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

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

Refer to: 08-2177G

MAY 01 2015

CERTIFIED MAIL

Sherman Law Office PLLC
Teresa A. Sherman, Esq.
1212 N. Washington
Suite 220
Spokane, WA 99201

Blue Cross Blue Shield Association
Arthur E. Peabody, Jr., Esq.
Lead Medicare Counsel
1310 G Street, N.W.
Washington DC 20005-3004

RE: Hartford Hospital, Provider No. 07-0025, FYE 09/30/2000
Participant #8 in QRS CT 2000 General Assistance/Charity Care Days Group,
PRRB Case No. 08-2177G

Dear Ms. Sherman and Mr. Peabody,

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

Background

Case No.08-2177G was created by an "Initial Request for Hearing – Group Appeal" letter dated June 24, 2008. The Board acknowledged the creation of the QRS CT 2000 General Assistance/Charity Care Days (Case No. 08-2177G) by sending out a Group Acknowledgement and Critical Due Date letter on July 2, 2008 to the Group Representative. A number of providers were transferred, withdrawn, or dismissed from this group[1] resulting in eight current participants covering fiscal years 1997, 1999, and 2000.

Subsequent to the submission of the initial schedule of providers and the Board's jurisdictional findings, another provider, Hartford Hospital (Provider No. 07-0025, FYE 9/30/2000) ("Hartford"), requested to join the current fully formed group by letter dated April 25, 2011.[2] In

[1] On November 3, 2009, the Board granted the "Request to Nullify Transfer of Issue" for Case No. 06-0768, as the issue in dispute differed from the current group 08-2177G. On November 4, 2010, the Board dismissed two providers from the group for lack of supporting documentation related to revised NPRs and denied their request to be transferred to another group, granted the transfer of one provider, acknowledged the withdrawal of one provider, and found jurisdiction for five providers under the *Bethesda* rationale. On August 9, 2011, the Board reconsidered its previous jurisdictional decision related to revised NPRs, but made no change to its determination.
[2] The Board did not acknowledge or approve the transfer request at that time.

In this case, Hartford filed a timely appeal on September 17, 2010 from a revised NPR dated March 22, 2010. The Board assigned Case No. 10-1368 to the individual appeal, which included the general assistance ("GA") days issue. By Model Form D dated April 25, 2011, the Provider requested to transfer the GA days issue to the current fully formed group, QRS CT 2000 General Assistance/Charity Care Days (Case No. 08-2177G).

In column D on the schedule of providers, Hartford referenced the applicable audit adjustment as "1, s-d" to reference both a specific adjustment and a self-disallowed item. According to the supporting documentation provided behind Tab D, Hartford requested a reopening to address Medicaid days in the DSH calculation and the bed count for the indirect medical education payment. Specifically for the DSH payment, Hartford "furnished a list of 417 Connecticut Medicaid eligible days, 77 Massachusetts Medicaid eligible days and 3438 days paid by General Assistance *that [were] not included in the list of Medicaid days in the audited cost report.*" [4] Adjustment #1 increased Medicaid eligible days by 381 "[t]o include eligible days not previously paid and to update the DSH allowable percentage." Although Hartford requested the addition of previously unclaimed GA days, it did not supply audit work papers to demonstrate the scope of the Medicare Contractor's review or the basis for the specific adjustment in the revised NPR.[5]

The Board finds that it does not have jurisdiction over Hartford Hospital, Participant #8, because appeals from revised NPRs are limited to the specific matters revised in the revised determination under 42 C.F.R. § 405.1889(b)(1), and there is no evidence that GA days were adjusted in the revised NPR for Hartford.

As the Board lacks jurisdiction over Hartford Hospital, Participant #8, it is dismissed from this group appeal. The case will remain open because the appeal is still pending for the other Providers in the group.

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

Board Members
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); 42 C.F.R. §§405.1875 and 405.1877

cc: Kyle Browning, Appeals Lead, National Government Services, Inc.
Kevin D. Shanklin, Executive Director, Senior Gov. Initiatives, BCBSA

[4] Provider reopening request dated December 15, 2008 at 2 (emphasis added).
[5] Per Medicare Contractor e-mail correspondence dated February 20, 2014, the Contractor states that "...GA Days were not included in the adjustments to increase XIX Days."

preparation for the scheduled Board hearing,[3] the group representative submitted an updated schedule of providers with jurisdictional documents on October 6, 2014, which incorporated the prior jurisdictional findings and also included the new provider, Hartford, as Participant #8.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 - 405.1840 (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 Medicare 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 of receipt of the Notice of the final determination.

In accordance with 42 C.F.R. § 405.1889 (2009), a revised Notice of Program Reimbursement ("NPR") is considered a separate and distinct determination from which the provider may appeal. The regulation provides:

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

In *HCA Health Services v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994), the Court held that when a Medicare contractor reopens its original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening, and does not extend further to all determinations underlying the original NPR. More recently, this regulation has also been addressed in *Emanuel Med. Ctr., Inc. v. Sebelius,* No. CV 12-1962 (GK), 2014 WL 1557524 (D.D.C. Apr. 17, 2014). In *Emanuel*, the Court held that "issue-specific" interpretation of the NPR reopening regulation is reasonable and that any change to the DSH adjustment is not sufficient to establish that all of the elements of the DSH adjustment have been reconsidered.

[3] The hearing was initially scheduled as a live hearing to be held December 8, 2014, but was later converted to a hearing on the record, which was conducted November 28, 2014.

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Refer to:

05-2099G

MAY 05 2015

CERTIFIED MAIL

Reed Smith LLP
Salvatore G. Rotella, Jr.
Three Logan Square
Suite 3100
1717 Arch Street
Philadelphia, PA 19103-7301

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

RE: Jurisdiction Decision
Reed Smith 97 Medi-Medi Days Group
FYE: Various
PRRB Case No.: 05-2099G

Dear Mr. Rotella and Ms. Hartley,

The Provider Reimbursement Board (Board) has reviewed the jurisdictional documents in the above-referenced appeal, and noted a jurisdictional impediment for one Provider in this group appeal. The Board dismisses John Dempsey Hospital for its 09/30/1997 cost report period.

Background

Case number 05-2099G was established on June 27, 2005, when 97 Providers split from case no. 05-0497G and two additional Providers were added to from this group case. This is a group appeal with one issue, Medi-Medi Days, covered under Ruling 1498-R. On June 30, 2014, the Board requested an updated Schedule of Providers. On September 26, 2014, the Board received the requested Schedule of Providers and began its review.

Board's Decision

Pursuant to 42 U.S.C. §1395oo(a) and 42 C.F.R. §§ 405.1835 – 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 ($50,000 for a group), and the request for a hearing is filed within 180 days after the date of receipt by the provider of the intermediary determination.

The Board finds that it does not have jurisdiction over John Dempsey Hospital (07-0036, FYE 09/30/1997), because this Provider appealed from a revised notice of program reimbursement (NPR) that did not directly address the issue.

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

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

The version of 42 C.F.R. § 405.1889 in effect prior to the August 2008 rule change explains the effect of a cost report revision:

> Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in §405.1885, such revision shall be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. §§ 405.1811, 405.1835, 405.1875 and 405.1877 are applicable.

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 amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening, and does not extend further to all determinations underlying the original NPR. 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 (D.D.C. Apr. 17, 2014). In this case, the Court also held that "issue-specific" interpretation of the NPR reopening regulation is reasonable and that any change to the DSH adjustment is not sufficient to establish that all of the elements of the DSH adjustment have been reconsidered.

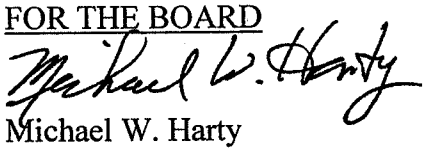
In its September 26, 2014 submission of the Schedule of Providers with jurisdictional documentation the Group Representative submitted the audit adjustments which reflected that Medicaid eligible days the and DSH percentage were adjusted. The Group Representative also submitted work papers created by the Medicare Contractor, but those work papers did not specifically address the Medi-Medi Days issue. This is the same scenario as in the *Emanuel* case. Because appeals from revised NPRs are limited to the specific matters considered in the revised determination, the Board finds that it does not have jurisdiction over John Dempsey Hospital (Participant #4) since there was no evidence that the Medi-Medi days were reviewed or adjusted.

As the Board lacks jurisdiction over John Dempsey Hospital (Participant #4) it is dismissed from this group appeal. The case will remain open because the appeal is still pending for the other Providers in the group.

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

Board Members
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Anderson, 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
Standard Remand Letter
Schedule of Providers

cc: Kevin Shanklin, Executive Director, BCBSA

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Refer to: 15-1260GC, 15-1265GC, 15-1520GC

Certified Mail

MAY 06 2015

Russell Kramer
Director
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue
Suite 570A
Arcadia, CA 91006

RE: QRS Asante Health 2015 DSH Uncompensated Care Payment Group
Provider Nos. Various, FFY 2015, PRRB Case No.15-1260GC
QRS Avera Health 2015 DSH Uncompensated Care Payment Group,
Provider Nos. Various, FFY 2015, PRRB Case No. 15-1265GC
QRS Carolinas HS 2015 DSH Uncompensated Care Payment Group,
Provider Nos. Various, FFY 2015, PRRB Case No. 15-1520GC

Dear Mr. Kramer:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 8, 2015 requests for expedited judicial review ("EJR") (received April 9, 2015) in the above referenced appeals. The decision of the Board is set forth below.

Issue

The issue before the Board, as presented in the hearing requests, is:

> Whether the Centers for Medicare and Medicaid Services ("CMS") failed to properly calculate Factors 1 and 2 of the pool of uncompensated care payments available for distribution to disproportionate share hospital ("DSH") eligible hospitals as set forth in the Fiscal year 2015 Hospital Inpatient Prospective Payment System Final Rule (the "FY 2015 IPPS Final Rule") dated August 22, 2014 as required by 42 U.S.C. § 1395ww(r)(2) and 42 C.F.R. § 412.106 (the "Distribution Pool")?

Uncompensated Care Background

Section 3133 of the Patient Protection and Affordable Care Act (PPACA), as amended by section 10316 of PPACA and section 1104 of the Health Care and Education Reconciliation Act (Pub. L. No. 111-152), added new section 42 U.S.C. § 1395ww(r) to the statute that modifies the

methodology for computing the Medicare DSH payment adjustment beginning in FFY 2014. This legislation is commonly known as section 3133 of Affordable Care Act ("ACA").[1]

Until FFY 2014, the Medicare DSH adjustment payments were calculated under a statutory formula that considers the hospital's Medicare utilization attributable to beneficiaries who receive Supplemental Security Income (SSI) benefits and the hospital's Medicaid utilization. Beginning for discharges in FY 2014, hospitals that qualify for Medicare DSH payments under 42 U.S.C. § 1395ww(d)(5)(F) will received 25 percent of the amount they previously would have received under the DSH formula. The remaining amount, equal to 75 percent of what otherwise would have been paid as Medicare DSH payments, reduced to reflect changes in the percentage of individuals under age 65 who are uninsured, will be available to make additional payments to each hospital that qualifies for Medicare DSH payments and that has uncompensated care. The payments to each hospital for a fiscal year will be based on the hospital's amount of uncompensated care for a given time period relative to the total amount of uncompensated care for that same time period reported by all hospitals that received Medicare DSH payments for that fiscal year.[2]

This will result in two payments to the hospital. Under 42 U.S.C. § 1395ww(r)(1), beginning in FFY 2014, a hospital that would receive a DSH payment under § 1395ww(d) will receive 25 percent of the amount the hospital would have received under § 1395ww(d)(5)(F) which the Secretary now calls "the empirically justified amount for such payment, as determined by the Medicare Payment Advisory Commission in its March 2007 Report to Congress."[3] Section 1395ww(r)(2) provides that for fiscal year end 2014 and subsequent years, the Secretary shall pay to each § 1395ww(d) hospital an additional amount equal to the product of three factors, collectively known as uncompensated care.

The first factor is the difference between the estimates of "the aggregate amount of payments that would be made to subsection (d) [DSH] hospitals under subsection (d)(5)(F) if this subsection did not apply" and "the aggregate amount of payments that are made to subsection (d) hospitals under paragraph (1) [1395ww(r)]." This factor amounts to the 75 percent of the payments that would otherwise have been paid as part of the DSH adjustment.[4]

For FYs 2014-2017, the second factor is 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured, determined by comparing the percent of such individuals who are uninsured in FY 2013, the last year before coverage expanded under ACA, minus 0.1 percentage point for FY 2014, and minus 0.2 percentage point for FYs 2015-2017. For FY 2018 and subsequent years, the second factor is 1 minus the percent change in the percent of

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[1] 78 Fed. Reg. 50,496, 50,620 (Aug. 19, 2013).
[2] *Id.* at 50,621. *See also id.* at 50,627 (Factor 1 is the difference between the Secretary's estimates of (1) the amount of Medicare DSH payments that would otherwise be made in the absence of the new payment provision; and (2) the amount of empirically justified Medicare DSH payments that are made for FY 2014 and subsequent years, which takes into account the requirement to pay 25 percent of what would have otherwise been paid under 42 U.S.C. § 1395ww(d)(5)(F).)
[3] *Id.* at 50,621.
[4] *Id.*

individuals who are uninsured, as determined by comparing the percentage of individuals who are uninsured in 2013 and who are uninsured in the most recent period for which data is available minus 0.2 percentage points for FFY 2018 and 2019.[5]

The third factor, is a "percent that for each subsection (d) [DSH] hospital, 'represents the quotient of … the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on appropriate data …),' including the use of alternative data 'where the Secretary determines that alternative data is available which is a better proxy for the costs of subsection (d) hospitals for … treating the uninsured,' and 'the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this subsection.'"[6] The Secretary explains that this third factor represents a hospital's uncompensated care amount for a given time period relative to the uncompensated care amount for that same time period for all hospitals that received Medicare DSH payments in that year, expressed as a percent. For each hospital, the product of these three factors represents its additional payment for uncompensated care for the applicable fiscal year.[7]

Providers' Hearing Requests and Requests for EJR

Providers' Hearing Requests

In their hearing requests, the Providers explain that 42 U.S.C. § 1395ww(r) established for FFY 2014 and forward, that

> "[S]ubsection (d) hospitals" that would otherwise receive a "disproportionate share payment made under subsection (d)(5)(F)" shall receive two separate payments: (1) 25 percent of the amount they previously would have received under subsection (d)(5)(F) for Medicare DSH; and (2) an additional payment for the DSH hospital's proportion of uncompensated care determined as the product of three factors. Those factors are: Factor 1 – a pool of funds is estimated by CMS at 75 percent of what empirical DSH payments would be without the Affordable Care Act changes; Factor 2 – the pool is reduced by the percentage change in national uninsured rates from 2013 to the present year; Factor 3 – the reduced pool is multiplied by a ratio of each hospital's uncompensated care cost compared to all other DSH eligible hospitals to derive each hospital's [uncompensated care] payments. *See* 78 Fed. Reg. 61,191, 61,192 (Oct. 3, 2013).

[5] *Id.*
[6] *Id.*
[7] *Id.*

The Providers are challenging the determination of the distribution pool (uncompensated care) set forth in the August 22, 2014 Federal Register at 50,009-50,022. They identified the problems below with respect to uncompensated care.

Administrative Procedures Act

The Providers assert that the Secretary did not comply with 5 U.S.C. § 553 (the Administrative Procedures Act) which requires that agencies make readily available any data or information that was relied upon in creating their regulations. The Providers believe that the Secretary failed to provide sufficient information regarding the calculation of the proposed Distribution Pool to allow for the "presentation of relevant comment" by the Providers.[8] For example, the Secretary acknowledged that the FY 2015 IPPS Distribution Pool was "lower than the commenters may have expected due to the assumption that the expansion population is healthier than the rest of the Medicaid population and will utilize fewer hospital services."[9] The Providers do not believe that this was supported by the evidence and was not disclosed until final rulemaking, depriving the Providers of the ability to comment.

Allina Health Care Servs. v. Sebelius

The Providers contend that the Secretary did not comply with the decision in *Allina Health Care Servs. v. Sebelius,* [10] in which the D.C. District court found that the Secretary's notice stating that Part C days would be counted in the Medicare fraction was done without adequate notice and comment. The Secretary stated that the *Allina* decision did not have any bearing on the estimates of Factor 1 or 3.[11,12] The Providers believe that this misses the point that CMS is using 2011 as the baseline period, since in 2011 there was no valid agency policy regarding treating patient days paid under Part C as entitled to benefits under Part A. Consequently, the Providers' assert, the Secretary was obligated to correct that baseline number to conform to the Court's binding determination.

CMS Otherwise Erred as Reflected by Comments

In addition to the comments regarding *Allina*, the Secretary erred in the calculation of the Distribution Pool because:

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[8] Providers' January 29, 2015 Group Appeal Request, Exhibit 2 Description of Issue at 5 (quoting U.S. v. Nova Scotia Food Prods, 568 F.2d 240 (2d Cir. 1977)).
[9] 79 Fed. Reg. 49,854, 50,011 (Aug. 22, 2014).
[10] 746 F.3d 1102, 1111 (D.C. Cir. 2014). (The final rule regarding whether enrollees in Part C are entitled to benefits under Part A, such that they should be counted in the Medicare fraction of the DSH calculation, or if not, should they be included in the Medicaid fraction. The "clarification," including Part C days in the Medicare fraction was not a logical outgrowth of the 2003 proposed rule in which the Secretary stated that they would be included in the Medicaid fraction and issued a final rule stating Part C days would be included in the Medicare fraction.)
[11] 79 Fed Reg. at 50,012.
[12] *See* 79 Fed. Reg. at 50,020. (The decision in *Allina* did not address the Secretary's readoption of the policy of counting Medicare Advantage days in the SSI fraction. Nor did it address the issue of how patient days should be counted for purposes of estimating uncompensated care.)

- The 2012 estimated DSH payments of $11.720 billion is understated because the 2012 "update" factor provided for in the FY 2015 IPPS proposed rule is understated. Specifically, the 1.1 percent increase in light of the *Cape Cod* litigation (budget neutrality adjustment) was not applied. As a result, instead of a 0.1 percent update factor, the projection should use a +1.0 percent update factor. The 2012 estimated DSH amount would be $11.732 billion.

- The estimate of DSH payments for FY 2015 of $14.205 billion is understated because the 2015 update factor is understated. The productivity adjustment should be 0.4 percent, not 0.5 percent. Consequently, the 1.2 percent update factor should be 1.3 percent, resulting in a DSH amount of $14.234 billion.

- There is no support for the discharge factor used in the DSH estimate. Further, a footnote to the discharge column states that all inpatient hospitals were used, not just IPPS hospitals. Since the purpose of the projection is to estimate the amount of DSH that will go to a subset of all inpatient hospitals, factors that drive the estimate should include only hospitals projected to share in the payments.

- The DSH estimate is subject to 100 percent of any documentation and coding adjustments due to Medicare Severity Diagnosis Related Groups (MS-DRGs). The 2015 IPPS proposed rule refers to a recoupment adjustment of $11 billion over a 4 year period for FFYs 2014-2017. The Secretary should model the impact of the adjustments on DSH and uncompensated care payments before subjecting the DSH estimates to the adjustments.

- The "Other" column from the Factor 1 source file is supposed to contain the DSH payment impact factor but it includes the impact of only IPPS discharges and the impact of DSH payments increasing or decreasing at a different rate than other IPPS payments. The Providers believe this should also reflect the impact of the Medicaid/ Children's Health Insurance Program (CHIP) expansion.

- There is no reconciliation between initial DSH estimates and final settlement.

- The calculation of the Distribution Pool should be based on the most accurate, available data under the decision in *Baystate.*[13]

The EJR Requests

The Providers explain that pursuant to 42 U.S.C. § 1395ww(r), for FFY 2014 and forward, PPS hospitals that would receive a DSH payment under § 1395ww(d)(5)(F) would receive two separate payments: (1) 25 percent of the amount they would have previously received under

[13] *See Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.C. Cir. Mar. 31, 2008), *as amended*, 587 F. Supp 2d 37, 44 (D.D.C. Nov. 7, 2008).

§ 1395ww(d)(5)(F) for DSH (empirical DSH) and (2) an additional payment for uncompensated care determined by a product of three factors:

> Factor 1: a pool of funds estimated at 75% of what empirical DSH payments would be without the ACA changes.
>
> Factor 2: the pool from Factor 1 is reduced by the percentage change in the national uninsured rates from 2013 to the present year.
>
> Factor 3: the reduced pool is multiplied by a ratio of each hospital's uncompensated care cost compared to all other DSH eligible hospitals to drive each hospital's uncompensated care payments.[14]

The Providers are challenging the final uncompensated care distribution pool (Factors 1 and 2) for FFY 2015.

Jurisdiction

The Providers acknowledge that 42 U.S.C. § 1395ww(r)(3) precludes administrative or judicial review of any estimate of the Secretary, or period selected by the Secretary, for purposes of determining the Factors in the calculation of the uncompensated care payment. The Medicare Contractors also assert that the Board lacks jurisdiction over the appeals on the same basis.

However, the Providers contend that the statute does not authorize the Secretary to estimate the uninsured patient population percentage involved in Factor 2, i.e., the 2014-2017 nationwide uninsured patient percentage.[15] The Providers assert the omission of the term "estimate" from the second prong of Factor 2 must be considered deliberate since it was employed elsewhere in the statute. The Providers believe that the Secretary should be required to reconcile her initial estimates with actual data that becomes available at the end of the fiscal year. The Providers believe that both the Board and Federal courts can review the uninsured patient percentage computed by the Secretary on the basis that the computation is not supposed to be an "estimate."

Since the wording of 42 U.S.C. § 1395ww(r)(3) does not preclude mandamus jurisdiction, the Providers believe it is an available basis for jurisdiction. The Providers argue that in *Ganem v. Heckler*[16] mandamus jurisdiction was not precluded by 42 U.S.C. § 405(h) which states in pertinent part "[n]o findings of fact or decision of the Commissioner … shall be reviewed by any person, tribunal, or governmental agency except as herein provided." The Providers believe that that mandamus is available where an agency acts outside the scope of its lawful authority or fails to act within a reasonable time. They believe that the Secretary's actions here were outside the

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[14] 78 Fed. Reg. 61,191, 61,192 (Oct. 3, 2013).
[15] 42 U.S.C. § 1395ww(r)(2)(B)(i)(II).
[16] 746 F.2d 844 (D.C. Cir. 1984).

scope of her authority and a clear violation of her statutory obligations, thus entitling the Providers to a writ of mandamus directing her to prepare revised estimates based on existing data and to reconcile her estimate of the FY 2015 nationwide uninsured patient percentage with actual data when it becomes available.

The Providers note that they are challenging the final IPPS rule as being procedurally and substantively deficient. They believe, under the decision set forth in *Bowen v. Michigan Academy of Family Physicians,*[17] that the ban on judicial review in § 405(h) applied only to individual payment determinations, not challenges to regulations and policies. Consequently, under this decision, the Providers believe they retain the right to appeal the estimates contained in the final Uncompensated Care Distribution Pool. They believe that failure to permit mandamus relief or to allow a *Michigan Academy* type relief will raise serious constitutional issues. However, since the Board lacks the authority to grant the relief sought, EJR is appropriate.

Decision of the Board

The Board concludes that it lacks jurisdiction over the appeals under the provisions of 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) (2014). Based on these provisions, judicial and administrative review is precluded under 42 U.S.C. §§ 1395ff and 1395oo for:

> (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[18]
>
> (B) Any period selected by the Secretary for such purposes.

Since jurisdiction to conduct a hearing is a prerequisite to granting a request for EJR, the Providers' requests for EJR are denied. Further, the D.C. District Court also found that there is no judicial or administrative review of uncompensated care in *Florida Health Sciences Ctr., Inc. (d/b/a Tampa Gen. Hosp.) v. DHHS*, No. 14-0791, 2015 WL 1478438 (Mar. 31, 2015) ("*Tampa General*"). With respect to review sought through a Writ of Mandamus, this is an equitable remedy not available to the Board.

Tampa General

In *Tampa General* the Provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The Provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of

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[17] 476 U.S. 667 (1986).

[18] Paragraph (2) is a reference to the three factors: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FFY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. at 50,627, 50,631 and 50,634, respectively.

data updated in April 2013, when calculating its uncompensated care payments. The Government argued that the statute precluded review of "[a]ny estimate of the Secretary for purposes of determining the factors" used to calculate the uncompensated care payment and "[a]ny period selected by the Secretary" for those purposes.[19]

The Court found that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The hospital had argued that it was not challenging either an "estimate" or a "period," but rather the "Secretary's choice of 'appropriate data' or 'alternative data.'"[20] The Court considered this was an exercise in semantics and concluded that it did not alter the essence of the hospital's claims. The Court noted that

> Congress did not specifically prohibit review of the methodology used to calculate the "estimated" amount of hospitals' uncompensated care in factor three, and it did not expressly bar review of the "appropriate data" upon which the estimate would be based, but it did plainly and broadly prohibit any legal challenge to the estimate itself, by precluding administrative or judicial review "under section 1395ff of this title, section 1395oo of this title, or otherwise of ... [a]ny estimate" or "[a]ny period" used by the Secretary for purposes of determining the factors that make up the additional payment. 42 U.S.C. § 1395ww(r)(3)(A)-(B). Because the Court finds that the complaint is, at its essence, a challenge to both an estimate and a period used by the Secretary for those very purposes, [the hospital's] claims are not subject to judicial review.[21]

The Board believes that these findings above are applicable to the facts in the cases under appeal in this case. The Providers are challenging the estimated amount of uncompensated care, a matter outside the Board's purview.

Mandamus

A Federal court of appeals has the power to issue a writ of mandamus pursuant to the All Writs Act, 28 U.S.C. § 1651, which provides that

> (a) The Supreme Court and all courts established by Act of Congress may issue all writs necessary or appropriate in aid of their respective jurisdictions and agreeable to the usages and principles of law.

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[19] *Tampa General*, 2015 WL 1478438 at *3.
[20] *Id.* at *5.
[21] *Id.* at *9.

It is an extraordinary remedy[22] not available to the Board. This is not a power granted to the Board by Congress and "an agency's power is no greater than that delegated to it by Congress."[23] Though an agency may promulgate rules or regulations pursuant to the authority granted by Congress, no such rule or regulation can confer on the agency any greater authority than conferred under the governing statute.[24] A petitioner seeking a writ must show how they lack alternative means to obtain the relief they seek and must show that their right to issuance of the writ is clear and indisputable.[25] Since there is no statutory or regulatory authority for the Board to grant this relief; it is outside the scope of the powers of the Board. Consequently, the Providers' requests that the Board issue a Writs of Mandamus are hereby denied.

Since the Board lacks jurisdiction over the appeals, Case Numbers 15-1260GC, 15-1265GC, and 15-1520GC are hereby dismissed and closed. Review of the jurisdictional 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.
Schedules of Providers

cc: Cecile Huggins, Palmetto GBA (Certified Mail w/Schedule of Providers)
James Ward, Noridian (Certified Mail w/Schedule of Providers)
Kevin Shanklin, BCBSA (w/Schedule of Providers)

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[22] *Gulfstream Aerospace Corp. v. Mayacamas Corp.*, 485 U.S. 271, 289 (1988).
[23] *Lyng v. Payne*, 476 U.S. 926, 937 (1986); *see also Gibas v. Saginaw Mining Co.*, 748 F.2d 1112, 1117 (6th Cir. 1984), *cert. denied*, 471 U.S. 1116 (1985) (administrative agencies are vested only with the authority given to them by Congress).
[24] *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 208 (1988).
[25] *Mallard v. U. S. Dist. Ct. for the S. Dist. of Iowa*, 490 U.S. 296,309 (1989).

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

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

Refer to: 10-0226 **CERTIFIED MAIL** MAY 06 2015

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

James Lowe
Cahaba Safeguard Administrators, LL
2803 Slater Road, Suite 215
Morrisville, NC 27560

RE: Jurisdiction Determination
Covenant Medical Center
Provider No.: 45-0040
FYEs: 06/30/2007
PRRB Case No.: 10-0226

Dear Mr. Olvera and Mr. Lowe:

This case involves a provider's individual appeal of its Medicare reimbursement for the fiscal year ending ("FYE") on June 30, 2007. The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above-referenced appeal and dismisses Covenant Medical Center's ("Covenant's") remaining issues for lack of jurisdiction as explained below.

Pertinent Facts

On December 14, 2009, the Board received Covenant's request for hearing ("RFH") in which Covenant appealed 29 issues from its notice of program reimbursement ("NPR") for FYE June 30, 2007. On May 1, 2013, the Board received Covenant's final position paper ("FPP") in which Covenant addresses 6 issues. Issue 3 is listed as "Disproportionate Share Hospital Payment (DSH)—Medicaid Eligible Days."

On July 9, 2013, the Board received BlueCross and BlueShield Association's ("BCBSA's") jurisdictional challenge filed on behalf of the Medicare contractor. In its jurisdictional challenge, BCBSA argues that Covenant has improperly "attempted to expand its DSH appeal issue to include several other aspects of DSH reimbursement determination."

On March 5, 2014, the Board received Covenant's "Partial Administrative Resolution" ("AR") for the instant appeal. Covenant states that the AR was "executed on 2/26/14[,]" and reports that the only issues pending will require a Board decision on jurisdiction. Although Covenant filed a response to the Board's Alert 10 on July 22, 2014, it has not substantively responded to BCBSA's jurisdictional challenge.

Jurisdictional Challenge

BCBSA argues that the Board does not have jurisdiction over the following "sub-issues" listed in Covenant's FPP as "Issue 3: Disproportionate Share Hospital Payment (DSH)—Medicaid Eligible Days":

(1) Issue 3a: DSH—Medicare Advantage, Medicare Managed Care, Medicare+Choice and/or Part C Days (collectively "MA" Days)
(2) Issues 3b/3c: DSH—Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)
(3) Issue 3d: DSH—Labor Room Days
(4) Issue 3e: DSH—Observation Bed Days
(5) Issue 3f: DSH—General Assistance Charity Care Days
(6) Issue 3g: DSH—Medicaid Out-of-State Days

BCBS argues that these issues do not meet the Board's jurisdictional requirements because (1) the issues were not addressed in Covenant's RFH or timely added to the appeal, and (2) the Medicare contractor did not adjust the specific DSH issues during Covenant's audit.

Covenant's FPP

In the FPP, Covenant appears to have combined two of its original issues from its RFH to create its new "Issue 3: Disproportionate Share Hospital Payment (DSH)—Medicaid Eligible Days." The original issues from Covenant's RFH are described as follows:

(1) Issue 6—Whether the Fiscal Intermediary properly adjusted allowable DSH % related to eligible days for strata 6 testing (less than 20 days) and strata 9 testing (unpaid 65 & over) (Adj. No. 11 & 50); and
(2) Issue 13—Whether the Fiscal Intermediary properly adjusted Medicaid days for paid and unpaid eligible claims (Adj. No. 11 & 50).

Board's Analysis and Decision

Under 42 C.F.R. § 405.1835(a) (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 hearing is filed within 180 days of the receipt of the final determination.

The Board received Covenant's timely filed RFH on December 14, 2009. Under the applicable regulation, 42 C.F.R. § 405.1835(b) (2009), a provider's RFH filed with the Board must contain

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

The Board Rules provide further guidance related to issues containing multiple components. Board Rule 8 titled "Framing Issues for Adjustments Involving Multiple Components" states

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

The regulations allow a provider to add issues to an existing appeal within the following timeframe set out in 42 C.F.R. § 405.1853(c) (2009):

> *Adding issues to the hearing request.* After filing a hearing request . . . a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board . . . if . . . (3) [t]he Board receives the request to add issues no later than 60 days after the expiration of the applicable 180-day period prescribed in paragraph (a)(3) of this section.

In order for the Board to have jurisdiction over Covenant's DSH "sub-issues" in this appeal, Covenant must demonstrate either that its RFH complied with the applicable regulations and Board Rules regarding framing issues for adjustments involving multiple components or that it timely added the DSH issues to its original hearing request.

In the Board Rules, "DSH" is noted as being an issue with multiple components. The Board Rules require that providers who wish to appeal a multiple-component issue specifically identify and narrowly describe the different components of the larger issue within the provider's RFH. In addition, the Rules provide a non-exhaustive list of examples of some of the DSH components that providers must specifically identify and describe within a RFH, including, but not limited to, dual eligible days, general assistance days and charity care days.

In its RFH, Covenant identified and described 29 distinct issues but failed to specifically identify the components of DSH that it wished to appeal. Now, within its FPP, Covenant has briefed a

number of DSH components, including dual eligible/general assistance/charity care days, as part of its combined "Disproportionate Share Hospital Payment (DSH)—Medicaid Eligible Days" issue and awaits a Board decision on jurisdiction with respect to these remaining issues.

Covenant was permitted to add issues to this appeal, if it chose to do so. By regulation, Covenant was to notify the Board, in writing, of any additional issues it wished to add to the instant appeal by February 16, 2010 (Covenant's NPR was dated June 16, 2009 + 180 days + 60 days + 5 day mailing presumption). No such request was received by the Board. Even if Covenant argues that it added these issues in its August 2, 2010 Preliminary Position Paper, the request is still untimely.

Consistent with the regulations, the Board Rules clearly state that, within an individual appeal request, providers must "specifically identify the items in dispute [and that] each contested component must be appealed as a separate issue and described as narrowly as possible . . ." In the present case, Covenant identified and described 29 distinct issues in its RFH but failed to identify the specific DSH components that it now seeks to include within its appeal. In addition, Covenant did not add these issues within the required regulatory timeframe.

Summary

The Board hereby dismisses Covenant's remaining issues in this appeal as listed above, labeled "3a-3g" in its FPP. As per Covenant's AR, since these issues were the only remaining issues in this appeal, case number 10-0226 is closed. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:
Michael W. Harty
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, Executive Director, Blue Cross and Blue Shield Association

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

MAY 08 2015

CERTIFIED MAIL

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

Cahaba Safeguard Administrators, LLC
James Lowe
2803 Slater Road, Suite 215
Morrisville, NC 27560-2008

RE: Kuakini Medical Center
Provider No.: 12-0007
FYEs: 6/30/2002, 6/30/2003, 6/30/2004, 6/30/2005, 6/30/2006
PRRB Case Nos.: 06-0626, 07-0448, 07-2787, 07-2864, 08-1337

Dear Mr. Blumberg and Mr. Lowe,

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

Background

Kuakini Medical Center (the Provider) filed appeals for each fiscal year from 2002 to 2006. These appeals contain a number of issues including SSI, Medicaid Eligible Days, Medicare/Medicaid Dual Eligible Days, DSH Capital Payments, and Budget Neutrality Adjustment. The SSI, Medicare/Medicaid Dual Eligible Days, and Budget Neutrality Adjustment issues were all transferred to group appeals.

A listing of these appeals and relevant dates is as follows:

Appeal No.	Fiscal Year End	NPR Date	Appeal Date
06-0626	6/30/2002	8/9/2005	2/3/2006
07-0448	6/30/2003	6/13/2006	12/4/2006
07-2787	6/30/2004	3/21/2007	9/17/2007
07-2864	6/30/2005	4/4/2007	9/18/2007
08-1337	6/30/2006	9/6/2007	2/26/2008

On July 9, 2013, the Intermediary filed separate but substantially identical jurisdictional challenges to the Medicaid Eligible Days issue in the appeals. The Intermediary also challenged the DSH Capital Payments (related to the additional Medicaid Eligible Days) issue in Case Nos. 07-2787 and 07-2864. The Provider did not file any responsive briefs.

Intermediary's Contentions

For fiscal years 2002, 2004, 2005, and 2006, the Intermediary contends that no adjustments were made for Medicaid eligible days. The Provider cannot be dissatisfied with an adjustment that was not made.[1] For these fiscal years, no DSH payments were included on the cost reports and therefore no related audit adjustments were made. Without a final determination, the Provider has nothing to appeal and the criteria for the right to a hearing has not been met.[2]

For fiscal year 2003, the Intermediary contends that DSH amounts were included inappropriately by the Provider on the cost report. Thus, adjustments were proposed to correctly present the data on the Provider's cost report. The Provider did not submit an explanation as to why the Provider believed the determination that the Provider did not meet DSH requirements was incorrect. No supporting documentation was submitted to indicate DSH requirements were met.[3]

The Intermediary asserts that the Provider failed to properly file DSH in its as-filed cost report or properly complete a correction with the reopening process or file an amended cost report within the regulatory guidelines. The Provider's decision to omit the DSH components is not consistent with self-disallowed costs as described in *Bethesda Hospital Ass'n. v. Bowen*, 485 U.S. 399 (1988). In *Bethesda*, the Supreme Court held that the Board did have jurisdiction over "self-disallowed" costs for the cost report being completed and filed in compliance with Medicare regulations and instructions. The Provider had failed to claim a cost because a regulation dictated that it would have been disallowed. However, there is no Medicare law, regulation or instructions which preclude a Provider from claiming or an Intermediary from allowing reimbursement for DSH if they meet the requirements. The lack of Medicaid eligible days was not noted as a protested item on the as-submitted cost report.[4]

The Intermediary argues that the Provider's failure to properly reflect DSH also was not an "inadvertent omission" as described in *Loma Linda Univ. Med. Ctr v. Leavitt,* 492 F. 3d 1065 (9th Cir. 2007). In that case, the Provider inadvertently zeroed out interest expense and filed the cost report without any claim for reimbursement. For the current situation, the Provider was fully aware that based on their submitted amounts, no DSH payment was to be calculated or included as a reimbursement amount. As reflected by the Provider's responses on the submitted cost report Worksheet S-2, the Provider does not qualify for Operating DSH (W/S S-2 line 21.01) or Capital DSH (W/S S-2 line 36.01). Since DSH payments were not claimed on the as-submitted cost report, the Intermediary never made a determination concerning them.[5]

Provider's Contentions

The Provider did not file any responsive briefs.

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

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) (2001) and 42 C.F.R. §§ 405.1835-405.1841 (2001), a provider has a right to a hearing before the Board with respect to a timely filed cost report if it is dissatisfied with the final determination of the Intermediary, the amount in controversy is $10,000 or more, and the request for hearing is received by the Board within 180 days of the date the notice of the intermediary's determination was mailed to the provider. The Board has *discretionary power* under 42 U.S.C. § 1395oo(d) after jurisdiction is established under 42 U.S.C. § 1395oo(a) to make a determination over all matters covered by the cost report. The Board can affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and make any other revisions on matters covered by the cost report even though such matters were not considered by the intermediary in making its final determination.

At the outset, the Board recognizes that CMS' computation of DSH payment has been shaped by decisions from the Supreme Court and administrative tribunals. In particular, the Board recognizes that the following decisions are relevant to this case in connection with whether the Board has jurisdiction to conduct a hearing on it: (1) the Supreme Court's decision in *Bethesda*; and (2) the Board's recent decision in *Danbury Hospital v. BlueCross BlueShield Ass'n* ("*Danbury*")[6].

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

In support of these findings, the Board notes that the preambles to the May 1986 Interim Final Rule and the September 1986 Final Rule confirm that providers have been required (both prior to and following 1986 when the DSH adjustment payment was added) to submit the Medicaid days data as part of the normal cost reporting process and that this information has been and continues to be subject to the normal cost report audit and settlement process.[7]

Second, the Board notes that the addition of the DSH adjustment in 1986 did not alter the scope of the providers' obligation to submit Medicaid days data. Specifically, in implementing the DSH adjustment in 1986, CMS did not substantively change the scope of providers' then-existing obligation to report Medicaid *paid* days on the cost report. In the preamble to the September 1986 Final Rule, CMS stated that its interpretation of the Medicaid days as used in the Medicaid percentage of the DSH calculation was "consistent with the way we require Medicaid days to be reported on the Medicare cost report."[8] CMS explained that its initial interpretation was based, in part, on CMS' belief that Congress did not intend that "an additional reporting mechanism, possibly tied to State eligibility records, be developed to obtain Medicaid statistics on noncovered patient days."[9] As a result, the Board concludes that the then-existing obligation to report Medicaid *paid* days data was not subsumed into the DSH adjustment

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[6] PRRB Dec. No. 2014-D3 (Feb. 11, 2014).
[7] The Board further notes that 42 C.F.R. § 413.24(f) describes a provider's cost report as a "report[] of its operations" which necessarily would include not only a report of costs but also certain occupancy and volume statistics such as Medicaid eligible days. *See also* Provider Reimbursement Manual, CMS Pub. No. 15-2 ("PRM 15-2"), § 3600.
[8] 51 Fed. Reg. at 31460. *See also* 56 Fed. Reg. 43358, 43379 (Aug. 30, 1991) (cross-referencing the September 1986 Final Rule discussion of CMS' interpretation of Medicaid days being based, in part, on how Medicaid days was then-currently being reported as part of the normal cost reporting process).
[9] 51 Fed. Reg. at 31460.

decision process (*i.e.*, that obligation remained separate and distinct from the DSH adjustment decision process).

Third, the preamble to the May 1986 Interim Final Rule confirms that, if a provider is dissatisfied with the intermediary's "determination of its Medicaid days" (whether for purposes of interim DSH adjustment determination or for the final DSH adjustment determination), the provider as part of the "year-end settlement on a cost reporting period basis" has "the . . . responsibility to demonstrate to the intermediary that the Medicaid statistics reported on its cost report are incorrect or were improperly applied."[10] This discussion confirms that CMS viewed decisions on Medicaid days as separate and distinct from the DSH adjustment determination itself. The separate and distinct nature of Medicaid days is supported by the facts that it is reported on a separate line and in a separate worksheet from where the DSH adjustment is claimed. Specifically, a provider claims Medicaid eligible days in Worksheet S-3 and claims a DSH adjustment in Worksheet E, Part A.

The DSH regulations have undergone numerous changes since the creation of the adjustment. Certain of these revisions came in the wake of circuit court decisions that invalidated HCFA's[11] computation of DSH payment, specifically its practices concerning the Medicaid fraction. In issuing HCFA Ruling 97-2, the agency acquiesced to these rulings, noting that:

> HCFA will count in the Medicaid fraction the number of days of inpatient hospital services for patients eligible for Medicaid on that day, whether or not the hospital received payment for those inpatient hospital services.[12]

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

> Pursuant to this ruling, Medicare fiscal intermediaries will determine the amounts due and make appropriate payments through normal procedures. Claims must, of course, meet all other applicable requirements. This includes the requirement for data that are adequate to document the claimed days. *The hospitals bear the burden of proof and must verify with the State that a patient was eligible for Medicaid (for some covered services) during each day of the patient's inpatient hospital stay. As the intermediaries may require, hospitals are responsible for and must furnish appropriate documentation to substantiate the number of patient days claimed.* Days for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid cannot be counted.[13]

In the final rule published on July 31, 1998, CMS conformed the DSH regulations located in 42 C.F.R. § 412.106 "to the new statutory construction issued in HCFA Ruling 97-2."[14] In particular, as part of this final rule, CMS incorporated the hospital's obligation to provide Medicaid eligible days data into

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[10] 51 Fed. Reg. at 16777 (emphasis added) (discussing the DSH adjustment process as being "similar to the process we use to make the additional payment for indirect medical education costs").
[11] CMS was formerly known as the Health Care Financing Administration ("HCFA").
[12] HCFA Ruling 97-2 at 3 (February 27, 1997), *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/Downloads/HCFAR972.pdf (last visited December 28, 2012).
[13] *Id.* (emphasis added).
[14] *See* 63 Fed. Reg. 40954, 40985 (July 31, 1998).

regulation at § 412.106(b)(4)(iii).[15] As a result of this revision (as well as other subsequent revisions), § 412.106(b)(4) read as follows during the time at issue:

> (4) *Second computation.* The fiscal intermediary determines, for the same cost reporting period used for the first computation [*i.e.*, the Medicare fraction], the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation [*i.e.*, the Medicaid fraction], the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> (ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.[16]

In 2003, Congress addressed a provider's access to information needed to calculate the DSH Medicare and Medicaid fractions, as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA").[17] Specifically, MMA § 951 requires CMS to "*arrange to furnish* to subsection (d) hospitals ... the data necessary for such hospitals to compute the number of patient days used in computing the disproportionate patient percentage under such section for that hospital for the current cost reporting year."[18]

In the preamble to the final rule published on August 12, 2005,[19] CMS discussed its implementation of MMA § 951. CMS stated that "we interpret section 951 to require CMS to arrange to furnish the personally identifiable information that would enable a hospital to compare and verify its records ..., in

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[15] *Id. See also* Program Memorandum, CMS Pub. No. 60A, Transmittal No. A-01-13 (Jan. 25, 2001) (reissuing Program Memorandum, CMS Pub. No. 60A, Transmittal No. A-99-62 (Dec. 1, 1999)). This memorandum specifies that: "Regardless of the type of allowable Medicaid day, *the hospital bears the burden of proof and must verify with the State* that the patient was eligible under one of the allowable categories during each day of the patient's stay. The Hospital is *responsible for* and must provide adequate *documentation to substantiate the number of Medicaid days* ***claimed***. *Days for patients that cannot be verified by State* records to have fallen within a period wherein the patient was eligible for Medicare as described in this memorandum *cannot be counted.*" *Id.* (emphasis added).

[16] 42 C.F.R. § 412.106(b)(4) (2005) (emphasis in original).

[17] Pub. L. No. 108-173, 117 Stat. 2066 (2003).

[18] *Id.* at 2427 (emphasis added.)

[19] 70 Fed. Reg. 47278 (Aug. 12, 2005).

the case of the Medicaid fraction, against the State-Medicaid agency's records."[20] CMS maintained that it has satisfied its § 951 obligation under this interpretation because the "established mechanisms" in place at the States allow providers to obtain access to this Medicaid days data and these mechanisms are sufficient.[21] Moreover, CMS reiterated the idea that providers bear ultimate responsibility for verifying the Medicaid eligibility of patients claimed on their cost reports since they furnished inpatient care to the patients underlying any claimed days and, thereby, should be in possession of much of the information needed to verify the days:

> In addition, we believe it is reasonable to continue to place the burden of furnishing the data adequate to prove eligibility for each Medicaid patient day claimed for DSH percentage calculation purposes on hospitals because, *since they have provided inpatient care to these patients for which they billed the relevant payers, including the State Medicaid plan, they will necessarily already be in possession of much of this information. We continue to believe hospitals are best situated to provide and verify Medicaid eligibility information.* Although we believe the mechanisms are currently in place to enable hospitals to obtain the data necessary to calculate their Medicaid fraction of the DSH patient percentage, there is currently no mandatory requirement imposed upon State Medicaid agencies to verify eligibility for hospitals. At this point, we continue to believe there is no need to modify the Medicaid State plan regulations to require that State plans verify Medicaid eligibility for hospitals. However, should we find that States are not voluntarily providing or verifying Medicaid eligibility information for hospitals, we will consider amending the State plan regulations to add a requirement that State plans provide certain eligibility information to hospitals.[22]

All providers are required to file cost reports annually, with reporting periods based on the provider's fiscal or accounting year. A cost report shows the costs incurred during the relevant fiscal year and the portion of those costs allocated to Medicare.[23] Each intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider, and issues the provider a Notice of Program Reimbursement ("NPR").[24] As noted in HCFA Ruling 97-2, under the "normal procedures," intermediaries determine DSH adjustment payments under the IPPS for a cost reporting period based, in part, on the Medicaid eligible days that providers claim on the relevant cost report forms. An intermediary's determination of a provider's eligibility for a DSH adjustment during a cost reporting period and, if eligible, the amount of that adjustment, is issued as part of the relevant NPR.

Based on the above, the Board concludes that: (1) the provider has an obligation to submit Medicaid days information as part of the cost reporting process; and (2) this obligation is separate and distinct from the DSH adjustment determination process. If a provider is dissatisfied with the intermediary's

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

determination of its Medicaid days, the provider can exercise appeal rights in accordance with the regulations set forth in 42 C.F.R. Part 405, Subpart R.[25]

As previously discussed, HCFA Ruling 97-2 expanded the days included in the numerator of the Medicaid fraction from Medicaid paid days to Medicaid paid and unpaid days (*i.e.*, Medicaid eligible days). Further, as part of HCFA Ruling 97-2 and the subsequent promulgation of 42 C.F.R. § 412.106(b)(4)(iii), CMS codified the provider's obligation to claim only those Medicaid eligible days that have been verified by State records. In this regard, that Ruling states that "[c]laims [for Medicaid eligible days] must, of course, meet other applicable requirements" such as "the requirement for data adequate to document the claimed [Medicaid eligible] days" and that "[d]ays for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid cannot be counted." Similarly, the preamble to the July 1998 Final Rule that promulgated § 412.106(b)(4)(iii) states "[o]ur proposed revisions to § 412.106(b)(4), like the Ruling, would continue to place on the provider the burdens of production, proof, and verification *as to each **claimed** Medicaid patient day*."[26] Thus, CMS made clear that, following the expansion of Medicaid days to include paid and unpaid days, providers continued to have the responsibility of claiming the relevant Medicaid days on the cost report (*i.e.*, "production") and proving and verifying with the State each of those claimed days.

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

Notwithstanding the increased complexity associated with reporting Medicaid eligible days data, CMS did not identify and adjust for that complexity when it implemented HCFA Ruling 97-2 as well as CMS' obligation under MMA § 951 to "arrange to furnish the personally identifiable information that would enable a hospital to compare and verify its records, . . . in the case of the Medicaid fraction, against the State-Medicaid agency's records."[27] In particular, CMS has not addressed how the practical impediment described above (*i.e.*, the fact that only Medicaid eligible days verified by the State can be claimed and

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

[26] 63 Fed. Reg. at 40985 (emphasis added).

[27] 70 Fed. Reg. at 47438.

that the data needed to verify Medicaid eligibility may not be available through no fault of the provider) may affect a provider's appeal rights under 42 U.S.C. § 1395oo(a).[28] As described below, the Board concludes that this practical impediment is similar to the legal impediment in *Bethesda*.

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

> We agree that under subsection (a)(1)(A)(i), a provider's dissatisfaction with the amount of its total reimbursement is a condition to the Board's jurisdiction. It is clear, however, that the submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations.[29]

The Supreme Court concluded that "petitioners could claim dissatisfaction within the meaning of the statute, without incorporating their challenge in the cost report filed with their fiscal intermediaries."[30]

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

The Board recognizes that CMS promulgated regulatory provisions to address *Bethesda* situations in the final rule published on May 23, 2008 (May 2008 Final Rule).[31] Specifically CMS promulgated new regulatory provisions at 42 C.F.R. § 405.1835(a)(1) describing how a provider can preserve its right to claim dissatisfaction and to pursue a Board hearing:

> (a) *Criteria.* A provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination, only if—
>
> (1) The provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue, by either—
>
> (i) Including a claim for specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy: or

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[28] The Board is not aware of CMS ever revisiting its 1986 evaluation of "the need to publish regulations to outline procedures and requirements for hospitals to follow in applying for a disproportionate share adjustment based on the patient revenue criteria under section 1886(d)(5)(F)(i)(II) of the Act." 51 Fed. Reg. at 31457.
[29] *Bethesda Hospital Ass'n v. Bowen*, 485 U.S. 399 (1988).
[30] *Id.* at 405.
[31] 73 Fed. Reg. 30190 (May 23, 2008).

> (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)).[32]

Significantly, CMS describes the new § 405.1835(a)(1)(ii) as "more akin simply to a presentment requirement" than "an exhaustion requirement."[33]

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

> In § 405.1811(b)(2)(i) and § 405.1835(b)(2)(i), we proposed that a provider would be required to explain its dissatisfaction with the amount of Medicare payment for the specific item(s) at issue by stating why Medicare payment is incorrect for each disputed item. *We acknowledge that there may be instances in which a provider may be uncertain as to whether Medicare payment is incorrect because it does not have access to the underlying data **(for example, data from a State agency)***. Accordingly, we have revised § 405.1811(b)(2)(i) and § 405.1835(b)(2)(i) to allow a provider to explain why it is unable to determine whether payment is correct as a result of not having access to underlying information.[34]

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

The Board's application of *Bethesda* is also consistent with Board Rule 7, entitled "Issue Statement and Claim of Dissatisfaction." The portions of Board Rule 7 which apply to this case are only those portions which do not involve the § 405.1835(a)(1)(ii) "presentment requirement" governing self-disallowed items.[35] Specifically, Board Rule 7.1 describes what is required for issue statements that are included in

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[32] *Id.* at 30249 (italics in original).
[33] *Id.* at 30196-30197.
[34] *Id* at 30194 (emphasis added) (quoting from Section II.D entitled "Provider Hearing Rights (§ 405.1803(d), § 405.1811, and § 405.1835)").
[35] Subsection C of Board Rule 7.2 addressing the protest of self-disallowed items applies to cost reporting periods ending on or after December 31, 2008. As the cost reporting years in these cases ended before December 31, 2008, subsection C is not applicable.

appeal requests and address "NPR or Revised NPR Adjustment." It recognizes in Paragraph B that there may situations where a provider may not have access to data:

> **B. No Access to Data**: If the Provider, *through no fault of its own*, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.[36]

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

> **B. No Access to Data**
> If the Provider elects to not claim an item on the cost report because, *through no fault of its own*, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon filing the cost report.[37]

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

In a February 2014 published decision, the Board ruled that it did not have jurisdiction over a reimbursement appeal filed by Danbury Hospital under circumstances very similar to the present case.[38] In *Danbury*, the provider claimed that it was unable to obtain the State-maintained information necessary to verify the Medicaid eligibility of its patients. The lack of verified information, it was argued, hindered the provider's ability to fully and accurately claim Medicaid eligible days on its cost report. Therefore, the provider filed a cost report that included only those days that were verified prior to the reporting deadline. The provider subsequently pursued a Board appeal in which it sought additional DSH reimbursement based on the inclusion of newly-verified Medicaid eligible days.

The provider argued that Board jurisdiction over its appeal was proper based upon *Bethesda*, claiming that *Bethesda* stands for the idea that a provider may appeal costs which it excludes from its cost report, if the inclusion of such items would be futile. The provider asserted that the Medicaid eligible days are often not available from the State in time for the provider to include them on the cost report prior to the filing deadline. In support of its position, the provider asserted that prior Board jurisdiction decisions have suggested that the "practical difficulties in getting [State] information combined with the Secretary's statement that it is not necessary for hospitals to formally apply for a DSH adjustment create circumstances in which a provider may demonstrate that it is dissatisfied with the Intermediary's determination of reimbursement despite not having made a claim on the cost report. The provider essentially asserted that the preambles to the May 1986 Interim Final Rule and the September 1986 Final

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[36] (Bold emphasis in original and italics added.)
[37] (Bold emphasis in original and italics added.)
[38] *Danbury Hospital v. BlueCross BlueShield Ass'n/Nat'l Govt. Serv. Inc.* PRRB Decision No. 2014-D3 (February 11, 2014).

Rule confirm that providers do not need to make a formal claim for a DSH adjustment and that providers can later submit additional Medicaid eligible days data if they believe their cost report is not accurate.[39]

As discussed above, the Board has interpreted and applied *Bethesda* such that, prior to the "presentment requirement" specified in § 405.1835(a)(1)(ii) going into effect, a provider was not required to "present" or "claim" Medicaid eligible days that (through no fault of the provider) could not be identified and/or verified with the State because the provider did not have access to the data from the State necessary for such identification and/or verification. However, a provider does have an obligation to establish that a practical impediment did exist preventing it from obtaining required verification from the State. In this regard, if the practical impediment theory were allowed to proceed, the provider would have a high burden of proof to establish the existence of such a practical difficulty.[40]

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

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

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

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

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

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[39] *Id.at 12.*

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

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

In the instant cases, the Provider neither responded to the Intermediary's jurisdictional challenge nor submitted any additional arguments and/or documentation in response to Alert 10. No detailed description of the process that the Provider used to identify and accumulate the actual paid and unpaid eligible days was supplied. Likewise, no detailed explanation why the additional days at issue could not be verified by the State at the time the cost report was filed was provided. The Provider has not identified the nature of the days that it seeks to include on appeal.

In the instant cases it is undisputed that the Intermediary did not review the Medicaid eligible days prior to cost report settlement and likewise did not make any adjustment to Medicaid eligible days.

The Board finds that it does not have jurisdiction under 42 U.S.C. § 1395oo(a) to hear the claims for additional Medicaid Eligible Days in Case Nos. 06-0626, 07-0448, 07-2787, 07-2864, and 08-1337 as well as the DSH Capital Payments (as this payment is related to the additional Medicaid Eligible Days) in Case Nos. 07-2787 and 07-2864, pursuant to *Bethesda* because the Provider failed to establish that there was a practical impediment, through no fault of the Provider, preventing the Provider from identifying and/or verifying the additional Medicaid eligible days with the State prior to the filing of the cost reports.

Therefore, the Board hereby dismisses these issues from the appeals. Since there are no remaining issues in these appeals, the Board hereby closes Case Nos. 06-0626, 07-0448, 07-2787, 07-2864, and 08-1337 and removes them from the Board's docket.

Review of these determinations 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.

FOR THE BOARD

Michael W. Harty
Chairman

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

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

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

MAY 13 2015

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

RE: Patton Boggs 2011 Medicare Outliers-NPR Optional Group, Provider Nos. Various, FYEs Various 2011, PRRB Case No. 14-1429G

Dear Mr. Nash:

The Provider Reimbursement Review Board (Board or PRRB) has reviewed the Schedule of Providers and the associated jurisdictional documents for case number 14-1429G. The Board's decision regarding jurisdiction for the Providers listed on the Schedule of Providers is set forth below.

Background

On December 18, 2013, Squire Patton Boggs (US) LLP (Patton Boggs) filed an appeal request to form a 2011 Medicare outliers Notice of Program Reimbursement (NPR) optional group. The participating Providers in this group raised the issue through appeals from NPR determinations. The Board assigned case number 14-1429G to the appeal.

On April 1, 2015, Patton Boggs submitted the cover page of the Providers' Preliminary Position Paper and a final Schedule of Providers for case number 14-1429G. On April 24, 2015, the Medicare Contractor submitted a letter to the Board identifying potential jurisdictional impediments with all four Providers in the group appeal. On April 30, 2015, the Medicare Contractor filed a jurisdictional challenge alleging that no adjustment was made by the Medicare Contractor to the outlier issue and that all four Providers in the group appeal did not preserve their appeal rights.

Medicare Contractor's Jurisdictional Challenge

The Medicare Contractor contends the Providers are disputing the outlier fixed loss threshold that is used to determine if an individual claim qualifies for an outlier payment. The outlier fixed loss threshold is determined by CMS each year through the Inpatient Prospective Payment System (IPPS) rulemaking process. The outlier fixed loss threshold is not reported on the cost report. Thus, the Medicare Contractor argues providers cannot seek payment for the outlier fixed loss threshold through the cost report. The Medicare Contractor maintains because this amount is not reported on the cost report the Providers in this appeal could not have possibly included a claim for the specific item on the cost report in accordance with 42 C.F.R. § 405.1835(a)(1)(i). The Medicare Contractor contends the only way a provider can preserve its right to appeal this

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.[3]

Decision of the Board

In the instant case, Provider 1, Good Samaritan Hospital (provider no. 05-0471, FYE 8/31/2011) and Provider 4, Parkview Medical Center (provider no. 06-0020, FYE 6/30/2011) included a statement in the jurisdictional documents under Tabs 1D and 4D that indicates "[t]he provider did not self-disallow the Outlier Claims issue; however, the provider challenges the validity of the self-disallowance regulation. As it is presently the subject of numerous court challenges. *See Banner Heart v. Burwell*, 1:14-cv-01195-APM (D.D.C.); *Denver Health Med. Ctr. v. Burwell*, 1:15-cv-00413-APM (D.D.C.)." These providers also provided a copy of Worksheet E, Part A, Line 75, of their cost reports demonstrating that a protested amount had been filed; however, Good Samaritan Hospital did not provide any documentation to specify the nature of the protested item(s) and Parkview Medical Center's documentation demonstrated that the protested amount did not include the outlier issue.

Provider 2, Bozeman Deaconess Hospital (provider no. 27-0057, FYE 12/31/2011) included a statement in the jurisdictional documents under Tab 2D that although it did list a protested amount on Worksheet E, Part A, Line 75 of the cost report, this amount did not include the outliers issue. However, Bozeman Deaconess Hospital states that it timely filed a written exception to its 2011 cost report to add additional protested amounts to Worksheet E, Part A, Line 75. The Medicare Contractor did not adjust the cost report to include the additional protested amounts requested.

Provider 3, Billings Clinic Hospital (provider no. 27-0004, FYE 6/30/2011) included a statement in the jurisdictional documents under Tab 3D that indicates "[i]n a good faith effort to comply with the self-disallowance regulation, the provider attempted to amend the cost report to add the outliers issue to its protested amounts. However the MAC rejected the amended cost report. In addition, the provider challenges the validity of the self-disallowance regulation . . . . " The Provider's letter requesting the amended cost report[4] and the Medicare Contractor's letter rejecting that submission are also in the record at Tab 3D.

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[3] *See* CMS Pub. 15-2 § 115 and § 3630.1.

[4] The request to include protested items on the cost report included a request to include outlier payments as well as rural floor budget neutrality, SSI percentage, dual eligible days, and Medicaid eligible days.

issue would be as a self-disallowed item. The Medicare Contractor maintains effective with cost reporting periods ending on or after December 31, 2008, providers must identify any self-disallowed items by including a protested amount specific to the item in dispute on their cost report.

The Medicare Contractor contends a review of the Schedule of Providers shows that all four Providers in the group have a cost reporting period ending on or after December 31, 2008. Thus, the Medicare Contractor argues in accordance with 42 C.F.R. § 405.1835(a)(1)(ii) these providers would need to have identified the outlier fixed loss threshold as a protested amount on their cost reports.[1] The Medicare Contractor maintains all four Providers in the group included protested amounts on their as filed cost reports, however, none of them specifically identified outlier payments or the outlier fixed loss threshold as an item being protested. Tab 1D, 2D, 3D, and 4D of the Providers' jurisdictional documents contain a note specific to each Provider in this appeal that states the Provider did not self-disallow the outlier issue by including a protested amount in the as filed Medicare cost report. As such, the Medicare Contractor requests the Board deny jurisdiction over all four providers in the group.[2]

Requirement to Claim Protested Items

With regard to the regulatory requirement that providers must present their claims with respect to items over which the intermediary lacks the discretion to award reimbursement, 42 C.F.R. § 405.1835(a)(1)(ii) (2012) provides:

> (a) A provider . . . has a right to a Board hearing . . . for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination, only if-
>
> (1) The provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue, by . . .
>
> (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)).

The Provider Reimbursement Manual (CMS Pub. 15-2) describes the information that is required to be entered and submitted for protested amounts on Worksheet E, Part A, Line 75 of the as-filed cost report. The Manual requires that providers:

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[1] Medicare Contractor's Jurisdictional Challenge at 4-5.
[2] Medicare Contractor's April 24, 2015 letter.

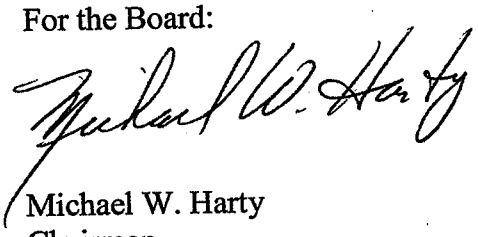
All four Providers have fiscal years that end after December 31, 2008, and thus, were required to file the outlier reimbursement at issue under protest on their cost reports pursuant to 42 C.F.R. §405.1835(a)(1)(ii). As each of the Providers failed to protest the outlier reimbursement at issue, the Board finds that it lacks jurisdiction over these Providers and dismisses case number 14-1429G. The group appeal is hereby closed and removed from the Board's docket.

Review of this jurisdictional 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: 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

MAY 13 2015

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

RE: *Banner Baywood Heart Hospital, provider no. 03-0105, FYE 12/31/11, Banner Desert Medical Center, provider no. 03-0065, FYE 12/31/11, and Banner Boswell Medical Center, provider no. 03-0061, FYE 12/31/11* as prior participants in "Patton Boggs Banner Health 2011 Medicare Outliers CIRP group," PRRB Case No. 14-0804GC

Dear Mr. Nash:

The Provider Reimbursement Review Board (Board or PRRB) has conducted an own motion review of case number 14-0804GC. The Board's decision with respect to the above referenced Providers is set forth below.

Background

On November 15, 2013, Squire Patton Boggs (US) LLP (Patton Boggs) filed an appeal request to form a 2011 Medicare outliers common issue related party (CIRP) group for Banner Health. The participating Providers raised the issue through appeals based on the lack of a timely issued Notice of Program Reimbursement (NPR). The Board assigned case number 14-0804GC to the appeal. On May 20, 2014, Patton Boggs, filed a request for expedited judicial review (EJR) in case number 14-0804GC. On June 13, 2014, the Board found that it lacked jurisdiction over Banner Baywood Heart Hospital (provider no. 03-0105, fiscal year end (FYE) 12/31/11), Banner Desert Medical Center (provider no. 03-0065, FYE 12/31/11) and Banner Boswell Medical Center (provider no. 06-0030, FYE 12/31/11) and denied the Providers' requests for EJR.

The Board found that the Providers' appeals in case number 14-0804GC, which were based on the Medicare contractor's failure to issue an NPR were moot, as subsequent to filing their initial appeals, the Providers' NPRs were issued on April 25, 2014, February 14, 2014 and February 12, 2014. The Board reasoned the Medicare contractor's issuance of the NPRs for FYE 2011 mooted the Medicare contractor's failure to issue their final determination. The Board dismissed Banner Baywood Heart Hospital, Banner Desert Medical Center and Banner Boswell Medical center from case number 14-0804GC and stated that if the Providers so chose, they could file appeals of their respective NPRs since the Providers were within the 180 day appeal period.

The Board issued a separate decision in case number 14-0804GC finding that it had jurisdiction for the remaining eight Providers in the case and granted EJR for the Providers. The Board found

that the Providers properly protested their outlier payments on Worksheet E, Part A, Line 75 as required by 42 C.F.R. § 405.1835(a)(1)(ii). The Board closed case number 14-0804GC since the Medicare outlier issue was the only issue under dispute in the case.

Providers' May 20, 2014 Request for EJR

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

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

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

The Providers note that beginning in 1997 through 2003, a number of hospitals were reported to have inflated their charge masters an action which the Department of Justice (DOJ) termed "turbo-charging." This practice greatly inflated cost to charge ratios which greatly increased the cost per case. DOJ termed this action a false claim and this also resulted in the Secretary greatly

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[1] See Providers' May 19, 2014 EJR request, Page 2, n. 2.
[2] *Id.* at n. 3.
[3] *See* 42 U.S.C § 1395ww(d)(5).
[4] Providers' May 19, 2014 EJR request at 3.
[5] *Id.* at 4 n. 9, 42 U.S.C. § 1395ww(d)(3)(B) (Reducing for the Value of Outlier Payments).
[6] Diagnostic Related Group.
[7] Providers' May 19, 2014 EJR request at 4.

increasing the FLT so that payments for outliers would remain at 5-6 percent of DRG payments. More specifically, beginning in or around Federal fiscal year (FFY) 1998, the Secretary began making upward adjustments to the FLTs which were in excess of the rate of inflationary indices routinely used such as the CPI-Medical Index or the Medicare Market Basket.

In 2002, the Secretary disclosed that he was aware of "turbo-charging" and that he would be amending the outlier regulations to fix "vulnerabilities" in the regulations. In the March 5th [8] and June 9, 2003[9] Federal Registers, the Secretary acknowledged three flaws in the outlier payment regulations and stated that the vulnerabilities would be fixed. The Providers maintain that the data used to correct the vulnerabilities had always been available and should have been used to calculate outlier reimbursement. The Providers noted that the Secretary stated that he believed that there was the authority to revise the outlier threshold given the manipulation of the outlier policy. However, he elected not to exercise this authority because of the short amount of time remaining in the FFY. The Providers allege that the Secretary was aware of the problem months before the final rule was published as demonstrated by Provider Exhibit 9, a copy of an Interim Final Rule submitted to the Office of Management and Budget on February 13, 2003.[10] As noted by the Providers,[11] the D.C. District Court in *Banner Health v. Sebelius*, 2013 U.S. Dist. Lexis 69889 (D.D.C. May 16, 2013) noted that the February 13, 2003 proposed rule was virtually identical to the final proposed rule with the exception that the later proposed rule published on March 5, 2003 did not recommend reduction of the FLT and the supporting analysis.

The Providers state that they did not learn of the February 13, 2003 unpublished, interim final rule until their counsel obtained it through a Freedom of Information Act request made to the Office of Management and Budget in 2012. They believe the document is still relevant because the Secretary has not accounted for the impact of the "turbo charging" data, and is, allegedly, still relying on inflated data to calculate outlier reimbursement. As a result, the Providers do not receive the full amount of outlier reimbursement to which they are entitled. Further, in the June 12, 2012 Office of Inspector General (OIG) report, the Inspector General noted that seven years after the 2003 publication of the regulation requiring reconciliation of outlier payments, CMS had not reconciled any of the cost reports screened and reported by Medicare Administrative

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[8] 68 Fed. Reg. 10,420, 10,423 (March 5, 2003) (Recent analysis indicates that some hospitals have taken advantage of two vulnerabilities in our methodology to maximize their outlier payments . . . [1] the time lag between the current charges on a submitted bill and the cost–to-charge ratio taken from the most recently settled cost report and [2] in some cases hospitals may increase their charges far above cost that their cost-to-charge ratios fall below 3 standard deviations from the geometric mean of cost-to-charge ratios and a higher statewide average cost-to-charge ratio is applied.)

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

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

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

Contractors.[12] In a later, 2013 report,[13] OIG noted that although nearly all hospitals receive outlier payments, a small percentage of hospitals receive a significantly higher proportion of payments. The hospitals receiving this higher portion of payments charged Medicare more for the same Medical Severity-Diagnostic Related Groups (MS-DRGs), yet had similar lengths of stay and cost-to-charge ratios. The Providers contend that this is another example of CMS' failure to correct the distribution of outlier payments.[14]

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

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

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

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

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

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

Decision of the Board

The 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.

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[12] *Id.* Ex. 10, OIG Report: The Centers for Medicare & Medicaid Services Did Not Reconcile Medicare Outlier Payments in Accordance with Federal Regulations and Guidance, Report A-07-10-02764 at 7-9 (June 2012).
[13] *Id.* Ex. 11 Medicare Hospital Outlier Payments Warrant Increased Scrutiny, Report OEI-06-10-00520 (November 2013). (incomplete document)
[14] *Id.* at 13.
[15] *Id.* at 15-24.

Banner Baywood Heart Hospital (provider no. 03-0105, FYE 12/31/11), Banner Desert Medical Center (provider no. 03-0065, FYE 12/31/11), and Banner Boswell Medical Center (provider no. 03-0061, FYE 12/31/11) were previously participants within PRRB case number 14-0804GC, in which the Providers appealed the outlier issue from the lack of the issuance of a NPR. Each of the Providers subsequently received their NPRs; on June 13, 2014, the Board dismissed the Providers from case number 14-0804GC reasoning that the Providers' receipt of their NPRs mooted the issue of the Medicare contractor's failure to issue a final determination.

The Board hereby reverses its prior June 13, 2014 decision to dismiss Banner Baywood Heart Hospital (provider no. 03-0105, FYE 12/31/11), Banner Desert Medical Center (provider no. 03-0065, FYE 12/31/11), and Banner Boswell Medical Center (provider no. 03-0061, FYE 12/31/11) from case number 14-0804GC. The Board reinstates the Providers' appeals into case number 14-0804GC and finds that it has jurisdiction over these Providers based on their appeals from the lack of the timely issuance of an NPR pursuant to the amendments made to 42 C.F.R § 405.1835 by the Final Rule dated August 22, 2014[16] and the corrections made to the Final Rule on October 3, 2014.[17] In addition, this decision is consistent with 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).[18]

42 C.F.R § 405.1835(c) as amended effective October 1, 2014, provides:

> (c) Right to a hearing based on untimely contractor determination. Notwithstanding the provisions of paragraph (a) of this section, a provider . . . has a right to a Board hearing, as a single provider appeal, for specific items for a cost reporting period if—

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[16] 79 Fed. Reg. 49854, 50200 (August 22, 2014) ("After reviewing the 2008 final rule [73 FR 30190] and the corresponding parts of the 2004 proposed rule (69 FR 35716; June 25, 2004), we determine that the inclusion in § 405.1835(a) of a provider dissatisfaction requirement for Board appeals based on an untimely contractor determination reflects an inadvertent error in the drafting of the 2008 final rule and the 2004 proposed rule. In this final rule, we are revising § 405.1835 of the regulations to eliminate provider dissatisfaction as a requirement for Board jurisdiction over appeals based on untimely contractor determinations. This is simply a technical correction inasmuch as this amendment to § 405.1835 conforms the regulations to the provisions in section 1878(a)(1)(B) of the Act for Board appeals based on an untimely contractor determination.")

[17] 79 Fed. Reg. 59675, 59680 (October 3, 2014) ("[o]n page 50350, in the third column, in § 405.1835(c), in lines 7 through 9, the phrase 'for specific items claimed for a cost reporting period if— ' is corrected to read 'for specific items for a cost reporting period if—'.")

[18] 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 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.*

> (1) A final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's perfected cost report or amended cost report . . . .
>
> (2) Unless the provider qualified for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the expiration of the 12 month period of issuance of the final contractor determination . . . ; and
>
> (3) The amount in controversy . . . is $10,000 or more.

Here, Banner Baywood Heart Hospital, Banner Desert Medical Center and Banner Boswell Medical Center each filed their appeals within 180 days after the expiration of the 12 month period of issuance of their final determinations and met the amount in controversy requirement. As such, the Providers met the requirements for Board jurisdiction over appeals based on untimely contractor determinations and are reinstated as participants within case number 14-0804GC.

Specific to the Providers' request for EJR for the outlier reimbursement issue, 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 Banner Baywood Heart Hospital (provider no. 03-0105, FYE 12/31/11), Banner Desert Medical Center (provider no. 03-0065, FYE 12/31/11) and Banner Boswell Medical Center's (provider no. 03-0061, FYE 12/31/11) requests for EJR for the outlier reimbursement issue in case number 14-0804GC. The Board hereby reopens case number 14-0804GC in order to reinstate the referenced Providers and to grant EJR for the Providers, and then recloses the case.

Case No.: 14-0804GC

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)(1) and 42 C.F.R. §§ 405.1875 and 405.1877,
Schedule of Providers

cc: Byron Lamprecht, Wisconsin Physicians Service
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

MAY 13 2015

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

RE: *Billings Clinic, provider no. 27-0004, FYE 6/30/11,* as a prior participant in "Patton Boggs 2011 Medicare Outliers Group," PRRB Case No. 13-3738G

Dear Mr. Nash:

The Provider Reimbursement Review Board (Board or PRRB) has conducted an own motion review of case number 13-3738G. The Board's decision with respect to the above referenced Provider is set forth below.

Background

On September 20, 2013, Squire Patton Boggs (US) LLP (Patton Boggs) filed an appeal request to form a 2011 Medicare outliers optional group. The participating Providers raised the issue through appeals based on the lack of a timely issued Notice of Program Reimbursement (NPR). The Board assigned case number 13-3738G to the appeal. On May 20, 2014, Patton Boggs, filed a request for expedited judicial review (EJR) in case number 13-3738G. On June 13, 2014, the Board found that it lacked jurisdiction over Billings Clinic (provider no. 27-0004, fiscal year end (FYE) 6/30/11) and denied Billings Clinic's request for EJR.

The Board found that Billings Clinic's appeal in case number 13-3738G, which was based on the Medicare contractor's failure to issue an NPR was moot, as subsequent to filing its initial appeal, Billings Clinic's NPR was issued on September 30, 2013. Billings Clinic thereafter filed an appeal of the same outlier issue in case number 14-1429G. The Board reasoned the Medicare contractor's issuance of the NPR for FYE 2011 mooted the Medicare contractor's failure to issue a final determination. In addition, Board Rule 4.5 preludes providers from appealing the same issue in more than one appeal. The Board dismissed Billings Clinic from case number 13-3738G and stated that that Billings Clinic would remain a participant in case number 14-1429G.

The Board issued separate decisions in case number 13-3738G finding that it lacked jurisdiction over the other ten Providers in the case and denying the Providers requests for EJR because the Providers either failed to file their hearing requests timely[1] or failed to claim Medicare outliers on the cost report as a protested item. The Board denied EJR as there were no jurisdictionally

[1] Parkview Medical Center (provider no. 06-0020, FYE 6/30/11) and Cabell Huntington Hospital (provider no. 51-0055, FYE 9/30/11) were dismissed from the appeal on June 13, 2014, and November 22, 2013, respectively because their hearing requests were not timely filed.

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

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

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

Decision of the Board

The 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.

Billings Clinic (provider no. 27-0004, FYE 6/30/11) was previously a participant within PRRB case number 13-3738G in which the Providers appealed the outlier issue from the lack of the issuance of a NPR. Billings Clinic subsequently received its NPR; on June 13, 2014, the Board dismissed Billings Clinic from case number 13-3738G reasoning that Billings Clinic's receipt of its NPR mooted the issue of the Medicare contractor's failure to issue a final determination.

The Board hereby reverses its prior June 13, 2014 decision to dismiss Billings Clinic (provider no. 27-0004, FYE 6/30/11) from case number 13-3738G. The Board reinstates Billings Clinic's appeal into case number 13-3738G and finds that it has jurisdiction over Billings Clinic based on Billings Clinic's appeal from the lack of the timely issuance of an NPR pursuant to the amendments made to 42 C.F.R § 405.1835 by the Final Rule dated August 22, 2014[19] and the corrections made to the Final Rule on October 3, 2014.[20] In addition, this decision is consistent with 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]

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

[19] 79 Fed. Reg. 49854, 50200 (August 22, 2014) ("After reviewing the 2008 final rule [73 FR 30190] and the corresponding parts of the 2004 proposed rule (69 FR 35716; June 25, 2004), we determine that the inclusion in § 405.1835(a) of a provider dissatisfaction requirement for Board appeals based on an untimely contractor determination reflects an inadvertent error in the drafting of the 2008 final rule and the 2004 proposed rule. In this final rule, we are revising § 405.1835 of the regulations to eliminate provider dissatisfaction as a requirement for Board jurisdiction over appeals based on untimely contractor determinations. This is simply a technical correction inasmuch as this amendment to § 405.1835 conforms the regulations to the provisions in section 1878(a)(1)(B) of the Act for Board appeals based on an untimely contractor determination.")

[20] 79 Fed. Reg. 59675, 59680 (October 3, 2014) ("[o]n page 50350, in the third column, in § 405.1835(c), in lines 7 through 9, the phrase 'for specific items claimed for a cost reporting period if— ' is corrected to read 'for specific items for a cost reporting period if—'.")

[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

42 C.F.R § 405.1835(c) as amended effective October 1, 2014, provides:

> (c) Right to a hearing based on untimely contractor determination. Notwithstanding the provisions of paragraph (a) of this section, a provider . . . has a right to a Board hearing, as a single provider appeal, for specific items for a cost reporting period if—
>
> (1) A final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's perfected cost report or amended cost report . . . .
>
> (2) Unless the provider qualified for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the expiration of the 12 month period of issuance of the final contractor determination . . . ; and
>
> (3) The amount in controversy . . . is $10,000 or more.

Here, Billings Clinic filed its appeals within 180 days after the expiration of the 12 month period of issuance of its final determination and met the amount in controversy requirement. As such, Billings Clinic met the requirements for Board jurisdiction over appeals based on untimely contractor determinations and is reinstated as a participant within case number 13-3738G.

Specific to Billings Clinic's request for EJR for the outlier reimbursement issue, the Board finds that:

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

2) based upon the Provider's 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

"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 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.*

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 Billings Clinic (provider no. 27-0004, FYE 6/30/11) request for EJR for the outlier reimbursement issue in case number 13-3738G. The Board hereby reopens case number 13-3738G in order to reinstate the referenced Provider and to to grant EJR for the Provider, and then recloses 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
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: Bill Tisdale, Novitas Solutions, Inc.
Kevin Shanklin, BCBSA

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

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

Refer to: 15-0656

MAY 14 2015

CERTIFIED MAIL

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

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

RE: Jurisdictional Decision – Saint Joseph's Medical Center
Provider No.: 33-0006
FYE: 12/31/2012
PRRB Case No.: 15-0656

Dear Mr. Blumberg and Mr. Browning,

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced appeal. The Board finds that it does not have jurisdiction over Saint Joseph's Medical Center's appeal. The decision of the Board is set forth below.

Background

On June 3, 2013, the Medicare Administrative Contractor ("MAC") received Saint Joseph's Medical Center's cost report. On December 10, 2014, Saint Joseph's Medical Center filed an individual appeal request with the Board.

Board's Decision

The Board finds that it does not have jurisdiction over this appeal because it was not timely filed from the non-issuance of the Provider's Notice of Program Reimbursement ("NPR").

42 C.F.R. 405.1835(a)(3)(ii) (2014) governs when the MAC fails to issue an NPR, as is the case here. It states:

> If the contractor determination is not issued (through no fault of the provider) within 12 months of the date of receipt by the contractor of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of this chapter), *no later than 180 days after the expiration of the 12 month period for issuance of the contractor determination.* (Emphasis added).

In the instant case, the MAC received the Provider's cost report on June 3, 2013, as evidenced by the tentative settlement summary worksheet prepared by the MAC, and had one year (until June 3, 2014) to issue its NPR but did not do so. Therefore, the Provider had within 180 days of June 3, 2014 to file its appeal request with the Board (until December 1, 2014[1]).

The Board received the Provider's appeal 191 days later, on December 11, 2014, which is outside the 180 day timeframe. Because Saint Joseph's Medical Center did not timely file its appeal request, the Board finds that it does not have jurisdiction over the appeal and hereby dismisses case number 15-0656.

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

Board Members
Michael W. Harty
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

[1] This is the 181st day because the 180th day fell on a Sunday.

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

Refer to: 08-1158

CERTIFIED MAIL

MAY 14 2015

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

Palmetto GBA
Cecile Huggins
Supervisor
Provider Audit – Mail Code AG380
2300 Springdale Drive – Bldg. ONE
Camden SC 29020-1728

RE: Jurisdictional Decision
Novant Presbyterian Hospital
Provider No.: 34-0053
FYE: 12/31/2005
PRRB Case No.: 08-1158

Dear Mr. Ravindran and Ms. Huggins:

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

Background

Novant Presbyterian Hospital was issued a Notice of Program Reimbursement ("NPR") for FYE 12/31/2005 on December 21, 2007. On February 22, 2008, the Provider filed an appeal request with the Board in which it appealed the following issues:

- Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") Proxy
- DSH/Medicaid Percentage (Eligible Days)

On June 13, 2008, the Provider added the Medicare Bad Debt issue to the appeal. On August 11, 2008, the Provider requested the formation of the following group appeals:

- Novant 2005 DSH/SSI Group Appeal
- Novant 2005 DSH/North Carolina Charity Care Days Group Appeal
- Novant 2005 DSH/Medicaid Eligible Days Group Appeal
- Novant 2005 DSH/Medicare Managed Care/Medicaid Eligible Days Group Appeal

The Provider also requested to add the following issues and transfer them to the newly established group appeals:

Issue:	Number of case transferred to:
DSH/SSI Percentage	Novant 2005 DSH/SSI Group Appeal, #08-2584G
DSH/North Carolina Charity Care Days	Novant 2005 DSH/North Carolina Charity Care Days Groups Appeal, #08-2583G
DSH/Medicaid Eligible Days	Novant 2005 DSH/Medicaid Eligible Days Group Appeal, #08-2581G
DSH/Medicare Managed Care/Medicaid Eligible Days	Novant 2005 DSH/Medicare Managed Care/Medicaid Eligible Days Group Appeal, #08-2580G

On October 20, 2008, the Provider requested to add the following issues:

- DSH/SSI Percentage
- DSH – Medicaid Eligible Observation Bed Days
- Medicare Crossover Bad Debts
- Medicare Charity Care Bad Debts
- DSH – Exclusion of Part C Days from the Denominator of the Medicare Percentage

On November 25, 2009, the Provider requested that the Charity Care and Crossover Bad Debt issues be withdrawn. The Provider also requested to transfer the following issue to a group appeal:

Issue:	Number of case transferred to:
DSH – Exclusion of Part C Days from the Denominator of the Medicare Percentage	QRS Novant DSH/Medicare Denominator – Exclusion of Part C Days, #10-0174GC

On December 23, 2009, the Provider requested to transfer the following issues to group appeals:

Issue:	Number of case transferred to:
DSH Payment – Medicaid Eligible Observation Bed Days	QRS Novant 2005 DSH/Medicaid Eligible Observation Bed Days, #10-0279GC

The only issue remaining in the appeal is the DSH/SSI Percentage issue raised in October 2008.

Decision of the Board

The Board finds that it does not have jurisdiction over the SSI Percentage issue raised on October 20, 2008 and dismisses the issue from case number 08-1158. The Provider appealed this issue using the following language:

> The Provider contends that [its] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include

> all patients that were entitled to SSI benefits in their calculation. This is based on certain data from the State of North Carolina and the Provider that does not support the SSI percentage issued by CMS. ... The Provider seeks to reconcile its records with CMS data and identify records that CMS may have failed to include in their determination of the SSI percentage. The Provider may exercise [its] right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.

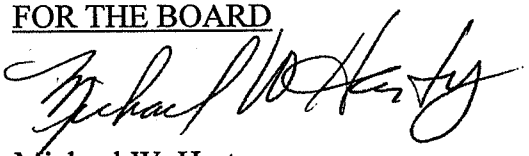
The Board finds that, to the extent the Provider is arguing that the SSI Percentage is understated and that it needs the underlying data to determine what records were not included, the issue is the same as the SSI Percentage issue that was initially raised and transferred to case number 08-2584GC. The basis of both issues is that the Provider does not have the underlying data and cannot determine if the SSI percentage is understated. Therefore, the Board finds that the accuracy portion of the issue is duplicative and dismisses this sub-issue from case number 08-1158 as it is already being pursued in a group appeal.[1]

To the extent the Provider is preserving its right to request realignment if it so chooses once the data is made available, the Board finds that this portion of the issue is premature. The Medicare contractor has not issued a final determination on this matter as the Provider has not yet requested realignment.[2] Therefore, the Board finds that does not have jurisdiction over the question of realignment and dismisses this sub-issue from case number 08-1158.

Since the SSI issue was the sole remaining issue in the individual appeal, case number 08-1158 is hereby closed. Review of this determination may be available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members
Michael W. Harty
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

---

[1] Per Board Rule 4.5 "A Provider may not appeal an issue from a final determination in more than one appeal."

[2] *See* 42 C.F.R. § 405.1835, which states: "The provider... has a right to a hearing before the Board about any matter designated in § 405.1801(a)(1), if... [a]n intermediary determination has been made with respect to the provider."

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

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

Refer to:

CERTIFIED MAIL

MAY 14 2015

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

RE: Highlands Regional Medical Center, Provider No. 10-0049, FYE 9/30/2012, PRRB Case No. 14-4059

Dear Mr. Ravindran:

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

Pertinent Facts:

QRS, Inc. filed an individual appeal for Highlands Regional Medical Center on August 28, 2014. The Board established case number 14-4059 and issued an acknowledgement letter on September 3, 2014. The appeal is based on the MAC's failure to issue a timely determination. The appeal request did not include evidence of the date the Intermediary received the filed/amended cost report nor the date of the Intermediary's acceptance of the same cost report. The Board issued a Request for Additional Information requesting copies of the documentation required to support filing from the MAC's failure to issue a timely final determination. On April 16, 2015, the Board closed the case since the requested information was not submitted.

QRS subsequently sent a Model Form D-Request to Transfer Issues to Group Appeals on April 22, 2015, requesting to transfer the following issues:

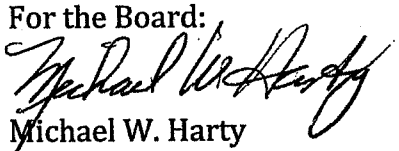
- DSH-SSI Percentage (Systemic Errors) to 15-0584GC, QRS HMA 2012 DSH Percentage (Baystate Errors) CIRP Group;
- DSH-SSI Fraction Medicare Managed Care Part C Days to 15-0585GC, QRS HMA 2012 DSH SSI Fraction Medicare Managed Care Part C Days CIRP Group;
- DSH-SSI Fraction Dual Eligible Days to 15-0580GC, QRS HMA 2012 DSH SSI Fraction Dual Eligible Days CIRP Group;
- DSH-Medicaid Fraction Medicare Managed Care Part C Days to 15-0587GC, QRS HMA 2012 DSH Medicaid Fraction Medicare Managed Care Part C Days CIRP Group;

- DSH-Medicaid Fraction Dual Eligible Days to 15-0586GC, QRS HMA 2012 DSH Medicaid Fraction Dual Eligible Days CIRP Group.

Board Determination:

The Board hereby denies the Provider's requests to transfer from the subject individual appeal into the various groups because the individual appeal is in a closed status and there is not a valid appeal from which the issues can be transferred.

Board Members Participating:
Michael D. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte Benson, C.P.A.

For the Board:

Michael W. Harty
Chairman

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

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

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

Phone: 410-786-2671
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Refer to:

CERTIFIED MAIL

MAY 18 2015

Long Beach Medical Center
Stanley Weber
Director of Reimbursement
455 East Bay Drive
Long Beach, NY 11561

RE: Long Beach Medical Center, Provider No. 33-0225, FYE 12/31/2008
PRRB Case No. 15-1187

Dear Mr. Weber:

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

PERTINENT FACTS:

Long Beach Medical Center filed an individual appeal on January 26, 2015. The appeal request did not include a copy of the final determination in dispute, the Notice of Program Reimbursement (NPR).[1]

The Board established case number 15-1187 and issued an acknowledgement letter on February 5, 2015. On the same date, the Board issued a Request for Additional Information, requesting a copy of the final determination, the audit adjustments and a calculation of the reimbursement impact. The Request for Additional Information allowed 15 days for the information to be submitted and advised that failure to submit the information would result in the dismissal of the appeal.[2]

To date, there is no record that the final determination (or any of the other information requested) was submitted.

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[1] The appeal letter indicates the NPR dated August 1, 2014 and accompanying audit adjustments were attached as Exhibit (A) –however there was no Exhibit A attached.

[2] These letters were sent to two email addresses for the Provider: the one addressed as (joyce130@optline.net) was returned as undeliverable. The correct email is joyce130@optonline.net. Copies of both the Acknowledgement and the Request for Information were resent to the corrected email address on February 9, 2015. The second email address (Sweber@lbmc.org) was already in our database. The email sent to this address was also returned on February 7, 2015. On February 9, 2015, staff sent an email to joyce130@optonline.net requesting the Provider's phone, fax and email address within 10 days, to which there has been no reply.

Note: the Provider simultaneously filed an appeal of its FYE 2009 to which the Board assigned case number 15-1188. The FYE 2009 appeal did include a copy of the NPR and audit adjustment pages.

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 final determination.

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

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

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

Because the appeal request was not filed in conformance with 42 C.F.R § 405.1835 and the Board Rules, the Board dismisses case number 15-1187. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the case on the merits.

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

For the Board:
Michael W. Harty
Chairman

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

cc: Kyle Browning, National Government Services
Kevin D. Shanklin, Executive Director, BC BS Association

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

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

Refer to: 09-2044

MAY 22 2015

CERTIFIED MAIL

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

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

Re: Provider: Bass Baptist Health Center
Provider No.: 37-0016
FYE: 06/30/2006
PRRB Case No.: 09-2044

Dear Mr. Ravindran and Mr. Tisdale:

The Provider, Bass Baptist Health Center ("Bass Baptist"), appealed the amount of its Medicare reimbursement calculated by the Medicare Administrative Contractor, Novitas Solutions, Inc. ("Novitas"). The Provider Reimbursement Review Board ("Board") determined that no open issues remain in Case Number 09-2044, and hereby closes the case.

Background

Bass Baptist timely appealed its revised Notice of Program Reimbursement ("RNPR") to the Board on the basis of two issues:

(1) Disproportionate share hospital ("DSH") supplemental security income percentage ("SSI%") "Provider Specific"
(2) DSH SSI% "Systemic Errors"[1]

Bass Baptist further described the "Provider Specific" issue as "[w]hether the Contractor . . . used the correct SSI% in the DSH calculation," and the "Systemic Errors" issue as "[w]hether the SSI% used in the DSH calculation by the Contractor accurately and correctly accounts for all patient days that must be included in the numerator and denominator of the SSI calculation."[2] The SSI% and DSH were adjusted for fiscal year end 06/30/2006 on Worksheet E, Part A.[3]

[1] Baptist Individual Appeal Request at Tab 3, Jul. 21, 2009.
[2] *Id.*
[3] *Id.* at Tab 4.

Bass Baptist subsequently requested that DSH SSI% "Systemic Errors" be transferred to the QRS Integris Health 2006 DSH SSI% Group.[4] This DSH/SSI% group appeal was established as Case No. 10-0741GC and remanded on April 4, 2013.

Board Determination

The Board finds that the DSH SSI% issue is not two separate issues as originally appealed in Bass Baptist's Appeal Request. The Board concludes that since the bifurcation of the issue is inappropriate, the only issue appealed by Bass Baptist has been transferred to a group appeal. Therefore, the individual appeal is closed as no open issues remain.

Board Rule 4.5 states that "[a] Provider may not appeal an issue from a final determination in more than one appeal."[5] Here, the Provider contends that (1) the Secretary improperly calculated its SSI% and (2) the Contractor used the incorrect SSI% in processing its DSH payment. Bass Baptist is making the same argument, as the Contractor is required to use the SSI ratio provided by CMS. Essentially, Bass Baptist contends that the SSI ratio applied to its cost report was incorrect; the SSI ratio is the underlying dispute for both SSI% "Provider Specific" and SSI% "Systemic Errors." Under Board Rules, Bass Baptist is barred from filing a duplicate SSI% issue. Therefore, the Board finds that the SSI% is one issue for appeal purposes.

Bass Baptist only requested the transfer of SSI% "Systemic Errors," but both SSI% "Provider Specific" and SSI% "Systemic Errors" will transfer to Case No. 10-0741GC as one issue. The SSI% issue will be handled in Case No. 10-0741GC pursuant to CMS Ruling 1498-R. Therefore, as the sole issue was transferred, no issues remain in Bass Baptist's individual appeal. 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.

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: Kevin Shanklin, Executive Director, BCBSA (without enclosures)

[4] Bass Baptist Transfer Request, Feb. 23, 2010.
[5] Board Rule 4.5 at 3, Jul. 1, 2009.

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: 13-3161

MAY 22 2015

CERTIFIED MAIL

Corinna Goron
President
Healthcare Reimbursement Services, Inc.
c/o Appeals Department
17101 Preston Road, Suite 220
Dallas, TX 75248-1372

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

Re: Provider: Yavapai Regional Medical Center
Provider No.: 03-0012
FYE: 12/31/2007
PRRB Case No.: 13-3161

Dear Ms. Goron and Mr. Ward:

The Provider, Yavapai Regional Medical Center ("Yavapai"), appealed the amount of its Medicare reimbursement calculated by the Medicare Administrative Contractor, Noridian Healthcare Solutions, LLC ("Noridian"). The Provider Reimbursement Review Board ("Board") determines that no open issues remain in Case Number 13-3161, and hereby closes the case.

Background

Yavapai timely appealed its Notice of Program Reimbursement ("NPR") to the Board on the basis of the following issues:

(1) Disproportionate share hospital ("DSH") supplemental security income percentage ("SSI%");
(2) DSH SSI%;
(3) Medicaid Eligible days;
(4) Part C days; and,
(5) Dual Eligible days.[1]

Yavapai further described the two DSH SSI% issues as "[w]hether the Secretary properly calculated the SSI%" and "[w]hether the Contractor used the correct SSI% in the DSH calculation."[2]

[1] Yavapai Individual Appeal Request at Tab 3, Aug. 15, 2013.
[2] *Id.*

Yavapai requested several transfers. Yavapai requested that Part C days be transferred to Case No. 14-0369G; DSH/SSI% to Case No. 14-0365G; and, Dual Eligible days to Case No. 14-0366G.3 Yavapai withdrew its Medicaid Eligible days issue. Yavapai stated that it only briefed SSI% (Provider Specific).[4]

Board Determination

The Board finds that the DSH SSI% issue is not two separate issues as originally appealed in Yavapai's Appeal Request. The Board concludes that since the bifurcation of the issue is inappropriate, the DSH SSI% issue appealed by Yavapai has been transferred to a group appeal. Therefore, the individual appeal is closed as no open issues remain.

Board Rule 4.5 states that "[a] Provider may not appeal an issue from a final determination in more than one appeal."[5] Here, the Provider contends that (1) the Secretary improperly calculated its SSI% and (2) the Contractor used the incorrect SSI% in processing its DSH payment. Yavapai is making the same argument, as the Contractor is required to use the SSI ratio provided by CMS. Essentially, Yavapai contends that the SSI ratio applied to its cost report was incorrect. Therefore, the SSI ratio is the underlying dispute for both of the DSH SSI% issues. Under Board Rules, Yavapai is barred from filing a duplicate SSI% issue. The Board finds that the SSI% is one issue for appeal purposes.

Since all of the issues were either transferred or withdrawn, no issues remain in Yavapai's individual appeal. 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.

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: Kevin Shanklin, Executive Director, BCBSA (without enclosures)

---

[3] *See* Yavapai Transfer Requests, Apr. 2, 2014.
[4] *See* Provider's Preliminary Position Paper Letter to Noridian Healthcare Solutions, May 1, 2014.
[5] Board Rule 4.5 at 3, Jul. 1, 2009.

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: 13-2338

MAY 22 2015

CERTIFIED MAIL

Corinna Goron
President
Healthcare Reimbursement Services, Inc.
c/o Appeals Department
17101 Preston Road, Suite 220
Dallas, TX 75248-1372

Judith E. Cummings
Accounting Manager
CGS Administrators
CGS Audit & Reimbursement
P.O. Box 20020
Nashville, TN 37202

RE: Provider: St. Vincent Charity Medical Center
Provider No.: 36-0037
FYE: 09/30/2006
PRRB Case No.: 13-2338

Dear Ms. Goron and Ms. Cummings:

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documentation submitted in the above-captioned case. The Board determined that the issues related to the DSH Medicaid fraction must be dismissed; however, the Board grants jurisdiction over the DSH SSI fraction issues.

Background

The Provider, St. Vincent Charity Medical Center ("St. Vincent"), filed a timely individual appeal with the Board, disputing several issues related to its Medicare reimbursement, which was calculated by the Medicare Administrative Contractor, CGS Administrators ("CGS"). St. Vincent appealed the following issues:

(1) DSH/SSI (Systemic Errors);
(2) DSH/SSI% (Provider Specific);
(3) DSH Medicaid Eligible days;
(4) DSH Medicare Managed Care Part C days; and,
(5) DSH Dual Eligible days (Exhausted Benefit, Medicare Secondary Payer, and No-Pay Part A days).[1]

St. Vincent sent in proof to the Board that it filed its Preliminary Position Paper with

[1] Individual Appeal Request Tab 3, May 29, 2013.

CGS.[2] In its letter, St. Vincent stated:

> The Medicaid Eligible days issues will not be briefed since they have been settled and/or going through a reopening process. All other issues have been transferred to various groups; therefore we are only briefing SSI Provider Specific.[3]

St. Vincent stated that all of its other issues, aside from SSI Provider Specific have been transferred to various groups; however, there is no indication in the instant casefile that any issues have been requested to be transferred.

CGS filed a Jurisdictional Challenge with the Board. CGS requests that the Board dismiss the case for lack of jurisdiction because St. Vincent appealed from an original Notice of Program Reimbursement ("NPR") on Model Form A; however, it should have appealed from a revised Notice of Program Reimbursement ("RNPR").[4] Further, St. Vincent failed to include the required documentation for RNPR appeals.[5] CGS also alleged that it did not specifically revise the issues of Medicaid Eligible days, Managed Care Part C days, and Dual Eligible days.[6] Additionally, CGS argued that St. Vincent improperly appealed the Managed Care Part C days by including multiple components in one issue, where Board Rule 8.1 requires multiple components to be appealed separately.[7]

St. Vincent responded to CGS's Jurisdictional Challenge. St. Vincent states that it has withdrawn the Medicaid Eligible days issue.[8] St. Vincent argues that there was an adjustment to its DSH calculation and that St. Vincent is dissatisfied, which is sufficient to warrant jurisdiction.[9] St. Vincent argues that CGS also specifically adjusted its Medicare fraction, or SSI fraction, which included a revised SSI ratio made up of SSI patients, Part C and Dual Eligible patients.[10] St. Vincent further states that it is currently working to forward copies of the required documentation to the Board, under separate cover.11 St. Vincent identifies the following issues in its Jurisdictional Response:

(1) DSH/Medicaid Fraction Part C days;
(2) DSH/Medicaid Fraction Dual Eligible days;

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[2] *See* St. Vincent's Preliminary Position Paper Letter to the Board, Jan. 30, 2014.
[3] *Id.*
[4] CGS's Jurisdictional Brief at 2, May 12, 2014.
[5] *Id.*
[6] *Id.* at 3-5.
[7] *Id.* at 4; *see also* Board Rule 8.1 at 8, Mar. 1, 2013 (Some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible . . .).
[8] St. Vincent's Jurisdictional Response at 1, Aug. 20, 2014.
[9] *Id.* at 4.
[10] *Id.*
[11] *Id.* at 1.

(3) DSH/SSI Percentage;
(4) Part C days – DSH/SSI Fraction; and,
(5) Dual Eligible days – DSH/SSI Fraction.[12]

St. Vincent states " . . . [it] has bifurcated the various issues by transferring the issues in the appeal request . . . ."[13] St. Vincent claims that it made the following transfers:

(1) DSH/Medicare Part C days – Medicaid Fraction issues to Case Nos. 14-0367G and 14-0146G;
(2) DSH/SSI% to Case No. 14-0364G;
(3) Part C days – DSH/SSI Fraction to Case No. 14-[3521G]; and,
(4) Dual Eligible days – DSH/SSI Fraction to Case No. 14-3522G.[14]

Again, there is no proof in the instant casefile that St. Vincent properly requested these transfers.

Board's Determination

The Board grants jurisdiction in part and denies jurisdiction in part. The Board finds that it has jurisdiction over the SSI issues; however, since the Medicaid fraction was not specifically revised in St. Vincent's RNPR, the issues related to the Medicaid fraction are improper and will be dismissed.

Pursuant to 42 C.F.R. § 405.1889 (2012), RNRP regulations limit an appeal to only those items specifically revised upon reopening:

> (a) If a revision is made in a Secretary or [Contractor] 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.

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[12] *See id.* at 4.
[13] *Id.*
[14] *Id.* There is no record of St. Vincent's Transfer Requests in Case Nos. 14-0367G or 14-0146G. There is evidence of St. Vincent's Transfer Request in Case No. 14-0364G. Case Nos. 14-3521G and 14-3522G were bifurcated from an SSI group appeal.

Recently, 42 C.F.R. § 405.1889 was addressed in *Emanuel Medical Center, Inc. v. Sebelius,* No. CV 12-1962 (GK), 2014 WL 1557524 (D.D.C. Apr. 17, 2014). In that case, the Court held that the "issue-specific" interpretation of the RNPR regulation is reasonable and that any change to the DSH adjustment is not sufficient to establish that all of the elements of the DSH adjustment have been reconsidered. This means that for an RNPR appeal, the specific issue raised on appeal must have been specifically revised in the reopening.

St. Vincent appeals from an "original" NPR using Model Form A for Individual Appeal Requests; however, the attached documentation clearly shows that it is appealing from an "Amended" NPR.[15] The Audit Adjustment Report filed with the Individual Appeal Request shows that the only adjustment documented was an update to the SSI%.[16] Accordingly, the change to the SSI% also updated DSH.[17]

The Board finds that the adjustment to the SSI% means that St. Vincent may appeal SSI% (however, SSI% is one issue and need not be broken down into Systemic Errors and Provider Specific issues), Part C days, and Dual Eligible days. The caveat is that St. Vincent may only appeal Part C days and Dual Eligible days as they related to the SSI% and not the Medicaid fraction. Since the Medicaid fraction was not specifically revised in the reopening, any issue related to the Medicaid fraction is hereby dismissed.

The Board need not make a determination regarding Medicaid Eligible days since the issue was withdrawn. Further, St. Vincent claims that it made the following transfers:

(1) DSH/Medicare Part C days – Medicaid Fraction "issues" (presumably Part C days and Dual Eligible days) to Case Nos. 14-0367G and 14-0146G;
(2) DSH/SSI% to Case No. 14-0364G;
(3) Part C days – SSI Fraction to Case No. 14-[3521G]; and,
(4) Dual Eligible days – SSI Fraction to Case No. 14-3522G.

The Board denies the transfers to Cases 14-0367G and 14-0146G since the Medicaid fraction appeals are invalid. The Board grants the transfers of issues related to the SSI Fraction; however, the Board instructs the Provider to file appropriate transfer requests pursuant to Board Rules for any future requests.

The Board concludes that no open issues remain and the individual appeal 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.

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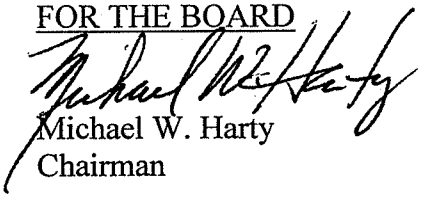
[15] Individual Appeal Request at 1.
[16] *See* Audit Adjustment Report Tab 1 *attached to* Individual Appeal Request Tab 3.
[17] *Id.*

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

FOR THE BOARD



Michael W. Harty
Chairman

cc: Kevin Shanklin, BCBSA

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

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

Refer to: 08-2450GC

CERTIFIED MAIL MAY 22 2015

Toyon Associates, Inc.
Thomas P. Knight
President
1800 Sutter Street, Suite 600
Concord, CA 94520-2546

Noridian Healthcare Solutions, LLC
Donna Kalafut
Senior Consultant, Federal Specialized Serv.
P.O. Box 6782
Fargo, ND 58108-6782

RE: Request for Case Bifurcation–Daughters of Charity 1999 DSH Dual Eligible Days CIRP
Provider No.: Various
FYE: 6/30/1999
PRRB Case No.: 08-2450GC

Dear Mr. Knight and Ms. Kalafut,

The Provider Reimbursement Review Board (Board) has reviewed the above-referenced appeal in response to the Providers' Request for Case Bifurcation. The Board hereby denies the Providers' request for case bifurcation of the dual eligible and Part C/HMO[1] days issues. The decision of the Board with regard to jurisdiction and the bifurcation request is set forth below.

Background

FORMATION OF GROUP

On July 24, 2008, the Board received the Providers' initial request for the establishment of a group appeal for the Daughters of Charity 1999 DSH Dual Eligible Days Common Issue Related Party (CIRP) Group. There were two Providers included in this request, which are the only two Providers that remain in the group.[2] This appeal was established because there were CIRP Providers identified in case numbers 06-1943G, Toyon 1999 DSH Dual Eligible Days Group #2. Case number 06-1943G was closed on May 25, 2010.[3] Providers requested to establish the Toyon 1999 DSH Dual Eligible Days Group with the following language:

> *Whether the Medicaid Ratio used to calculate Medicare Disproportionate Share Payments (DSH) accurately reflects the number of patient days*

[1] Any individual who was enrolled on December 31, 1998, with an eligible organization under section 1876 of the Social Security Act was considered to be enrolled under Part C as of January 1, 1999. 42 U.S.C. § 1395w-21. Therefore, the Board will refer to the issue as HMO days for periods before January 1, 1999 and as Part C days for periods after January 1, 1999. It should be noted, however, that the Providers have used the terms HMO days and Part C Days interchangeably for both time periods.

[2] Per the September 17, 2008 Schedule of Providers.

[3] Case number 06-1943G was closed prior to the December 21, 2012 bifurcation request that Toyon Associates, Inc. submitted; therefore the Board did not address whether bifurcation would be appropriate in case number 06-1943G.

> *furnished to patients eligible for Medicaid in situations where the patient is also enrolled in the Medicare Part A Program but is not entitled to Medicare Part A benefits.*[4]

Participant 1, O'Connor Hospital, included the dual eligible days issue in its individual appeal request using the following language:

> The Provider contends that certain dual eligible Medicare/Medicaid patient days should have been included in the disproportionate share entitlement calculation. The patient days pertaining to Medicaid eligible patients whose Part A benefits were exhausted or had no Medicare Part A paid claim should be included in the Medicaid eligible days used to calculate the disproportionate share amount. These days should be included because they are excluded from the calculation of the Medicare SSI ratio.[5]

O'Connor Hospital transferred the dual eligible days issue to case number 06-1943G as part of the appeal request for that group. The appeal request language is quoted above and does not include the HMO days issue.

Participant 2, Seton Medical Center did not include the dual eligible days issue in its individual appeal request. It later requested to add the issue to its individual appeal and transfer it to case number 06-1943G with the following language: "The Intermediary excluded Medi-Cal days for dual eligible patients (patients eligible for Medi-Cal and Medicare Part A). The Provider contends that these dual eligible days should be included in Medi-Cal Days for computing DSH entitlement."[6]

O'Connor Hospital and Seton Medical Center were transferred from case number 06-1943G to this CIRP Group appeal by way of the group appeal request, which did not include an issue statement, it only identified the issue as Dual Eligible Days, and did not raise the HMO days issue.

JURISDICTIONAL POSITION OF PARTICIPATING PROVIDERS

O'Connor Hospital appealed from a revised Notice of Program Reimbursement (NPR). The revised NPR indicates that O'Connor Hospital's cost report was reopened "To incorporate the DSH Medicaid Eligible Days on the cost report." The Provider indicates that it is appealing adjustments R3-001, which served "to incorporate the Medi-Cal eligible days total and Medi-Cal labor & delivery room days" and R3-002 which adjusted DSH.

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[4] Schedule of Providers at Tab 1G.
[5] Schedule of Providers at Tab 1B.
[6] Schedule of Providers at Tab 2B.

Providers' Position

On December 21, 2012, the Providers' Representative, Toyon Associates, Inc., submitted a request that the Board bifurcate a number of dual eligible day group appeals that were pending before the Board. Toyon argues that the dual eligible day group appeals in fact cover two issues: Part C days and other Part A dual-eligible non-covered patient days. Toyon explains that in light of CMS Ruling 1498-R, the Part C days at issue need to be in separate appeals from the other Part A dual eligible non-covered patient days at issue, because the Part C days are not subject to the remand.

Board's Decision

JURISDICTIONAL DETERMINATION

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841 (2006), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for a hearing is filed within 180 days of the date the notice of the intermediary's determination was mailed to the provider.

The Board finds that it does not have jurisdiction over Participant 1, O'Connor Hospital (05-0153, FYE 6/3/1999), because it appealed from a revised NPR that did not specifically adjust dual eligible days. The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2006) provides in relevant part:

> A determination of an intermediary . . . may be reopened with respect to findings on matters at issue in such determination or decision to revise any matter in issue at any such proceedings.

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

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

More recently, 42 C.F.R. § 405.1889 was addressed in *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F. Supp. 3d 348 (D.D.C. Apr. 17, 2014). In that case, the Court held that the "issue-specific" interpretation of the revised NPR regulation is reasonable and that any change to the DSH adjustment is not sufficient to establish that all of the elements of the DSH adjustment have been reconsidered.

Here, Participant 1, O'Connor Hospital, is appealing from an audit adjustment report that

adjusted DSH. However, the Provider did not submit any documentation to establish that dual eligible days were adjusted as part of the DSH adjustment. Therefore, pursuant to 42 C.F.R. § 405.1889, dual eligible days are beyond the scope of the appeal of the Provider's revised determination.[7] Accordingly, O'Connor Hospital (provider number 05-0153, FYE 6/30/1999), is hereby dismissed from this appeal.

BIFURCATION OF THE DUAL ELIGIBLE DAYS ISSUE

The Board hereby denies the request to bifurcate the HMO days as a separate and distinct issue from the dual eligible days issue contained in case number 08-2450GC. In making this determination, the Board considered the whole record before it, including all individual and group appeal requests, transfer requests, and position papers. The Board has determined that these documents together are not sufficient to establish that the Providers intended the HMO days to be an issue in this group appeal for the reasons discussed below.

The request to form the group appeal received on July 24, 2008, did not include an issue statement. The appeal was established when two CIRP providers were identified in case number 06-1943G. The HMO days issue was not raised in the group appeal request for case number 06-1943G. Furthermore, neither Provider in this group appeal raised the HMO days issue in their individual appeals or in their respective transfer requests to case number 06-1943G. Because the HMO days issue was not raised in the appeal request for this CIRP group or in case number 06-1943G, which was the optional group appeal where the two Providers previously were, the Board will not bifurcate case number 08-2450GC in two separate appeals.

The Board has dismissed Participant 1, O'Connor Hospital, from this appeal earlier in this letter leaving only one Provider remaining in the appeal, which does not meet the requirements for a group appeal.[8] The Board hereby transfers Participant 2, Seton Medical Center (provider number 05-0289, FYE 6/30/1999) to case number 08-2451GC, Daughters of Charity 2000 DSH Dual Eligible Days CIRP Group.[9] As no Providers remain in the group, case number 08-2450GC is hereby closed.

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

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

[8] PRRB Rule 12.5 indicates that there must be at least two different Provider in a CIRP group upon completion of the group.

[9] The group name will be changed to Daughters of Charity 1999-2000 DSH Dual Eligible Days CIRP Group to reflect both fiscal years now in case number 08-2451GC.

Case No.: 08-2450GC

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
Schedule of Providers dated September 17, 2008

cc: Kevin D. Shanklin, BCBSA

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

CERTIFIED MAIL

MAY 26 2015

Debbie Teate
Truman Medical Center, Inc.
Corporate Director Reimbursement
7900 Lee's Summit Road
Kansas City, MO 64139

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

RE: Jurisdictional Decision
PRRB Case No.: 13-2475GC
Truman 2004-2005 (through 9/30/2004) Medi-Medi Days CIRP Group

Dear Ms. Teate and Mr. Lamprecht,

The Provider Reimbursement Review Board (PRRB or Board) has reviewed the Schedule of Providers and the associated jurisdictional documents for case number 13-2475GC, as it is subject to CMS 1498-R. The jurisdictional decision of the Board is set forth below.

Background

PRRB appeal 13-2475GC, Truman 2004-2005 (through 9/30/2004) was established by the Board on October 21, 2013, as part of a bifurcation of PRRB appeal 09-0251GC. 09-0251GC was initially entitled Truman 2006-2007 Medi-Medi Days group, however the Provider representative attempted to add additional years to this group appeal, where the underlying legal issue was different in those added years. The Board therefore bifurcated the case and established 13-2475GC for the time period prior to 10/01/2004. There are eight providers in this group appeal, Truman Medical - Lakewood and Truman Medical - Hospital Hill for FYE's 2002-2005.[1]

Review of Providers

Provider 1. Truman Medical Center Lakewood, Provider No. 26-0102, FYE 04/30/2002,
Provider 2. Truman Medical Center Lakewood, Provider No. 26-0102, FYE 4/30/2003
Provider 7. Truman Medical Center Hospital Hill, Provider No. 26-0048, FYE 04/30/2002,
Provider 8. Truman Medical Center Hospital Hill, Provider No. 26-0048, FYE 04/30/2003,
Provider 9. Truman Medical Center Hospital Hill, Provider No. 26-0048, FYE 06/30/2004

Providers 1, 7, 8 and 9 all filed timely appeals of their respective NPR's, and included similar issue statements challenging the Medicare SSI Percentage as generated by SSA, citing it was understated. Provider 2 also filed a timely appeal of their respective NPR; however it only

[1] For the FYE 6/30/2005 Providers, only the portion for 7/1/2004-9/30/2004 is reflected in this group appeal. The remaining 9 months, 10/1/04-06/30/2005 remained in 09-0251GC, as the legal issue in that period is different than that under appeal in this case.

included the cover letter stating their "Intent to appeal" but failed to include the detail related to the specific issues under appeal. In 2010 and 2011, each of the five providers requested to transfer the SSI% issue to PRRB appeal 09-0253GC, Truman 2006 DSH SSI Days group. On April 11, 2012, the providers requested an amendment to their previously filed transfer requests of the SSI percentage issue. The Providers asked to have "the 'Medi-Medi' component of the 'SSI Days/SSI %'" issue be transferred from 09-0253GC to case number 09-0251GC.[2] The model forms request that the dual eligible days issue be transferred from the individual appeals (all five of which were still open), to the Medi-Medi group appeal, 09-0251GC.[3]

Provider 4. Truman Medical Center Lakewood, Provider No. 26-0102, FYE 06/30/2005,
Provider10. Truman Medical Center Hospital Hill, Provider No. 26-0048, FYE 06/30/2005

Providers 4 and 10 also filed timely appeals of their respective NPR's and did include the issue of Dual Eligible days in their appeal requests. On January 18, 2011, both providers requested to transfer the SSI% issue to 09-0253GC. On March15, 2011 and October 3, 2011, Providers 10 and 4's respective individual appeals, 07-2414 and 07-2416 were closed. On April 11, 2012, the providers each requested an amendment to their previously filed transfer requests of the SSI percentage issue to 09-0253GC. The Providers asked to have "the 'Medi-Medi' component of the 'SSI Days/SSI %'" issue previously transferred to 09-0253GC, transferred from their individual appeals (both of which were closed), to the Medi-Medi group appeal, 09-0251GC.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) (2005) and 42 C.F.R. § 405.1835-405.1841 (2005), 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. Pursuant to 42 C.F.R. § 405.1835(c) (3) (2008), a provider can add issues to the appeal if the Board receives the request to add issues no later than 60 days after the expiration of the 180 day period from the date of the NPR or, for appeals pending when the regulation was promulgated, as is the case with the current providers, no later than October 20, 2008.

PRRB Rule 16.1 requires Providers who wish to transfer issues from individual appeals to group appeals to demonstrate that the issue being transferred was in fact appealed in the individual appeal request or the issue was added subsequently to filing the individual appeal request. PRRB Rule 13 provides, in relevant part, that the matter at issue for common groups must involve a single question of fact or interpretation of law, regulation or CMS policy or ruling. If the facts are not common to all group members or if the facts that must be proved are unique to respective Providers, a group case is not appropriate.

Provider 1, Truman Medical Center Lakewood, Provider No. 26-0102, FYE 04/30/2002
Provider 2, Truman Medical Center Lakewood, Provider No. 26-0102, FYE 04/30/2003

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[2] The Provider claims the issue was reflected on their original model from D and transferred to case number 09-0253GC.

[3] As noted above, case number 09-0251GC was established by a single provider with a FYE of 6/30/06, and was later bifurcated into separate appeals by the year in question.

Provider 7, Truman Medical Center Hospital Hill, Provider No. 26-0048, FYE 04/30/2002
Provider 8, Truman Medical Center Hospital Hill, Provider No. 26-0048, FYE 04/30/2003
Provider 9, Truman Medical Center Hospital Hill, Provider No. 26-0048, FYE 06/30/2004

In the instant case, the above referenced Providers did not include the dual eligible days issue in their original hearing requests nor did they timely add the issue to their individual appeals. The above referenced Providers requested to transfer the dual eligible days issue on April 11, 2012, from their individual appeals to case number 09-0251GC. However, as the dual eligible days issue was not originally appealed in their underlying individual appeals nor timely added to their appeals, it cannot be transferred to case number 09-0251GC (and ultimately to case number 13-2475GC). The Providers assert in their April 11, 2012 transfer request that the dual eligible days issue ("the 'Medi-Medi' component of the 'SSI days/SSI %'") was reflected in their Model form D transfer requests and transferred to case number 09-0253GC. However, the Board finds that the issue was not raised, and therefore could not have been transferred to 09-0253GC as the provider stated and bifurcated out of the appeal. Per Board rule 13, only one issue is permitted per group. As such, the Board denies Provider 1, 2, 7, 8, and 9, requests to transfer the dual eligible days issue from their individual appeals (case nos. 06-0070, 06-2187, 06-1637 and 07-0089) to case number 09-0251GC (and ultimately to 13-2475GC) and dismisses the Providers from case number 13-2475GC.

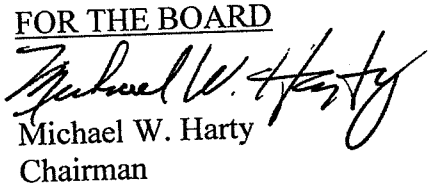
Provider 4, Truman Medical Center Lakewood, Provider No. 26-0102, FYE 06/30/2005
Provider 10, Truman Medical Center Hospital Hill, Provider No. 26-0048, FYE 06/30/2005

The above referenced Providers included the dual eligible days issue in their original hearing requests, however, the Providers' April 11, 2012 requests to transfer the dual eligible days issue from their individual appeals, case numbers 07-2416 and 07-2414, were after the appeals were closed. The dual eligible days issue therefore could not be transferred, as the cases were in a closed status. The Providers' assert in their April 11, 2012 transfer request that the dual eligible days issue ("the 'Medi-Medi' component of the SSI %) was reflected in their Model Form D transfer request and transferred to case number 09-0253GC. However, case number 09-0253GC is an SSI % group, not a dual eligible days group, therefore the dual eligible issue would not have been transferred to 09-0235GC, as the Providers assert. Per PRRB Rule 13, only one issue is permitted per group. As such, the Board denies Providers 4 and10 requests to transfer the dual eligible issue from their individual appeals and dismisses the Providers from 13-2475GC.

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

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

FOR THE BOARD



Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, BCBSA

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

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

Refer to:

09-0606

MAY 27 2015

CERTIFIED MAIL

Hooper, Lundy & Bookman, P.C.
Laurence D. Getzoff, Esq.
Watt Plaza, Suite 1600
1875 Century Park East
Los Angeles, CA 90067-2799

Cahaba Safeguard Administrators, LLC
James Lowe
2803 Slater Road
Suite 215
Morrisville, NC 27560-2008

RE: Pomona Valley Hospital Medical Center
Provider No: 05-0231
FYE: 12/31/2003
PRRB Case No.: 09-0606

Dear Mr. Getzoff and Mr. Lowe,

The Medicare contractor in this appeal, Cahaba Safeguard Administrators, LLC, (hereinafter "Cahaba"), has challenged the Provider Reimbursement Review Board's (hereinafter "Board") jurisdiction to hear three Disproportionate Share Hospital payment issues which the Provider, Pomona Valley Hospital Medical Center (hereinafter "Pomona Valley"), seeks to include in this appeal. The Board has reviewed the jurisdictional documentation submitted by both parties, and its jurisdiction decision is set forth below.

Background

Pomona Valley appealed the amount of Medicare reimbursement as determined by a former Medicare Contractor. The second issue in Pomona Valley's request for appeal is entitled "DSH Adjustment – Medicare Part B Days," and alleges that 266 patient days were excluded from the numerator of the Medicaid fraction of the Disproportionate Share Hospital payment calculation. Pomona Valley identified two types of patient days as excluded: (1) "patients who were Medicaid-eligible but had exhausted their Medicare Part A benefits," and (2) "patients who were Medicaid-eligible and had Medicare coverage only for Part B services." Pomona Valley asks that these 266 patient days now be included in the Medicaid fraction of its Disproportionate Share Hospital payment calculation.[1]

[1] Pomona Valley's Individual Appeal Request, Tab 3.

Pomona Valley filed a position paper dated August 14, 2009, which renames the second issue in the appeal as "DSH Adjustment – Medicaid Eligible Days (Part A Exhausted- Part B Only Days), Straight Part B Days, Medicare MSP Days, and Denied Days." Pomona Valley describes the issue in the position paper as including four types of Medicaid-eligible days. These include the two types of days stated in the original appeal request, as well as 95 Medicare Part A denied days and 33 Medicare secondary payer days.[2]

Via letter dated August 28, 2013, Pomona Valley requested that Cahaba acknowledge the inclusion of Dual Eligible Part C days as an issue in this appeal, and also requested Cahaba resolve the issue by including Dual Eligible Part C days in the Medicaid fraction of the Disproportionate Share Hospital payment calculation.[3]

Medicare Contractor's Contentions

Cahaba alleges that Pomona Valley has attempted to improperly expand the second issue in its appeal request to include Medicare secondary payer days and Medicare Part A denied days through the submission of its position paper. Cahaba states that these two Disproportionate Share Hospital payment components were not contained in the original appeal request, nor were they timely added to the appeal. Cahaba also asserts that Pomona Valley has attempted to add a third issue to the appeal - Dual Eligible Part C days. Cahaba references recent discussions with Pomona Valley, as well as an August 28, 2013 letter from Pomona Valley which seeks the inclusion of additional Dual Eligible Part C days.

Pomona Valley's Contentions

Pomona Valley asserts the Board has jurisdiction over the Disproportionate Share Hospital payment Dual Eligible Part C days issue it alleges is now a part of this appeal. Pomona Valley claims it appealed all dual eligible days for which there was no entitlement to benefits under Part A of Medicare in its original appeal request. Pomona Valley explains it had difficulty verifying Part C days with the State of California, and it is now able to confidently test and verify these days. Pomona Valley states its preliminary position paper correctly identifies the issue to be decided as "Whether the Intermediary has properly calculated Pomona's DSH [Disproportionate Share Hospital] adjustment reimbursement with respect to the Provider's Medicaid eligible days?"[4]

Analysis and Decision:

A provider must include an explanation for each issue of the provider's dissatisfaction with an intermediary's determination.[5] For multiple component issues, each contested component must be appealed as a separate issue and described as narrowly as possible using the applicable format outlined in the Provider Reimbursement Review Board Rules. The Board Rules even provide an

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[2] Pomona Valley's Response to Jurisdiction Challenge, Exhibit 1.
[3] *See* Exhibit I-8.
[4] Pomona Valley's Response to Jurisdiction Challenge at 3.
[5] *See* 42 C.F.R. § 405.1835(b).

example for Disproportionate Share Hospital issues which states that it should be broken down into components such as dual eligible, general assistance, charity care, and HMO determination. Pomona Valley appealed 224 dual eligible exhausted Part A days and 42 Part B only days in its initial appeal request, including an explanation that Issue Two covered these Disproportionate Share Hospital components.

Effective August 21, 2008, new Board regulations went into effect that limited the addition of issues to appeals. 42 C.F.R. § 1835 provides in relevant part:

> (c) Adding issues to the hearing request. After filing a hearing request in accordance with paragraphs (a) and (b) of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if the following requirements are met:
>
> ***
>
> (3) The Board receives the request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) of this section.

Pomona Valley's Notice of Program Reimbursement was issued on July 17, 2008, which makes the deadline for adding issues to its appeal March 14, 2009. The position paper that attempted to add Medicare secondary payor days and Medicare Part A denied days issues to this appeal is dated August 14, 2009, which is well after the deadline for adding issues. The same can be said for Pomona Valley's August 28, 2013 letter requesting inclusion of the Dual Eligible Part C days issue in the appeal. While Pomona Valley asserts several legal arguments why Dual Eligible Part C days should be included in the Disproportionate Share Hospital payment calculation, the Board cannot consider these arguments because the issue was not included in the original appeal request, nor was it properly added to the appeal. Therefore, the Board finds that it does not have jurisdiction over the Medicare secondary payer days, Medicare Part A denied days, and the Medicare Part C dual days issues which the Medicare Contractor has challenged.

This case is now closed as all other issues in this appeal have been either administratively resolved or are subject to CMS Ruling 1498-R.

Review of this decision may be available under 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: Kevin D. Shanklin, Blue Cross and Blue Shield Association

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

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

Refer to: 08-2843

CERTIFIED MAIL

MAY 28 2015

Jeffery R. Reid
Sharp Healthcare, Finance
8695 Spectrum Center Boulevard
San Diego, CA 92123

Donna Kalafut
JE Part A Appeals Coordinator
P.O. Box 6782
Fargo, ND 58108

RE: Sharp Memorial Hospital
Provider No.: 05-0100
FYEs: 09/30/1999
PRRB Case No.: 08-2843

Dear Mr. Reid and Ms. Kalafut:

This case involves Sharp Memorial Hospital's ("Sharp's") appeal of its Medicare reimbursement for the fiscal year ending ("FYE") on September 30, 1999. The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above-referenced appeal and dismisses Sharp's request for hearing ("RFH") for lack of jurisdiction over the issue being appealed.

Sharp's RFH

On September 19, 2008, the Board received Sharp's RFH in which Sharp appeals one issue, Disproportionate Share Hospital ("DSH") Adjustment-- Medicare Ratio based on Supplemental Security Income ("SSI") Entitled Beneficiaries, from its March 26, 2008 revised notice of program reimbursement ("RNPR"). Sharp states that its request is based on a "court decision" and that the Centers for Medicare & Medicaid Services ("CMS") "must recalculate the DSH Medicare ratio based on the best available data in accordance with [such] decision . . . and provide the [Medicare Contractor] the revised DSH SSI ratio to use in the hospital's DSH adjustment."

In its RFH, Sharp claims that "the amount was understated in [its] filed cost report as a protested item . . ." and that Sharp requested a revision "to [its] cost report based on the decision for Baystate Medical Center . . ." Sharp states that the Medicare Contractor issued its March 26, 2008 RNPR without incorporating a corrected SSI ratio into that determination.

Background

On August 13, 2003, the Medicare Contractor issued Sharp's original notice of program reimbursement ("NPR") for the cost reporting period ending on September 30, 1999.[1] In an August 9, 2006 letter ("August 2006 Letter"), Sharp requested that the Medicare Contractor reopen its September 30, 1999 cost report in order to (1) revise Sharp's DSH operating and capital reimbursement; (2) include costs related to organ programs; (3) allow for Outpatient Psychiatric Clinics; and (4) allow for pastoral care residency programs. Sharp also stated that it wished to preserve its "right to a potential future revision pending the outcome of future court cases related to the . . ." DSH-SSI issue and "[w]hether CMS used the best available data . . ."[2]

On January 17, 2008, the Medicare Contractor issued a Notice of Reopening ("January 2008 Notice") to Sharp in which it agreed to reopen Sharp's cost report for the first 4 issues listed above. However, the Medicare Contractor noted that it could not reopen Sharp's SSI ratio at that time because all SSI ratios "must be used[ ] as published by CMS or modified by CMS through the hospital[']s request to CMS."[3] In Sharp's March 26, 2008 RNPR, the Medicare Contractor documented that it had revised the 4 issues as stated above.

In response to the Board's December 9, 2013 request for additional documentation ("December 2013 Request"), the Board received Sharp's jurisdictional documents on January 6, 2014 ("January 2014 Documents"). In its cover letter accompanying these documents, Sharp states that "Audit Adjustment R1-002 shows a revision to the Allowable DSH Percentage which is the issue being appealed in this case because the [Medicare Contractor] did not incorporate a revision to the SSI as requested in the reopening." Sharp also states that "[i[f it is determined that the [Board] does not have jurisdiction, then the case should be remanded to the [Medicare Contractor] and CMS to correct the SSI percentage in accordance with the now final Baystate case because the provider's reopening of the issue has never been resolved."

On July 22, 2014, the Board received Sharp's response to the Board's Alert 10 ("July 2014 Response"). In its July 2014 Response, Sharp claims that "Case No. 08-2843 is in regards to the issue of whether Medicare Dual Eligible patients with Medicare Part C, Exhausted Benefits, Medicare Part B only, are not Medicare entitled during their full length of stay but are eligible for Medicaid (Dual Eligibles) were improperly included in the Medicare fraction (SSI ratio) and excluded from the numerator of the Medicaid fraction of the DSH calculation."

Board's Analysis and Decision

Under 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-1841 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more, and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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[1] January 2014 Documents Ex. P-1-7.
[2] RFH Ex. P-1-3.
[3] January 2014 Documents Ex. P-1-10.

The Code of Federal Regulations provides for an opportunity for an RNPR. 42 C.F.R. § 405.1855 (2007) provides in relevant part:

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

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

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

In the present case, Sharp timely filed its RFH from its March 26, 2008 RNPR, seeking Board review of only one issue—SSI percentage. As Sharp is appealing from an RNPR, in order for it to establish that the Board has jurisdiction over its SSI percentage issue, it must demonstrate that this issue was adjusted in the reopening. However, as noted in the both the Medicare Contractor's January 2008 Notice and March 26, 2008 RNPR, the Medicare Contractor did not specifically revise the SSI percentage upon reopening Sharp's September 30, 1999 cost report. Sharp admits this in its January 2014 Documents when it states that "Audit Adjustment R1-002 shows a revision to the Allowable DSH Percentage which is the issue being appealed in this case because the [Medicare Contractor] did not incorporate a revision to the SSI as requested in the reopening." Accordingly, the regulations preclude the Board from assuming jurisdiction over Sharp's SSI percentage issue in the present case.

In its January 2014 Documents, Sharp claims that "[i[f it is determined that the [Board] does not have jurisdiction, then the case should be remanded to the [Medicare Contractor] and CMS to correct the SSI percentage in accordance with the now final Baystate case because the provider's reopening of the issue has never been resolved." According to this statement, it appears that Sharp is requesting that its SSI percentage issue be remanded under the mandate set out in CMS Ruling CMS-1498-R.

On April 28, 2010, CMS issued CMS-1498-R to address three specific Medicare DSH issues. One of these issues involved CMS' processes for matching Medicare and SSI eligibility data when calculating providers' SSI fractions. With respect to this data matching process issue—also known as "SSI percentage" issue—CMS-1498-R requires an administrative appeals tribunal to remand each qualifying provider appeal to the appropriate Medicare contractor in order to recalculate the provider's DSH payment adjustment according to the specific mandates set out in CMS-1498-R.[4] As such, in order for the Board to remand Sharp's SSI percentage issue pursuant to CMS-1498-R, Sharp must have an appeal that qualifies for remand.

CMS-1498-R states that in order to qualify for remand, the administrative tribunal before which an appeal is pending must first determine whether a DSH issue is one of the three DSH issues covered by CMS-1498-R and "whether such claim satisfies the applicable jurisdictional and procedural requirements of section 1878 of the [Social Security] Act, the Medicare regulations, and other agency rules and guidelines."[5] If the administrative tribunal finds that the applicable jurisdictional and procedural requirements have been met for an appeal of an appropriate DSH issue, the administrative tribunal will remand the appeal so that CMS and the Medicare contractors may resolve the issue. For each properly pending DSH appeal of the SSI percentage issue, CMS will resolve the issue by "applying a suitably revised data matching process . . . for purposes of recalculating the hospital's SSI fraction . . ."[6]

In the present case, however, Sharp's SSI percentage issue that it appealed from its March 26, 2008 RNPR is not jurisdictionally valid (as explained prior). As such, according to the mandates set out in CMS-1498-R, this issue does not qualify for remand.

Lastly, in its July 2014 Response, Sharp claims that "Case No. 08-2843 is in regards to the issue of whether Medicare Dual Eligible patients with Medicare Part C, Exhausted Benefits, Medicare Part B only, are not Medicare entitled during their full length of stay but are eligible for Medicaid (Dual Eligibles) were improperly included in the Medicare fraction (SSI ratio) and excluded from the numerator of the Medicaid fraction of the DSH calculation." However, Sharp's sole issue for Case Number 08-2843, as described in its RFH and its May 28, 2009 preliminary position paper, is a challenge to whether Sharp's SSI percentage includes "all Medicare SSI entitled beneficiaries[,]" not a challenge to dual eligible patients in the DSH calculation. Therefore, as the Board has determined that it does not have jurisdiction over Sharp's SSI percentage issue, there are no remaining issues in Case Number 08-2843.

Summary

The Board has determined that it does not have jurisdiction over Sharp's SSI percentage issue in Case Number 08-2843 because that issue was not revised in Sharp's March 26, 2008 RNPR, the determination from which Sharp filed the present appeal. As Sharp's SSI percentage issue is not jurisdictionally valid, this issue is not subject to the mandatory remand set out in CMS-1498-R. In addition, as Sharp's SSI percentage issue is the sole issue in the present appeal, Sharp's appeal is dismissed and Case Number 08-2843 is hereby closed.

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[4] CMS-1498-R at 6.
[5] *Id.*
[6] *Id.*

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

Board Members Participating:
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA

For the Board:

Clayton J. Nix, Esq.
Board Member

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

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