate participants as required by the regulations and Board rules. The DSH SSI Data Match issue, the Medicare Fraction Dual Eligible Days issue and the Medicaid Fraction Dual Eligible Days issue will remain in the individual appeal, PRRB Case No. 13-1691.

Board Members Participating
Michael W. Harty
Clayton J. Nix, Esquire
L. Sue Anderson, Esquire
Charlotte F. Benson, CPA

FOR THE BOARD



Michael W. Harty
Chairman

cc: Timothy LeJeune, Novitas Solutions, Inc.
Kevin D. Shanklin, BCBSA