DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
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CERTIFIED MAIL

SEP 01 2015

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James Lowe
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RE: Washington Hospital
Provider No.: 05-0195
FYE: 6/30/08
PRRB Case No.: 13-1270

Dear Ms. Bhatnagar and Mr. Lowe,

The Provider Reimbursement Review Board (the Board) has reviewed the jurisdictional briefs of the parties in the above-referenced appeal. The Board's jurisdictional decision regarding the SSI Ratio Realignment issue is set forth below.

Background

The Provider submitted a request for hearing on March 20, 2013, based on a Notice of Program Reimbursement ("NPR") dated September 24, 2012. The hearing request included seven issues, two of which were subsequently transferred to group appeals on October 23, 2013.[1] One of the seven issues appealed was Medicare Disproportionate Share Hospital (DSH) Payments – SSI Ratio Alignment to Provider's Cost Reporting Year.

In its Final Position Paper received on June 9, 2015, the Provider withdrew the Medicare Settlement Data, Medicare Bad Debt Reimbursement, Medicare Bad Debt Reimbursement – 2% Share of Cost Adjustment, and Rural Floor Budget Neutrality issues from the appeal.

The last issue remaining in the appeal is the SSI Ratio Realignment issue. The Medicare Contractor filed a jurisdictional challenge on the issue on February 11, 2014. The Provider filed a responsive brief on February 14, 2014.

Medicare Contractor's Position

The Medicare Contractor explains that the Provider submitted a request for SSI Ratio Realignment to the Contractor on October 22, 2013. At this time, CMS has not issued a final determination of the Provider's SSI Ratio based on the provider fiscal year end.[2]

[1] The transferred issues include Accuracy of SSI Ratio and SSI Ratio – Section 951.
[2] Medicare Contractor's Jurisdictional Brief at 2.

The Medicare Contractor argues that the regulations at 42 C.F.R. § 405.1835 set forth the criteria for a provider's right to a PRRB hearing:

> 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.

The Medicare Contractor contends that it made no adjustment to the cost report related to realignment of the SSI Ratio based on the Provider's fiscal year end. A final determination has not been issued by CMS. Therefore, the Provider's request for appeal of this issue is premature.[3]

Provider's Position

The Provider contends that it has appealed audit adjustment numbers 13, 19, 27, and 28 from its NPR, in conjunction with the SSI Ratio Realignment issue. Each one of these audit adjustments revises the Provider's as-filed SSI ratio to agree with CMS' published SSI ratio, which is developed and published by CMS on a federal fiscal year basis. The Provider is not appealing any lack of adjustment to the cost report related to the Provider's request for SSI ratio alignment.[4]

The Provider argues that CMS made a final determination the Provider's SSI ratio applicable to this cost reporting period is to be developed on a federal fiscal year and the Medicare Contractor implemented CMS' final determination into the Provider's Medicare cost report. The Provider contends they have a right to pursue an appeal of the decisions made by CMS and the Medicare Contractor under 42 C.F.R. § 405.1835(a).[5]

The Provider contends that the regulation concerning the "Contents of Request for a Board Hearing"[6] requires the Provider to describe their dispute[7] and provide a remedy describing how and why the Provider believes Medicare payment must be determined differently.[8] The Provider contends that it performed both of these tasks, including identifying two remedies: 1) Request CMS to realign the Provider's SSI percentage to the Provider's cost reporting year, or 2) Use the Provider's own data to seek a resolution to the issue. The Provider explains that it sought a remedy to the issue by submitting a DSH Ratio Realignment Request to the Contractor on October 22, 2013.[9]

The Provider explains that the SSI ratio was adjusted by the Contractor from 21.00% to a value of 20.32% that is developed by CMS on a federal fiscal year basis. The Provider argues that it has a right to be dissatisfied with any aspect of the Contractor audit adjustments, including the aspect of the Contractor's adjustment implementing a SSI ratio that has been developed on a federal fiscal year basis

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[3] *Id.*
[4] Provider's Responsive Brief at 2 (Emphasis included).
[5] *Id.*
[6] 42 C.F.R. § 45.1835(b).
[7] 42 C.F.R. § 45.1835(b) (2)(i).
[8] 42 C.F.R. § 45.1835(b) (2)(ii).
[9] Provider's Responsive Brief at 3.

because all other DSH payment elements for this Provider are developed upon a cost reporting period basis.[10]

Board's Decision

The Board finds that it does not have jurisdiction over the SSI Ratio Realignment issue as the appeal of that issue is premature. 42 C.F.R. § 405.1835 (2012) states,

> 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 . . . [t]he provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue. . .

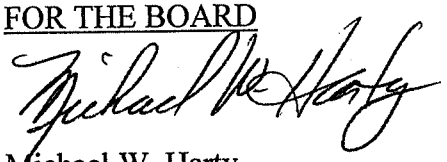
In this case, the Medicare Contractor did not make a final determination with regard to the SSI Ratio Realignment issue. Therefore, because the Medicare Contractor has not made a determination regarding SSI Ratio Realignment with which the Provider could be dissatisfied, the Board finds that the appeal of the SSI Ratio Realignment issue is premature and dismisses the issue from the appeal.

As the SSI Ratio Realignment issue was the last issue remaining in the appeal, the Board hereby closes the appeal and removes it from the Board's docket.

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

Board Members 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: Sharon L. Keyes, Executive Director, Blue Cross Blue Shield Association

[10] *Id.* (Emphasis included).

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Refer to: 14-2101, 14-4302

SEP 08 2015

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RE: Edward W. Sparrow Hospital
Provider No. 23-0230
FFYs 2014 and 2015
PRRB Case Nos. 14-2101 and 14-4302
Decision Regarding Own Motion EJR

Dear Messrs. Marcus and Lamprecht:

The Provider Reimbursement Review Board (Board) has reviewed the parties comments with respect to the proposed own motion expedited judicial review (EJR) in the above-referenced appeals. The decision of the Board is set forth below.

Background

Issue Under Appeal

Whether the action of the Centers for Medicare & Medicaid Services (CMS) to reduce IPPS payment rates by 0.2 percent effective as of Federal Fiscal Year (FFY) 2014 (October 1, 2013 - September 30, 2014) and FFY 2015 (October 1, 2014 – September 30, 2015), is consistent with law?[1]

Statutory and Regulatory Background

In the final IPPS rule for Federal fiscal year (FFY) 2014, the Secretary of Health and Human Services (Secretary) indicated that she had expressed concern in the proposed calendar year (CY) Outpatient PPS (OPPS) rule[2] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving observation services. In recent years, the number of cases of

[1] Provider's January 27, 2014 Hearing Request, Tab3, for FFY 2014 and Provider's September 19, 2014 Hearing Request, Tab 3, for FFY 2015.
[2] 77 Fed. Reg. 45,061, 45,155-57 (July 30, 2012) and the final rule with comment period, 77 Fed. Reg. 68,210, 68,426-33 (Nov. 15, 2012).

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

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

In response to this concern, the Secretary proposed clarifications and changes regarding hospital payment under both Part A and Part B. The Secretary proposed to revise the Part B inpatient payment policy to allow payment under Part B for all reasonable and necessary hospital services furnished if the beneficiary had been treated as a hospital outpatient, rather than admitted as an inpatient. This policy would apply when a Medicare Part A hospital inpatient claim was denied or when a hospital determines after a discharge that the inpatient visit was not reasonable and necessary. The timely filing restrictions for Part B billing were not changed (claims must be filed within one year from the date of service).[5]

Medicare Part A

In addition, the Secretary reviewed hospital inpatient status criteria to improve CMS' policies governing when a Medicare beneficiary should be admitted as an inpatient and how hospitals should be paid for associated costs. The Medicare Benefit Policy Manual[6] states that the typical decision to admit a beneficiary as an inpatient should be made within 24 to 48 hours after observation care and that an overnight stay may be a factor in the admission decision. Physicians should use the 24-hour or overnight period as a benchmark, i.e., patients who are expected to need care for 24 hours or overnight should be admitted. Generally, a beneficiary is considered an inpatient if formally admitted with the expectation that he or she will remain in the hospital overnight, regardless of whether there is a later transfer or discharge resulting in no overnight patient stay. Only rarely and in exceptional cases do reasonable and necessary observation services span more than 48 hours. Length of stay is not the sole basis for payment; it is the physician responsible for patient care who determines if the patient should be admitted.[7]

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[3] 78 Fed. Reg. 50,496, 50,907 (Aug. 19, 2013).
[4] *Id.*
[5] *Id.*
[6] CMS Pub. 100-02, Chapter 6, §20.6 and Chapter 1, §10.
[7] 78 Fed. Reg. at 50,907-08.

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

Medicare Part B

In the final IPPS rule, the Secretary noted there had been an increasing number of hospitals appealing Part A inpatient claim denials in which it was determined the inpatient admissions were not reasonable or necessary. These claims received partial favorable treatment by the Medicare Appeals Council or Administrative Law Judges (ALJs). In those cases, the Medicare review contractor determinations that the inpatient admission was not reasonable or necessary was upheld, however, the Medicare Appeals Council and ALJ decisions ordered payment of the services as if they were rendered in an outpatient or observation level of care. These decisions effectively required Medicare to issue payment for all Part B services that would have been payable had the patient been treated as an outpatient (rather than an inpatient). In addition, payments were made regardless of whether or not the subsequent hospital claims were within the applicable time limit for filing Part B claims. The Secretary pointed out that this was contrary to longstanding polices that permitted billing for only a limited list of Part B inpatient services and required that the services be billed within specific timeframes.[10]

As a result of the number of these administrative adjudications, the CMS Administrator issued Ruling CMS-1455-P[11] (the Ruling) which established a standard process for effectuating the decisions granting Part B coverage. Among other things, where the administrative adjudicator had issued an order for payment under Medicare Part B, the request for Part B payment would not be rejected if more than one year had elapsed (the time period for filing Part B claims), if the Part A claim had been submitted timely. The Ruling was to remain in effect until the effective date of regulations that finalized "Medicare Program; Part B Billing in Hospitals." In the August 19, 2013 Federal Register, the Secretary revised the Part B inpatient payment policy to allow payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require outpatient status.[12]

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[8] *See generally* 78 Fed. Reg. 27,486 (May 10, 2013).
[9] 78 Fed. Reg. 50,908.
[10] *Id.*
[11] *See* 78 Fed. Reg. 16,614 (Mar. 18, 2013), http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings.html.
[12] 78 Fed. Reg. at 50,909.

The 1-year deadline for filing claims remained unchanged and the Secretary stated that she was not creating an exception to this requirement (as found in 42 C.F.R. §§ 424.44(b)(1)-(4)) even though the contractor claims review and appeal process could exceed the 1-year filing period.[13]

The 2-Midnight Rule

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

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

The Secretary's actuaries estimated that the 2-midnight rule would increase IPPS expenditures by approximately $220 million. These additional expenditures would result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving from OPPS to IPPS and some encounters of less than 2 midnights moving from IPPS to OPPS. The actuaries estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient from the approximately 11 million encounters paid under IPPS. This shift of 40,000 net encounters represents an increase of approximately 1.2 percent in the number of shorter stay hospital inpatient encounters paid under IPPS. This additional expenditure would be partially offset by reduced expenditures from the shift of shorter stay hospital inpatient encounters to hospital outpatient encounters. The actuaries estimated that, on average, the per encounter payments for these hospital outpatient encounters would be approximately 30 percent of the per encounter payments for the inpatient encounters. In light of the impact of the 2-midnight rule on

[13] *Id.* at 50,927.
[14] *Id.* at 50,944.
[15] *Id.*
[16] *Id.* at 50,945.

IPPS and the systematic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, the Secretary decided it was appropriate to use her exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i) to offset the $220 million in additional IPPS expenditures associated with the 2-midnight policy. Consequently, the standardized amount was reduced by 0.2 percent.[17] The Secretary made the same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[18] In the final IPPS rule for 2015, the Secretary did not reverse the 0.2 percent reduction to the standardized amount made in 2014, and, therefore, continued to apply the contested reduction for the FFY 2015 period.[19]

Provider's Position

The Provider notes that the Secretary states that she is relying on 42 U.S.C. § 1395ww(d)(5)(I)(i) which states:

> The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate.

The Provider asserts that this authority does not authorize CMS to implement the IPPS rate reduction. It points out that CMS has rarely exercised this authority, and on the occasions it has done so, the purpose was to more fully or appropriately implement a recent Congressional requirement. It has never been exercised as broadly as the IPPS rate reduction.

The Provider further contends that, even if this authority is applicable, this authority requires CMS [sic, the Secretary] to "provide by regulation" the IPPS rate reduction.[20] Instead, CMS merely discussed the IPPS rate reduction in the preamble to the IPPS final rule.[21] As a result, even if CMS claims it is authorized to implement the IPPS rate reduction under 42 U.S.C. § 1395ww(d)(5)(I)(i), CMS failed to provide for the IPPS rate reduction by regulation, which the Provider believes is invalid. Further, the Provider asserts, the IPPS rate reduction violates the Administrative Procedure Act, 5 U.S.C. § 551 *et seq.*

In addition, the Provider asserts that CMS is not under a statutory requirement to make budget-neutrality adjustments for changes in coverage decisions or service volume. The IPPS rate reduction is in effect a coverage decision, or at a minimum a clarification of policy, that CMS believes would result in an increase in volume. As a result, inpatient hospital services would be

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[17] *Id.* at 50,952-53.
[18] *Id.* at 50,990.
[19] 79 Fed. Reg. 49,854,50,382-83 (Aug. 22, 2014).
[20] *See International Union, United Mine Workers of Am.v . Mine Safety & Health Admin.*, 68 Fed. Appx. 205, 206 (D.C. Cir. 2003) (unpublished per curiam).
[21] *See* 78 Fed. Reg. at 50,953-54.

covered under Medicare Part A if the physician expects that the beneficiary's length of stay will exceed a 2-midnight threshold or if the beneficiary requires a procedure specified as inpatient-only. CMS purports to have determined that this coverage decision would lead to a net increase of 40,000 in inpatient hospital admissions. The Provider argues that what CMS has failed to recognize is that the 2-midnight rule does not increase payment rates for inpatient cases, which are made budget neutral as part of the annual rate adjustment process. Moreover, apply budget neutrality to coverage decisions or volume changes would violate the fundamental structure and policy that has governed IPPS since its inception in 1983. Specifically, the IPPS payments adjust automatically for both service mix and volume of hospital admissions which vary from year to year. CMS has never made budget-neutrality adjustments for these changes.

The Provider also argues that CMS [sic, the Secretary] failed to adequately respond to and take into account comments challenging the actuarial analysis that resulted in the 0.2 percent reduction in IPPS payments. It believes that CMS' response was inadequate and when subject to independent actuarial scrutiny, is shown to be defective.[22] The Provider believes that, as the result of the application of the 2-midnight rule, there will be a substantial shift from inpatient admissions to outpatient encounters, entitling the Provider to an increase in its IPPS rate.

Decision of the Board

The Board has reviewed the Provider's requests for hearing and the parties' comments regarding the proposed own motion EJR determination. The regulation, 42 C.F.R. § 405.1842(c), permits the Board to consider on its own motion whether it lacks the authority to decide a legal question relevant to the matter at issue once it has made a finding that it has jurisdiction to conduct a hearing under the provisions of 42 C.F.R. § 405.1840(a). With respect to jurisdiction, the Board concludes that the Provider in these cases timely filed the requests for hearing from the issuance of the August 19, 2013 and August 22, 2014 Federal Registers and the amount in controversy exceeds the $10,000 threshold necessary for an individual appeal.[23, 24] Consequently, the Board has determined that it has jurisdiction over the appeals. This issue involves a challenge to the validity of a regulation, for which the promulgation background is found in the proposed and final rules published in the Federal Registers. Further, the Board finds, on its own motion, that it lacks the authority to decide the legal question of whether the 0.2 percent adjustment to IPPS is appropriate; therefore, EJR is appropriate for the issue under dispute in these cases.

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[22] *See* Provider's Hearing Request in case number 14-4302, Tab 3, ftnt.1.
[23] *Wash. Hosp. Ctr. v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986) ("[A] year end cost report is *not* a report which is necessary in order for the Secretary to make PPS payments, and the appeals provision applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal") and *Dist. of Colum. Hosp. Ass'n Wage Index Group Appeal*, HCFA Adm'r Dec., Medicare & Medicaid Guide (CCH) ¶ 41,025 (Jan. 15, 1993) (publication of the wage index in the Federal Register is a final determination which can be appealed to the Board).
[24] *See* 42 C.F.R. § 405.1835(a).

The Board finds that:

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

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

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

4) it is without the authority to decide the legal question of whether the Secretary's 0.2 percent reduction to the standardized amount, the hospital specific rate for the issue, is valid.

Accordingly, the Board finds that the 0.2 percent reduction issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants expedited judicial review on its own motion for the issue and the subject years. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the cases.

Board Members Participating

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

FOR THE BOARD:

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f)

cc: Sharon L. Keyes, BCBSA

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Refer to: 14-1901GC. 14-4056GC

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SEP 08 2015

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RE: Baptist Memorial HCC 2014 0.2% IPPS Reduction Group
Baptist Memorial HCC 2015 0.2% IPPS Reduction Group
Provider Nos. Various
FFYs 2014 and 2015
PRRB Case Nos. 14-1901GC and 14-4056GC
Decision/Own Motion Expedited Judicial Review

Dear Mr. Marcus and Ms. Wills:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' comments with respect to the Board's proposed own motion expedited judicial review (EJR) determination. The Board's decision is set forth below.

Background

Issue Under Appeal

Whether the action of the Centers for Medicare & Medicaid Services ("CMS') to reduce inpatient prospective payment system ("IPPS") payments by 0.2% effective as of Federal Fiscal Years 2014 (October 1, 2013-September 30, 2014) [and 2015 (October 1, 2014-September 30, 2015)], is consistent with law?[1]

Statutory and Regulatory Background

In the final IPPS rule for Federal fiscal year (FFY) 2014, the Secretary of Health and Human Services (Secretary) indicated that she had expressed concern in the proposed calendar year (CY) Outpatient PPS (OPPS) rule[2] about the length of time Medicare beneficiaries were spending as

[1] Providers' January 22, 2014 Hearing Request in case number 1901GC and August 27, 2014 Hearing Request in case number 14-4056GC, Tab 2
[2] 77 Fed. Reg. 45,061, 45,155-57 (July 30, 2012) and the final rule with comment period, 77 Fed. Reg. 68,210, 68,426-33 (Nov. 15, 2012).

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

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

In response to this concern, the Secretary proposed clarifications and changes regarding hospital payment under both Part A and Part B. The Secretary proposed to revise the Part B inpatient payment policy to allow payment under Part B for all reasonable and necessary hospital services furnished if the beneficiary had been treated as a hospital outpatient, rather than admitted as an inpatient. This policy would apply when a Medicare Part A hospital inpatient claim was denied or when a hospital determines after a discharge that the inpatient visit was not reasonable and necessary. The timely filing restrictions for Part B billing were not changed (claims must be filed within one year from the date of service).[5]

Medicare Part A

In addition, the Secretary reviewed hospital inpatient status criteria to improve CMS' policies governing when a Medicare beneficiary should be admitted as an inpatient and how hospitals should be paid for associated costs. The Medicare Benefit Policy Manual[6] states that the typical decision to admit a beneficiary as an inpatient should be made within 24 to 48 hours after observation care and that an overnight stay may be a factor in the admission decision. Physicians should use the 24-hour or overnight period as a benchmark, i.e., patients who are expected to need care for 24 hours or overnight should be admitted. Generally, a beneficiary is considered an inpatient if formally admitted with the expectation that he or she will remain in the hospital overnight, regardless of whether there is a later transfer or discharge resulting in no overnight patient stay. Only rarely and in exceptional cases do reasonable and necessary

[3] 78 Fed. Reg. 50,496, 50,907 (Aug. 19, 2013).
[4] *Id.*
[5] *Id.*
[6] CMS Pub. 100-02, Chapter 6, §20.6 and Chapter 1, §10.

observation services span more than 48 hours. Length of stay is not the sole basis for payment; it is the physician responsible for patient care who determines if the patient should be admitted.[7]

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

Medicare Part B

In the final IPPS rule, the Secretary noted there had been an increasing number of hospitals appealing Part A inpatient claim denials in which it was determined the inpatient admissions were not reasonable or necessary. These claims received partial favorable treatment by the Medicare Appeals Council or Administrative Law Judges (ALJs). In those cases, the Medicare review contractor determinations that the inpatient admission was not reasonable or necessary was upheld, however, the Medicare Appeals Council and ALJ decisions ordered payment of the services as if they were rendered in an outpatient or observation level of care. These decisions effectively required Medicare to issue payment for all Part B services that would have been payable had the patient been treated as an outpatient (rather than an inpatient). In addition, payments were made regardless of whether or not the subsequent hospital claims were within the applicable time limit for filing Part B claims. The Secretary pointed out that this was contrary to longstanding polices that permitted billing for only a limited list of Part B inpatient services and required that the services be billed within specific timeframes.[10]

As a result of the number of these administrative adjudications, the CMS Administrator issued Ruling CMS-1455-P[11] (the Ruling) which established a standard process for effectuating the decisions granting Part B coverage. Among other things, where the administrative adjudicator had issued an order for payment under Medicare Part B, the request for Part B payment would not be rejected if more than one year had elapsed (the time period for filing Part B claims), if the Part A claim had been submitted timely. The Ruling was to remain in effect until the effective date of regulations that finalized "Medicare Program; Part B Billing in Hospitals." In the August 19, 2013 Federal Register, the Secretary revised the Part B inpatient payment policy to allow payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the

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[7] 78 Fed. Reg. at 50,907-08.
[8] *See generally* 78 Fed. Reg. 27,486 (May 10, 2013).
[9] 78 Fed. Reg. 50,908.
[10] *Id.*
[11] *See* 78 Fed. Reg. 16,614 (Mar. 18, 2013), http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings.html.

hospital as an inpatient, except for those services that specifically require outpatient status.[12] The 1-year deadline for filing claims remained unchanged and the Secretary stated that she was not creating an exception to this requirement (as found in 42 C.F.R. §§ 424.44(b)(1)-(4)) even though the contractor claims review and appeal process could exceed the 1-year filing period.[13]

The 2-Midnight Rule

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

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

The Secretary's actuaries estimated that the 2-midnight rule would increase IPPS expenditures by approximately $220 million. These additional expenditures would result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving from OPPS to IPPS and some encounters of less than 2 midnights moving from IPPS to OPPS. The actuaries estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient from the approximately 11 million encounters paid under IPPS. This shift of 40,000 net encounters represents an increase of approximately 1.2 percent in the number of shorter stay hospital inpatient encounters paid under IPPS. This additional expenditure would be partially offset by reduced expenditures from the shift of shorter stay hospital inpatient encounters to hospital outpatient encounters. The actuaries estimated that, on average, the per encounter

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[12] 78 Fed. Reg. at 50,909.
[13] *Id.* at 50,927.
[14] *Id.* at 50,944.
[15] *Id.*
[16] *Id.* at 50,945.

payments for these hospital outpatient encounters would be approximately 30 percent of the per encounter payments for the inpatient encounters. In light of the impact of the 2-midnight rule on IPPS and the systematic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, the Secretary decided it was appropriate to use her exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i) to offset the $220 million in additional IPPS expenditures associated with the 2-midnight policy. Consequently, the standardized amount was reduced by 0.2 percent.[17] The Secretary made the same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[18] In the final IPPS rule for 2015, the Secretary did not reverse the 0.2 percent reduction to the standardized amount made in 2014, and, therefore, continued to apply the contested reduction for the FFY 2015 period.[19]

Providers' Position

The Providers note that the Secretary states that she is relying on 42 U.S.C. § 1395ww(d)(5)(I)(i) which states:

> The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate.

The Providers assert that this authority does not authorize CMS to implement the IPPS rate reduction. They point out that CMS has rarely exercised this authority, and on the occasions it has done so the purpose was to more fully or appropriately implement a recent Congressional requirement. It has never been exercised as broadly as the IPPS rate reduction.

The Providers further contend that, even if this authority is applicable, this authority requires CMS [sic the Secretary] to "provide by regulation" the IPPS rate reduction.[20] Instead, CMS merely discussed the IPPS rate reduction in the preamble to the IPPS final rule.[21] As a result, even if CMS claims it is authorized to implement the IPPS rate reduction under 42 U.S.C. § 1395ww(d)(5)(I)(i), CMS failed to provide for the IPPS rate reduction by regulation, which the Provider believes is invalid. Further, the Providers assert, the IPPS rate reduction violates the Administrative Procedure Act, 5 U.S.C. § 551 *et seq.*

In addition, the Providers assert that CMS is not under a statutory requirement to make budget-neutrality adjustments for changes in coverage decision or service volume. The IPPS rate reduction is in effect a coverage decision, or at a minimum a clarification of policy, that CMS

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[17] *Id.* at 50,952-53.
[18] *Id.* at 50,990.
[19] 79 Fed. Reg. 49,854,50,382-83 (Aug. 22, 2014).
[20] *See International Union, United Mine Workers of Am. V. Mine Safety & Health Admin.*, 68 Fed. Appx. 205, 206 (D.C. Cir. 2003) (unpublished per curiam).
[21] *See* 78 Fed. Reg. at 50,953-54.

believes would result in increase in volume. As a result, inpatient hospital services would be covered under Medicare Part A if the physician expects that the beneficiary's length of stay will exceed a two-midnight threshold or if the beneficiary requires a procedure specified as inpatient-only. CMS purports to have determined that this coverage decision would lead to a net increase of 40,000 in inpatient hospital admissions. The Providers argue that what CMS has failed to recognize is that the 2-midnight rule does not increase payment rates for inpatient cases, which are made budget neutral as part of the annual rate adjustment process. Moreover, apply budget neutrality to coverage decisions or volume changes would violate the fundamental structure and policy that has governed IPPS since its inception in 1983. Specifically, the IPPS payments adjust automatically for both service mix and volume of hospital admissions which vary from year to year. CMS has never made budget-neutrality adjustments for these changes.

The Providers also argue that CMS [sic the Secretary] failed to adequately respond to and take into account comments challenging the actuarial analysis that resulted in the 0.2 percent reduction in IPPS payments. They believe that CMS' response was inadequate and when subject to independent actuarial scrutiny is shown to be defective.[22] The Providers believe that, as the result of the application of the 2 midnight rule, there will be a substantial shift from inpatient admissions to outpatient encounters, entitling the Providers to an increase in its IPPS rate.

Decision of the Board

The Board has reviewed the Providers' requests for hearing and comments regarding the proposed own motion EJR determination. The regulation, 42 C.F.R. § 405.1842(c), permits the Board to consider on its own motion whether it lacks the authority to decide a legal question relevant to the matter at issue once it has made a finding that it has jurisdiction to conduct a hearing under the provisions of 42 C.F.R. § 405.1840(a). With respect to jurisdiction, the Board concludes that the Provider in these cases timely filed the requests for hearing from the issuance of the August 19, 2013 and August 22, 2014 Federal Registers and the amount in controversy exceeds the $50,000 threshold necessary for a group appeal.[23, 24] Consequently, the Board has determined that it has jurisdiction over the appeals. This issue involves a challenge to the validity of a regulation, for which the promulgation background is found in the proposed and final rules published in the Federal Registers. Further, the Board finds, on its own motion, that it lacks the authority to decide the legal question of whether the 0.2 percent adjustment to IPPS is appropriate; therefore, EJR is appropriate for the issue under dispute in these cases.

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[22] *See* Provider's Hearing Request in case number s 14-1901GC and 14-4056GC, Tab 2, ftnt.1.
[23] *Wash. Hosp. Ctr. v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986) ("[A] year end cost report is *not* a report which is necessary in order for the Secretary to make PPS payments, and the appeals provision applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal") and *Dist. of Colum. Hosp. Ass'n Wage Index Group Appeal*, HCFA Adm'r Dec., Medicare & Medicaid Guide (CCH) ¶ 41,025 (Jan. 15, 1993) (publication of the wage index in the Federal Register is a final determination which can be appealed to the Board).
[24] *See* 42 C.F.R. § 405.1837(a)(3).

The Board finds that:

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

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

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

4) it is without the authority to decide the legal question of whether the Secretary's 0.2 percent reduction to the standardized amount, the hospital specific rate for the issue, is valid.

Accordingly, the Board finds that the 0.2 percent reduction issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants expedited judicial review on its own motion for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the cases.

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 Schedules of Providers

cc: Sharon L. Keyes, BCBSA (w/Schedule of Providers)

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RE: Olean General Hospital
Provider No. 33-0103
FFY 2014
PRRB Case No. 14-2406
Decision Regarding Own Motion EJR

Dear Messrs. Blumberg and Browning:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's comments regarding the Board's proposed own motion expedited judicial review (EJR) determination regarding the issue of the 0.2 percent reduction to the inpatient prospective payment system (IPPS) payments in the above-referenced appeal. The Board's decision regard EJR is set forth below.

Background

Issue Under Appeal

Whether the action of the Centers for Medicare & Medicaid Services ("CMS") to reduce [IPPS] payment rates by 0.2% effective as of Federal Fiscal Year 2014 (*i.e.*, October 1, 2013 - September 30, 2014) is consistent with law?[1]

Statutory and Regulatory Background

In the final IPPS rule for FFY 2014, the Secretary expressed concern in the proposed calendar year outpatient PPS (OPPS) rule[2] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving observation services. In recent years, the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours increased from approximately 3 percent in 2006 to 8 percent in 2011. This raised a concern about the financial

[1] Providers' February 12, 2014 Hearing Request, Tab P-3.
[2] Proposed rule at 77 Fed. Reg. 45,061, 45,155-57 (July 30, 2012) and the final rule with comments at 77 Fed. Reg. 68,210, 68,426-33 (Nov. 15, 2012).

impact on Medicare beneficiaries who may incur greater financial liability than they would if they were admitted to the hospital as inpatients.[3]

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

In response to this concern, the Secretary proposed clarifications and changes regarding hospital payment under both Part A and Part B. The Secretary proposed to revise Part B inpatient payment policy to allow payment under Part B for all hospital services furnished that were reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted as an inpatient. This policy would apply when a Medicare Part A hospital inpatient claim was denied or when a hospital determines after a discharge that the inpatient visit was not reasonable and necessary. The timely filing restrictions for Part B billing were not changed (claims must be filed within 1 year from the date of service).[5]

Medicare Part A

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

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[3] 78 Fed. Reg. 50,496, 50,907 (Aug. 19, 2013).
[4] *Id.*
[5] *Id.*
[6] CMS Pub. 100-02, Chapter 6, § 20.6 and Chapter 1, § 10.
[7] 78 Fed. Reg. at 50,907-08.

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

Medicare Part B

In the final IPPS rule, the Secretary noted there had been an increasing number of hospitals appealing Part A inpatient claim denials in which it was determined the inpatient admission was not reasonable or necessary. These claims received partial favorable treatment by the Medicare Appeals Council or Administrative Law Judges (ALJs). In those cases, the Medicare review contractor determinations that the inpatient admission was not reasonable or necessary was upheld, however, the Medicare Appeals Council and ALJ decisions ordered payment of the services as if they were rendered in an outpatient or observation level of care. These decisions effectively required Medicare to issue payment for all Part B services that would have been payable had the patient been treated as an outpatient (rather than an inpatient). In addition, these payments were made whether the subsequent hospital claim for payment was made within the applicable time limit for filing Part B claims. The Secretary pointed out that this was contrary to longstanding polices that permitted billing only for a limited list of Part B inpatient services and required the services be billed within specific timeframes.[10]

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

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[8] *See generally* 78 Fed. Reg. 27,486 (May 10, 2013).
[9] 78 Fed. Reg. at 50,908.
[10] *Id.*
[11] *See* 78 Fed. Reg. 16,614 (Mar. 18, 2013), http://www.cms.gov/Regulations-and-Guidance/ Guidance/ Rulings/CMS-Rulings.html.
[12] 78 Fed. Reg. at 50,909.

§ 424.44(b)(1)-(4)), even though the contractor claims review and appeal process could exceed the 1-year filing period.[13]

The 2-Midnight Rule

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

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

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

[13] *Id.* at 50,927.
[14] *Id.* at 50,944.
[15] *Id.*
[16] *Id.* at 50,945.

the $220 million in additional IPPS expenditures associated with the 2-midnight policy. Consequently, the standardized amount was reduced by 0.2 percent.[17] The Secretary made the same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[18]

Provider's Position

The Provider notes that the Secretary states that she is relying on 42 U.S.C. § 1395ww(d)(5)(I)(i) which states:

> The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate.

The Provider asserts that this authority does not authorize CMS to implement the IPPS rate reduction. It points out that CMS has rarely exercised this authority, and on the occasions it has done so the purpose was to more fully or appropriately implement a recent Congressional requirement. It has never been exercised as broadly as the IPPS rate reduction.

The Provider further contends that, even if this authority is applicable, this authority requires CMS [sic the Secretary] to "provide by regulation" the IPPS rate reduction.[19] Instead, CMS merely discussed the IPPS rate reduction in the preamble to the IPPS final rule.[20] As a result, even if CMS claims it is authorized to implement the IPPS rate reduction under 42 U.S.C. § 1395ww(d)(5)(I)(i), CMS failed to provide for the IPPS rate reduction by regulation, which the Provider believes is invalid. Further, the Provider asserts, the IPPS rate reduction violates the Administrative Procedure Act, 5 U.S.C. § 551 *et seq.*

In addition, the Provider asserts that CMS is not under a statutory requirement to make budget-neutrality adjustments for changes in coverage decision or service volume. The IPPS rate reduction is in effect a coverage decision, or at a minimum a clarification of policy, that CMS believes would result in increase in volume. As a result, inpatient hospital services would be covered under Medicare Part A if the physician expects that the beneficiary's length of stay will exceed a two-midnight threshold or if the beneficiary requires a procedure specified as inpatient-only. CMS purports to have determined that this coverage decision would lead to a net increase of 40,000 in inpatient hospital admissions. The Provider argues that what CMS has failed to recognize is that the 2-midnight rule does not increase payment rates for inpatient cases, which are made budget neutral as part of the annual rate adjustment process. Moreover, to apply budget neutrality to coverage decisions or volume changes would violate the fundamental structure and policy that has governed IPPS since its inception in 1983. Specifically, the IPPS

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[17] *Id.* at 50,952-53.
[18] *Id.* at 50,990.
[19] *See International Union, United Mine Workers of Am. V. Mine Safety & Health Admin.*, 68 Fed. Appx. 205, 206 (D.C. Cir. 2003) (unpublished per curiam).
[20] *See* 78 Fed. Reg. at 50,953-54.

payments adjust automatically for both service mix and volume of hospital admissions which vary from year to year. CMS has never made budget-neutrality adjustments for these changes.

The Provider also argues that CMS [sic the Secretary] failed to adequately respond to and take into account comments challenging the actuarial analysis that resulted in the 0.2 percent reduction in IPPS payments. It believes that CMS' response was inadequate and when subject to independent actuarial scrutiny is shown to be defective.[21] The Provider believes that, as the result of the application of the 2 midnight rule, there will be a substantial shift from inpatient admissions to outpatient encounters, entitling the Provider to an increase in its IPPS rate.

Decision of the Board

The Board has reviewed the Provider's request for hearing and the parties comments regarding the proposed own motion EJR determination. The regulation, 42 C.F.R. § 405.1842(c), permits the Board to consider on its own motion whether it lacks the authority to decide a legal question relevant to the matter at issue once it has made a finding that it has jurisdiction to conduct a hearing under the provisions of 42 C.F.R. § 405.1840(a). With respect to jurisdiction, the Board concludes that the Provider timely filed its request for hearing from the issuance of the August 19, 2013 Federal Register and the amount in controversy exceeds the $10,000 threshold necessary for an individual appeal.[22, 23] Consequently, the Board has determined that it has jurisdiction over the appeal. This issue involves a challenge to the validity of a regulation, for which the promulgation background is found in the proposed and final rules published in the Federal Register. Further, the Board finds that it lacks the authority to decide the legal question of whether the 0.2 percent adjustment to IPPS is appropriate; therefore, EJR is appropriate for the issue under dispute in this case.

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 0.2 percent reduction to the standardized amount, there are no findings of fact for resolution by the Board;

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

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[21] *See* Provider's Hearing Request, Tab 3, ftnt. 1.
[22] *Wash. Hosp. Ctr. v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986) ("[A] year end cost report is *not* a report which is necessary in order for the Secretary to make PPS payments, and the appeals provision applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal") and *Dist. of Colum. Hosp. Ass'n Wage Index Group Appeal* (HCFA Adm. Dec., Medicare & Medicaid Guide (CCH) ¶ 41,025 (Jan. 15, 1993), *Medicare & Medicaid Guide* (CCH) ¶ 41,025 (publication of the wage index in the Federal Register is a final determination which can be appealed to the Board).
[23] *See* 42 C.F.R. § 405.1835(a)(2).

4) it is without the authority to decide the legal question of whether the Secretary's 0.2 percent reduction to the standardized amount, the hospital specific rate for the issue, is valid.

Accordingly, the Board finds that the 0.2 percent reduction issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants expedited judicial review on its own motion for the issue and the subject year. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

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

cc: Sharon L. Keyes, BCBSA

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RE: Bradford Hospital
Provider No. 39-0118
FFY 2014
PRRB Case No. 14-2404
Decision Regarding Own Motion EJR

Dear Messrs. Blumberg and Snyder:

The Provider Reimbursement Review Board (Board) has reviewed the parties comments regarding the Board's proposed own motion expedited judicial review (EJR) determination in the above-referenced appeal. Set forth both is the Board's decision with respect to EJR.

Background

Issue Under Appeal

Whether the action of the Centers for Medicare & Medicaid Services ("CMS") to reduce inpatient prospective payment system ("IPPS") payment rates by 0.2% effective as of Federal Fiscal Year 2014 (*i.e.*, October 1, 2013 - September 30, 2014) is consistent with law?[1]

Statutory and Regulatory Background

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

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[1] Providers' February 12, 2014 Hearing Request, Tab P-3.
[2] Proposed rule at 77 Fed. Reg. 45,061, 45,155-57 (July 30, 2012) and the final rule with comments at 77 Fed. Reg. 68,210, 68,426-33 (Nov. 15, 2012).
[3] 78 Fed. Reg. 50,496, 50,907 (Aug. 19, 2013).

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

In response to this concern, the Secretary proposed clarifications and changes regarding hospital payment under both Part A and Part B. The Secretary proposed to revise Part B inpatient payment policy to allow payment under Part B for all hospital services furnished that were reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted as an inpatient. This policy would apply when a Medicare Part A hospital inpatient claim was denied or when a hospital determines after a discharge that the inpatient visit was not reasonable and necessary. The timely filing restrictions for Part B billing were not changed (claims must be filed within 1 year from the date of service).[5]

Medicare Part A

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

In the FFY 2014 IPPS proposed rule,[8] the Secretary proposed a new benchmark for purposes of medical review of hospital inpatient admissions (Medicare Part A payment). Under this proposal, beneficiaries who were expected to remain in the hospital to receive medically necessary care surpassing 2-midnights after the initiation of care would generally be appropriate

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[4] *Id.*
[5] *Id.*
[6] CMS Pub. 100-02, Chapter 6, § 20.6 and Chapter 1, § 10.
[7] 78 Fed. Reg. at 50,907-08.
[8] *See generally* 78 Fed. Reg. 27,486 (May 10, 2013).

for inpatient admission and inpatient payment (known as the "2-midnight rule"). Medicare contractors were to consider all the time after the initiation of care at the hospital in applying the benchmark that inpatient admissions are generally reasonable and necessary (as long as a hospital was not prolonging the provision of care to surpass the 2-midnight timeframe).[9]

Medicare Part B

In the final IPPS rule, the Secretary noted there had been an increasing number of hospitals appealing Part A inpatient claim denials in which it was determined the inpatient admission was not reasonable or necessary. These claims received partial favorable treatment by the Medicare Appeals Council or Administrative Law Judges (ALJs). In those cases, the Medicare review contractor determinations that the inpatient admission was not reasonable or necessary was upheld, however, the Medicare Appeals Council and ALJ decisions ordered payment of the services as if they were rendered in an outpatient or observation level of care. These decisions effectively required Medicare to issue payment for all Part B services that would have been payable had the patient been treated as an outpatient (rather than an inpatient). In addition, these payments were made whether the subsequent hospital claim for payment was made within the applicable time limit for filing Part B claims. The Secretary pointed out that this was contrary to longstanding polices that permitted billing only for a limited list of Part B inpatient services and required the services be billed within specific timeframes.[10]

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

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[9] 78 Fed. Reg. at 50,908.
[10] *Id.*
[11] *See* 78 Fed. Reg. 16,614 (Mar. 18, 2013), http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings.html.
[12] 78 Fed. Reg. at 50,909.
[13] *Id.* at 50,927.

The 2-Midnight Rule

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

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

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

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[14] *Id.* at 50,944.
[15] *Id.*
[16] *Id.* at 50,945.
[17] *Id.* at 50,952-53.

same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[18]

Provider's Position

The Provider notes that the Secretary states that she is relying on 42 U.S.C. § 1395ww(d)(5)(I)(i) which states:

> The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate.

The Provider asserts that this authority does not authorize CMS to implement the IPPS rate reduction. It points out that CMS has rarely exercised this authority, and on the occasions it has done so the purpose was to more fully or appropriately implement a recent Congressional requirement. It has never been exercised as broadly as the IPPS rate reduction.

The Provider further contends that, even if this authority is applicable, this authority requires CMS [sic the Secretary] to "provide by regulation" the IPPS rate reduction.[19] Instead, CMS merely discussed the IPPS rate reduction in the preamble to the IPPS final rule.[20] As a result, even if CMS claims it is authorized to implement the IPPS rate reduction under 42 U.S.C. § 1395ww(d)(5)(I)(i), CMS failed to provide for the IPPS rate reduction by regulation, which the Provider believes is invalid. Further, the Provider asserts, the IPPS rate reduction violates the Administrative Procedure Act, 5 U.S.C. § 551 *et seq.*

In addition, the Provider asserts that CMS is not under a statutory requirement to make budget-neutrality adjustments for changes in coverage decision or service volume. The IPPS rate reduction is in effect a coverage decision, or at a minimum a clarification of policy, that CMS believes would result in increase in volume. As a result, inpatient hospital services would be covered under Medicare Part A if the physician expects that the beneficiary's length of stay will exceed a two-midnight threshold or if the beneficiary requires a procedure specified as inpatient-only. CMS purports to have determined that this coverage decision would lead to a net increase of 40,000 in inpatient hospital admissions. The Provider argues that what CMS has failed to recognize is that the 2-midnight rule does not increase payment rates for inpatient cases, which are made budget neutral as part of the annual rate adjustment process. Moreover, to apply budget neutrality to coverage decisions or volume changes would violate the fundamental structure and policy that has governed IPPS since its inception in 1983. Specifically, the IPPS payments adjust automatically for both service mix and volume of hospital admissions which vary from year to year. CMS has never made budget-neutrality adjustments for these changes.

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[18] *Id.* at 50,990.
[19] *See International Union, United Mine Workers of Am. V. Mine Safety & Health Admin.*, 68 Fed. Appx. 205, 206 (D.C. Cir. 2003) (unpublished per curiam).
[20] *See* 78 Fed. Reg. at 50,953-54.

The Provider also argues that CMS [sic the Secretary] failed to adequately respond to and take into account comments challenging the actuarial analysis that resulted in the 0.2 percent reduction in IPPS payments. It believes that CMS' response was inadequate and when subject to independent actuarial scrutiny is shown to be defective.[21] The Provider believes that, as the result of the application of the 2 midnight rule, there will be a substantial shift from inpatient admissions to outpatient encounters, entitling the Provider to an increase in its IPPS rate.

Decision of the Board

The Board has reviewed the Provider's request for hearing and comments regarding the proposed own motion EJR determination. The regulation, 42 C.F.R. § 405.1842(c), permits the Board to consider on its own motion whether it lacks the authority to decide a legal question relevant to the matter at issue once it has made a finding that it has jurisdiction to conduct a hearing under the provisions of 42 C.F.R. § 405.1840(a). With respect to jurisdiction, the Board concludes that the Provider timely filed its request for hearing from the issuance of the August 19, 2013 Federal Register and the amount in controversy exceeds the $10,000 threshold necessary for an individual appeal.[22, 23] Consequently, the Board has determined that it has jurisdiction over the appeal. This issue involves a challenge to the validity of a regulation, for which the promulgation background is found in the proposed and final rules published in the Federal Register. Further, the Board finds that it lacks the authority to decide the legal question of whether the 0.2 percent adjustment to IPPS is appropriate; therefore, EJR is appropriate for the issue under dispute in this case.

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 0.2 percent reduction to the standardized amount, there are no findings of fact for resolution by the Board;

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

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[21] *See* Provider's Hearing Request, Tab 3, ftnt.1.
[22] *Wash. Hosp. Ctr. v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986) ("[A] year end cost report is *not* a report which is necessary in order for the Secretary to make PPS payments, and the appeals provision applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal") and *Dist. of Colum. Hosp. Ass'n Wage Index Group Appeal* (HCFA Adm. Dec., Medicare & Medicaid Guide (CCH) ¶ 41,025 (Jan. 15, 1993), *Medicare & Medicaid Guide* (CCH) ¶ 41,025 (publication of the wage index in the Federal Register is a final determination which can be appealed to the Board).
[23] *See* 42 C.F.R. § 405.1835(a)(2).

4) it is without the authority to decide the legal question of whether the Secretary's 0.2 percent reduction to the standardized amount, the hospital specific rate for the issue, is valid.

Accordingly, the Board finds that the 0.2 percent reduction issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants expedited judicial review on its own motion for the issue and the subject year. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

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

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Refer to: 14-4054GC

SEP 08 2015

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RE: Oakwood HC 2015 0.2% IPPS Reduction Group
Provider Nos. Various
PRRB Case No. 14-4054GC
EJR Determination of the 2-Midnight Issue

Dear Messrs. Plaskey and Lamprecht:

Through correspondence dated April 20, 2015, the Provider Reimbursement Review Board (Board) notified the parties that it was considering issuing a decision regarding expedited judicial review (EJR) for the issue under appeal in the above-referenced appeal. The Board asked for the parties' comments, and the Group Representative and the Medicare Contractors responded, indicating agreement with the appropriateness of the Board's proposed action.

Issue Under Appeal

Whether the action of the Centers for Medicare & Medicaid Services ("CMS") to reduce inpatient hospital prospective payment system ("IPPS") payments by 0.2 percent, effective as of Federal fiscal year (FFY) 2015 (October 1, 2014 - September 30, 2015), is consistent with the law? If lawful, whether the adjustment (-0.2 percent) was in the correct amount or whould it have been less of a reduction or an increase in the standardized amount?[1]

Statutory and Regulatory Background

In the final IPPS rule for FFY 2014, the Secretary noted that she had expressed concern in the proposed calendar year outpatient PPS (OPPS) rule[2] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving observation services. In recent years, the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours increased from approximately 3 percent in 2006 to 8 percent in 2011. This raised

[1] Providers' August 27, 2014 Hearing Request, Tab 2.
[2] Proposed rule at 77 Fed. Reg. 45,061, 45,155-57 (July 30, 2012) and final rule with comments at 77 Fed. Reg. 68,210, 68,426-33 (Nov. 15, 2012).

a concern about the financial impact on Medicare beneficiaries who may incur greater financial liability than they would if they were admitted to the hospital as inpatients.[3]

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

In response to this concern, the Secretary proposed clarifications and changes regarding hospital payment under both Part A and Part B. The Secretary proposed to revise Part B inpatient payment policy to allow payment under Part B for all hospital services furnished that were reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted as an inpatient. This policy would apply when a Medicare Part A hospital inpatient claim was denied or when a hospital determines after a discharge that the inpatient visit was not reasonable and necessary. The timely filing restrictions for Part B billing were not changed (claims must be filed within 1 year from the date of service).[5]

Medicare Part A

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

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[3] 78 Fed. Reg. 50,496, 50,906-7 (Aug. 19, 2013).
[4] *Id.*
[5] *Id.*
[6] CMS Pub. 100-02, Chapter 6, § 20.6 and Chapter 1, § 10.
[7] 78 Fed. Reg. at 50,907-08.

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

Medicare Part B

In the final IPPS rule, the Secretary noted there had been an increasing number of hospitals appealing Part A inpatient claim denials in which it was determined the inpatient admission was not reasonable or necessary. These claims received partial favorable treatment by the Medicare Appeals Council or Administrative Law Judges (ALJs). In those cases, the Medicare review contractor determinations that the inpatient admission was not reasonable or necessary was upheld, however, the Medicare Appeals Council and ALJ decisions ordered payment of the services as if they were rendered in an outpatient or observation level of care. These decisions effectively required Medicare to issue payment for all Part B services that would have been payable had the patient been treated as an outpatient (rather than an inpatient). In addition, these payments were made whether the subsequent hospital claim for payment was made within the applicable time limit for filing Part B claims. The Secretary pointed out that this was contrary to longstanding polices that permitted billing only for a limited list of Part B inpatient services and required the services be billed within specific timeframes.[10]

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

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[8] *See generally* 78 Fed. Reg. 27,486 (May 10, 2013).
[9] 78 Fed. Reg. at 50,908.
[10] *Id.*
[11] *See* 78 Fed. Reg. 16,614 (Mar. 18, 2013), http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings.html.
[12] 78 Fed. Reg. at 50,909.

§ 424.44(b)(1)-(4)), even though the contractor claims review and appeal process could exceed the 1-year filing period.[13]

The 2-Midnight Rule

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

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

The Secretary's actuaries estimated that the 2-midnight rule would increase IPPS expenditures by approximately $220 million. These additional expenditures would result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving from OPPS to IPPS and some encounters of less than 2 midnights moving from IPPS to OPPS. The actuaries estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient from the approximately 11 million encounters paid under IPPS. This shift of 40,000 net encounters represents an increase of approximately 1.2 percent in the number of shorter stay hospital inpatient encounters paid under IPPS. This additional expenditure would be partially offset by reduced expenditures from the shift of shorter stay hospital inpatient encounters to hospital outpatient encounters. The actuaries estimated that, on average, the per encounter payments for these hospital outpatient encounters would be approximately 30 percent of the per encounter payments for the inpatient encounters. In light of the impact of the 2-midnight rule on IPPS and the systematic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, the Secretary decided it was appropriate

[13] *Id.* at 50,927.
[14] *Id.* at 50,944.
[15] *Id.*
[16] *Id.* at 50,945.

to use her exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i) to offset the $220 million in additional IPPS expenditures associated with the 2-midnight policy. Consequently, the standardized amount was reduced by 0.2 percent.[17] The Secretary made the same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[18] In the final IPPS rule for 2015, the Secretary did not reverse the 0.2 percent reduction to the standardized amount made in 2014, and, therefore, continued to apply the contested reduction for the FFY 2015 period.[19]

Providers' Position

The Providers note that the Secretary states she is relying on 42 U.S.C. § 1395ww(d)(5)(I)(i), which states:

> The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate.

The Providers assert that this authority does not authorize CMS to implement the IPPS rate reduction. They do not believe that CMS is required by statute to make budget-neutrality adjustments for changes in coverage decisions or service volume. The Providers assert that the IPPS rate reduction is, in effect, a coverage decision, or at a minimum, a clarification of policy that CMS believes would result in an increase in volume. As a result, inpatient hospital services would be covered under Part A if the physician expects that the beneficiary's length of stay will exceed a 2-midnight threshold or if the beneficiary requires a procedure specified as inpatient-only. CMS purports to have determined that this coverage decision would lead to a net increase of 40,000 in inpatient hospital admissions. The Providers contend that what CMS failed to recognize is that a 2-midnight rule does not increase payment rates for inpatient cases which are made budget neutral as part of the annual rate adjustment process. Moreover, applying budget neutrality to coverage decisions or volume changes would violate the fundamental structure and policy that has governed IPPS since its inception in 1983. Specifically, IPPS adjusts automatically to both the service mix and volume of hospital admissions, which vary from year to year based on many factors. CMS has never made budget neutrality adjustments for these changes.

Further, the Providers contend that CMS failed to adequately respond to and take into account comments challenging its actuarial analysis. More specifically, CMS did not respond to the Federal Register comment claiming the actuaries' estimated increase in IPPS expenditures of $220 million was unsupported and insufficiently explained to allow for meaningful comment.[20] The Providers believe that the application of the 2-midnight rule will result in a substantial shift

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[17] *Id.* at 50,952-53.
[18] *Id.* at 50,990.
[19] 79 Fed. Reg. 49,854,50,382-83 (Aug. 22, 2014).
[20] 78 Fed. Reg. at 50,953.

from inpatient admissions to outpatient encounters and, if budget neutrality is to govern CMS' actions, the Providers are entitled to an increase in the IPPS payment rate.

Decision of the Board

The Board has reviewed the Providers' request for hearing and the parties' comments regarding the proposed own motion EJR determination. The regulation, 42 C.F.R. § 405.1842(c), permits the Board to consider on its own motion whether it lacks the authority to decide a legal question relevant to the matter at issue once it has made a finding that it has jurisdiction to conduct a hearing under the provisions of 42 C.F.R. § 405.1840(a). With respect to jurisdiction, the Board concludes that each of the Providers in this case timely filed their request for hearing from the issuance of the August 22, 2014 Federal Register and the amount in controversy exceeds the $50,000 threshold necessary for a group appeal.[21, 22] Consequently, the Board has determined that it has jurisdiction over the appeal. This issue involves a challenge to the validity of a regulation, for which the promulgation background is found in the proposed and final rules published in the Federal Register. Further, the Board finds, on its own motion, that it lacks the authority to decide the legal question of whether the 0.2 percent adjustment to IPPS is appropriate; therefore, EJR is appropriate for the issue under dispute in this case.

The Board finds that:

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

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

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

4) it is without the authority to decide the legal question of whether the Secretary's 0.2 percent reduction to the standardized amount, the hospital specific rate for the issue, is valid.

Accordingly, the Board finds that the 0.2 percent reduction issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants expedited judicial review on its own

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[21] *Wash. Hosp. Ctr. v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986) ("[A] year end cost report is *not* a report which is necessary in order for the Secretary to make PPS payments, and the appeals provision applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal") and *Dist. of Colum. Hosp. Ass'n Wage Index Group Appeal*, HCFA Adm'r Dec., Medicare & Medicaid Guide (CCH) ¶ 41,025 (Jan. 15, 1993) (publication of the wage index in the Federal Register is a final determination which can be appealed to the Board).

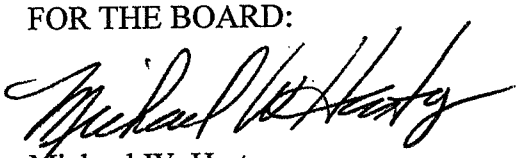
[22] *See* 42 C.F.R. § 405.1837(a)(3).

motion for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

Board Members Participating

Michael W. Harty
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)
Schedule of Providers

cc: Sharon L. Keyes, BCBSA

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SEP 09 2015

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RE: QRS 2005 DSH SSI Denominator Days Group
Jurisdictional Review
Fiscal Year 2005
PRRB Case No. 09-1562G

Dear Mr. Ravindran and Mr. Browning:

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

BACKGROUND

On April 23, 2009, Quality Reimbursement Services, Inc., ("QRS") requested a group appeal stating the issue as "Whether the Intermediary correctly determined [the] denominator of the SSI percentage of the Disproportionate Share Payment calculation ... Among other problems with the SSI denominator, CMS included Medicare Part C/Medicare + Choice pat[i]ents in the calculation of the Provider's SSI percentage."[1]

On May 15, 2015, QRS submitted its final position paper briefing *Baystate* SSI, with no mention of the M+C denominator issue which is the issue under appeal in this group.[2]

On June 30, 2015, the Medicare Contractor submitted a jurisdictional challenge. The Medicare Contractor challenged the issue briefed in the Provider's final position paper as well as citing jurisdictional concerns regarding the Schedule of Providers filed by QRS in final position paper as Exhibit 1.

[1] *See* Provider's initial request for group appeal at Tab 2.
[2] *See* Provider's final position paper at 10.

On July 31, 2015, QRS submitted its response to the Medicare Contractor's jurisdictional challenge and a revised Schedule of Providers ("SOP") with jurisdictional documentation. Review of the jurisdictional documentation verified that the group issue limited to the M+C days in the SSI denominator was properly included in all of the individual appeals and all but two participants timely transferred the issue to Case No. 09-1562G.[3]

MEDICARE CONTRACTOR'S CONTENTIONS

The Medicare Contractor contends that the Provider changed the issue description and arguments in its May 15, 2015 final position paper. The Medicare Contractor argues that the Provider's initial appeal request and preliminary position paper addressed the treatment of Medicare + Choice days in the denominator of the SSI percentage. However, the Provider's final position paper addressed the issue as relating to the SSI percentage.[4]

The Medicare Contractor also challenged a number of participants in the original Schedule of Providers submitted in 2010.[5]

PROVIDER'S CONTENTIONS

The Provider contends that the issue argued in its final position paper covers the same components as the issue initially appeal as well as briefed in its preliminary position paper. The issue under appeal is the incorrect treatment of the denominator of the SSI calculation.

The Provider argues that it stated the issue in both the intial appeal request and final position paper per PRRB Rule 8.2. Also, PRRB Rule 27.1 states "The final positon paper should reflect the refinement of the issues from the preliminary positon paper or proposed JSO."[6]

The Provider submitted a revised Schedule of Providers with its Jurisdictional Response to address the Medicare Contractor's concerns.

BOARD DECISON

Issue Under Appeal

The subject appeal issue challenged the M + C exclusion from the "old" SSI denominator. All providers included in the subject appeal did appeal separately the *Baystate* SSI data match issue and transfer the *Baystate* old SSI issue to Case No. 08-2269G. Case No. 08-2269G was remanded to the Medicare contractor on July 11, 2014 and closed.

Further, arguments related to the "old" SSI issue are now moot with the release of new SSI percentages and the previous remands of the data match issue to include the new SSI percentage

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[3] Participants 2 and 14 requested the issue be transferred after the individual case was closed.
[4] *See* Medicare Contractor's jurisdictional challenge cover page.
[5] *Id.*
[6] *See* Provider's Jurisdictional Response at 2.

for each of the Providers. All of the Providers in the subject appeal should have received revised Notices of Reimbursement with new SSI percentages.

Position Paper – Filed May 15, 2015

The issue briefed in the Final position paper is not the issue in the appeal (no mention of Part C Days), but is the "old" *Baystate* SSI data match issue, which was in Case No. 08-2269G and remanded. The Board finds that the initial appeal issue of M+C exclusion from the SSI denominator as being abandon per PRRB Rule 41.2.1. The Board finds that the SSI issue as briefed in the Provider's final position paper is not the issue under appeal and is moot. Hereby, the Board dismisses Case No. 09-1562G.

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.

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: BC BS Association
Sharon L. Keyes, Executive Director
Senior Government Initiatives
225 North Michigan Avenue
Chicago, IL 60601 7680

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

Refer to: 05-2172G

CERTIFIED MAIL

SEP 14 2015

Joanne B. Erde, P.A.
Duane Morris
200 South Biscayne Boulevard
Suite 3400
Miami, FL 33131

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

Re: **Duane Morris/McKay Consulting DSH DE Days Bifurcation to (1) Part A Non-Covered/Exhausted Benefits Days and (2) Part C Days**
PRRB Case No.: 05-2172G
FYE: 2000

Dear Ms. Erde:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal regarding the bifurcation of Dual Eligible days into (1) Exhausted Benefits days and (2) Part C days. The Board determined that, for providers deemed eligible (see below), it will grant the bifurcation request. The Part C days issue will be adjudicated in Case No. 15-3289G, McKay 2000 Part C Days Group Appeal II.[1] If the Board finds jurisdiction over providers appealing Part A Non-Covered and Exhausted Benefit days, those providers will be remanded pursuant to CMS Ruling 1498-R.

Background

The instant group appeal, established in 2005, framed the issue as follows:

> Is the [Medicare Administrative Contractor's] exclusion from the Medicaid percentage of all days of care rendered to dually eligible patients who were eligible for reimbursement under the State's Medicaid plan and either whose Medicare Part A benefits were exhausted or who received Part C benefits correct?[2]

---

[1] This letter will serve as the Acknowledgement Letter normally sent via e-mail. The parties will be informed of new position paper deadlines in a Notice of Hearing.
[2] Group Request for Hearing at 1-2, Sep. 9, 2005.

The initial appeal request included three providers, Albany Medical Center (Prov. No. 33-0013), Arnot-Ogden Medical Center (Prov. No. 33-0090)[3] and Strong Memorial Hospital (Prov. No. 33-0285).[4] Subsequent to the establishment of the instant case, other providers transferred into this group appeal.

On June 3, 2013, the Provider Representative, Duane Morris, submitted a Case Management Plan for the "McKay Consulting Appeals," including the instant case, which adopted new deadlines for the Schedule of Providers.[5] On August 30, 2013, the Board received the Schedule of Providers from McKay Consulting ("McKay") for both Part C days and "Dual Eligible," or Exhausted Benefits, days, along with a letter addressing the bifurcation of the Dual Eligible days issue.[6] McKay wrote that it determined that "... each of the group appeals ... challenges the exclusion of both non-covered and Medicare part [*sic*] C dual eligible patients from the numerator of the DSH Medicaid fraction."[7] However, not every provider was listed on both the Exhausted Benefits and Part C days' Schedules of Providers.

The list of providers for Case No. 05-2172G is in the table below.

Provider Number	Provider Name	Original Case Number	Request for Bifurcation?
33-0013	Albany Medical Center	05-2047 (closed 02.25.11); original provider in group	Yes, Dual Elig. and Part C
23-0021	Lakeland Regional Health System	06-0054 (closed 02.05.08)	No, Dual Elig. Schedule only
34-0070	Alamance Regional Medical Center	06-0753 (closed 05.31.06)	Yes, Dual Elig. and Part C
34-0030	Duke University Health System	06-2346 (closed 12.31.06)	No, Dual Elig. Schedule only
33-0005	Kaleida Health	08-1476 (closed 07.01.14)	Yes, Dual Elig. and Part C
34-0141	New Hanover	06-1844 (closed 03.03.09)	No, Dual Elig. Schedule only
33-0230	St. Vincent's Midtown Hospital	05-2040 (closed 02.05.08)	Yes, Dual Elig. and Part C

Board Determination on Bifurcation

The Board has granted the bifurcation request regarding the Dual Eligible issue into two groups:

[3] Arnot-Ogden was not included on either Schedule of Providers and will not be addressed.
[4] Strong was not included on either Schedule of Providers and will not be addressed.
[5] *See* Case Management Plan Letter, Jun. 3, 2013.
[6] *See* Bifurcation Letter, Aug. 30, 2013; *see also* Schedule of Providers, Aug. 30, 2013.
[7] *Id.* at 1.

(1) Dual Eligible Exhausted Benefits days
(2) Part C days

The Board's decision rests on the framing of the group issue and the regulations and Board Rules applicable at the time the group appeal was filed.

Prior to the 2008 revisions, the regulations required that, for a group appeal, "[t]he matters at issue involve a common question of fact or interpretation of law, regulations, or CMS Rulings."[8] Here, the group "matter at issue" is described as Dual Eligible days. The group clearly defines Dual Eligible days as "dually eligible" for Medicaid and Medicare with exhausted benefits and "dually eligible" for Medicaid and Medicare Part C. Seemingly, the group appealed multiple issues, since the group's definition of Dual Eligible days is viewed as two separate issues by the Board (i.e. Exhausted Benefits days and Part C days). However, the Board has decided to treat the "multi-component" issue as a valid appeal because of the way "Dual Eligible days" were defined in the 2004 group appeal request. The Board concludes that it will grant the bifurcation of Dual Eligible days, as long as all other jurisdictional requirements are met.

Board Determination on Jurisdiction

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Board finds that, although Alamance Regional Medical Center, Kaleida Health, and St. Vincent's Midtown requested bifurcation of the Part C days issue, these providers did not originally raise the sub-issue of Part C days in their respective original appeals. However, the request to transfer the "DE days" issue occurred prior to the 2008 regulation change, which limited the ability to add issues to an open appeal. Prior to the regulatory change, providers would regularly (and simultaneously) add issues to individual appeals and transfer those issues to group appeals. Therefore, the Board will deem the "transfers" of the Dual Eligible days issue as an "add/transfer" of the Part C days issue for each of these providers. The Board finds that the group that the providers were transferring to explicitly defined the issue under appeal as including the Part C days component. Further, the Board will grant Kaleida's request to join the fully formed group.

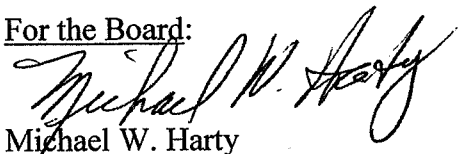
Albany Medical Center will also join the new Part C days group appeal. Albany was one of the original providers used to establish the instant group appeal, which means that Albany's issue statement matches the group's issue statement. The Board finds that Albany validly raised Part C days. The Part C days appeal will continue for the four providers in Case No. 15-3289G.

Finally, the Board finds that it has jurisdiction over the providers in Case No. 05-2172G

[8] 42 C.F.R. § 405.1837(a)(2) (2003).

who requested to appeal Dual Eligible days from original NPRs. These providers either established the instant group appeal or timely filed individual appeals and were properly transferred to this group appeal. All seven providers, Albany Medical Center, Lakeland Regional Health, Alamance Regional Medical Center, Duke University Health, Kaleida Health, New Hanover, and St. Vincent's Midtown, will be remanded under separate cover pursuant to CMS Ruling 1498-R.

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

cc: Sharon L. Keyes, BCBSA (Enclosure)

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Refer to: 05-2173G

CERTIFIED MAIL SEP 14 2015

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Kyle Browning
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National Government Services
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Re: **Duane Morris/McKay Consulting DSH DE Days Bifurcation to (1) Part A Non-Covered/Exhausted Benefits Days and (2) Part C Days**
PRRB Case No.: 05-2173G
FYE: 2001

Dear Ms. Erde:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal regarding the bifurcation of Dual Eligible days into (1) Exhausted Benefits days and (2) Part C days. The Board determined that, for providers deemed eligible (see below), it will grant the bifurcation request. The Part C days issue will be adjudicated in Case No. 15-3297G, McKay 2001 Part C Days Group Appeal II.[1] If the Board finds jurisdiction over providers appealing Part A Non-Covered and Exhausted Benefit days, those providers will be remanded pursuant to CMS Ruling 1498-R.

Background

The instant group appeal, established in 2005, framed the issue as follows:

> Is the [Medicare Administrative Contractor's] exclusion from the Medicaid percentage of all days of care rendered to dually eligible patients who were eligible for reimbursement under the State's Medicaid plan and either whose Medicare Part A benefits were exhausted or who received Part C benefits correct?[2]

[1] This letter will serve as the Acknowledgement Letter normally sent via e-mail. The parties will be informed of new position paper deadlines in a Notice of Hearing.
[2] Group Request for Hearing at 1-2, Sep. 9, 2005.

The initial appeal request included three providers, Rome Medical Center (Prov. No. 33-0215), Arnot-Ogden Medical Center (Prov. No. 33-0090)[3] and Strong Memorial Hospital (Prov. No. 33-0285).[4] Subsequent to the establishment of the instant case, other providers transferred into this group appeal.

On June 3, 2013, the Provider Representative, Duane Morris, submitted a Case Management Plan for the "McKay Consulting Appeals," including the instant case, which adopted new deadlines for the Schedule of Providers.[5] On August 30, 2013, the Board received the Schedule of Providers from McKay Consulting ("McKay") for both Part C days and "Dual Eligible," or Exhausted Benefits, days, along with a letter addressing the bifurcation of the Dual Eligible days issue.[6] McKay wrote that it determined that "... each of the group appeals ... challenges the exclusion of both non-covered and Medicare part [*sic*] C dual eligible patients from the numerator of the DSH Medicaid fraction."[7] However, not every provider was listed on both the Exhausted Benefits and Part C days' Schedules of Providers.

The list of providers for Case No. 05-2173G is in the table below.

Provider Number	Provider Name	Original Case Number	Request for Bifurcation?
33-0191	Glens Falls Hospital	06-0048 (closed 06.26.06)	Yes, Dual Elig. and Part C
23-0021	Lakeland Regional Medical Center	06-0717 (closed 01.11.08)	No, Dual Elig. Schedule only
34-0030	Duke University Health System	06-2347 (closed 12.13.06)	No, Dual Elig. Schedule only
33-0005	Kaleida Health	08-1477 (closed 07.01.14)	Yes, Dual Elig. and Part C
34-0141	New Hanover Regional Medical Center	06-1865 (closed 03.03.09)	No, Dual Elig. Schedule only
33-0215	Rome Memorial Hospital	05-1390 (closed 03.03.15); original provider in group	No, Dual Elig. Schedule only
34-0070	Alamance Regional Medical Center	06-1845 (closed 09.09.06)	No, Part C Schedule only

Board Determination on Bifurcation

The Board has granted the bifurcation request regarding the Dual Eligible issue into two groups:

---

[3] Arnot-Ogden was not included on either Schedule of Providers and will not be addressed.
[4] Strong was not included on either Schedule of Providers and will not be addressed.
[5] *See* Case Management Plan Letter, Jun. 3, 2013.
[6] *See* Bifurcation Letter, Aug. 30, 2013; *see also* Schedule of Providers, Aug. 30, 2013.
[7] *Id.* at 1.

(1) Dual Eligible Exhausted Benefits days
(2) Part C days

The Board's decision rests on the framing of the group issue and the regulations and Board Rules applicable at the time the group appeal was filed.

Prior to the 2008 revisions, the regulations required that, for a group appeal, "[t]he matters at issue involve a common question of fact or interpretation of law, regulations, or CMS Rulings."[8] Here, the group "matter at issue" is described as Dual Eligible days. The group clearly defines Dual Eligible days as "dually eligible" for Medicaid and Medicare with exhausted benefits and "dually eligible" for Medicaid and Medicare Part C. Seemingly, the group appealed multiple issues, since the group's definition of Dual Eligible days is viewed as two separate issues by the Board (i.e. Exhausted Benefits days and Part C days). However, the Board has decided to treat the "multi-component" issue as a valid appeal because of the way "Dual Eligible days" were defined in the 2004 group appeal request. The Board concludes that it will grant the bifurcation of Dual Eligible days, as long as all other jurisdictional requirements are met.

Board Determination on Jurisdiction

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Board finds that, although Alamance Regional Medical Center, Kaleida Health, and Glens Falls Hospital requested bifurcation of the Part C days issue, these providers did not originally raise the sub-issue of Part C days in their respective original appeals. However, the request to transfer the "DE days" issue occurred prior to the 2008 regulation change, which limited the ability to add issues to an open appeal. Prior to the regulatory change, providers would regularly (and simultaneously) add issues to individual appeals and transfer those issues to group appeals. Therefore, the Board will deem the "transfers" of the Dual Eligible days issue as an "add/transfer" of the Part C days issue for each of these providers. The Board finds that the group that the providers were transferring to explicitly defined the issue under appeal as including the Part C days component. Further, the Board will grant Kaleida's request to join the fully formed group. The Part C days appeal will continue for the four providers in Case No. 15-3297G.

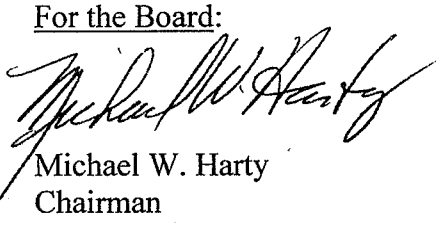
Finally, the Board finds that it has jurisdiction over the providers in Case No. 05-2173G who requested to appeal Dual Eligible days from original NPRs. These providers either established the instant group appeal or timely filed individual appeals and were properly transferred to this group appeal. All six providers, Lakeland Regional Health, Glens Falls Hospital, Duke University Hospital, Kaleida Health, New Hanover Regional Medical Center, and Rome Memorial Hospital, will be remanded under separate cover pursuant to CMS Ruling

[8] 42 C.F.R. § 405.1837(a)(2) (2003).

1498-R.

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

For the Board:



Michael W. Harty
Chairman

Enclosure

cc: Sharon L. Keyes, BCBSA

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CERTIFIED MAIL SEP 14 2015

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Indianapolis, IN 46206-6474

Re: **Duane Morris/McKay Consulting DSH DE Days Bifurcation to (1) Part A Non-Covered/Exhausted Benefits Days and (2) Part C Days**
PRRB Case No.: 05-2253G
FYE: 2003

Dear Ms. Erde:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal regarding the bifurcation of Dual Eligible days into (1) Exhausted Benefits days and (2) Part C days. The Board determined that, for providers deemed eligible (see below), it will grant the bifurcation request. The Part C days issue will be adjudicated in Case No. 15-3296G, McKay Consulting 03 National Part C Days Group.[1] If the Board finds jurisdiction over providers appealing Part A Non-Covered and Exhausted Benefit days, those providers will be remanded pursuant to CMS Ruling 1498-R.

Background

The instant group appeal, established in 2005, framed the issue as follows:

> Is the [Medicare Administrative Contractor's] exclusion from the Medicaid percentage of all days of care rendered to dually eligible patients who were eligible for reimbursement under the State's Medicaid plan and either whose Medicare Part A benefits were exhausted or who received Part C benefits correct?[2]

---

[1] This letter will serve as the Acknowledgement Letter normally sent via e-mail. The parties will be informed of new position paper deadlines in a Notice of Hearing.
[2] Group Request for Hearing at 1-2, Sep. 21, 2005.

The initial appeal request included two providers, Butler Memorial Hospital (Prov. No. 39-0168) and St. John Hospital (Prov. No. 14-0053).[3] Subsequent to the establishment of the instant case, other providers transferred into this group appeal.

The Medicare Contractor filed a Jurisdictional Challenge against one of the providers transferred into the group, Mobile Infirmary Medical Center. The Board, however, granted jurisdiction over Mobile Infirmary's Dual Eligible days on May 29, 2007.

On June 3, 2013, the Provider Representative, Duane Morris, submitted a Case Management Plan for the "McKay Consulting Appeals," including the instant case, which adopted new deadlines for the Schedule of Providers.[4] On August 30, 2013, the Board received the Schedule of Providers from McKay Consulting ("McKay") for both Part C days and "Dual Eligible," or Exhausted Benefits, days, along with a letter addressing the bifurcation of the Dual Eligible days issue.[5] McKay wrote that it determined that "... each of the group appeals ... challenges the exclusion of both non-covered and Medicare part [*sic*] C dual eligible patients from the numerator of the DSH Medicaid fraction."[6] However, not every provider was listed on both the Exhausted Benefits and Part C days' Schedules of Providers.

The list of providers for Case No. 05-2253G is in the table below.

Provider Number	**Provider Name**	**Original Case Number**	**Request for Bifurcation?**
39-0168	Butler	05-0713 (closed 06.04.07); original provider in group	Yes, Dual Elig. and Part C
34-0109	Albemarle	06-1825 (closed 01.23.07)	Yes, Dual Elig. and Part C
36-0096	East Liverpool	06-0531 (closed 04.27.06)	No, Dual Elig. Schedule only
13-0049	Kootenai	06-0695 (closed 03.24.11)	Yes, Dual Elig. and Part C
34-0126	Wilson	06-1863 (closed 07.30.10)	No, Dual Elig. Schedule only
33-0005	Kaleida Health	08-1479 (closed 04.15.15)	Yes, Dual Elig. and Part C
14-0148	Memorial	05-2085 (closed 04.25.06)	Yes, Dual Elig. and Part C
33-0108	St. Joseph	06-2408G (closed 08.21.07)	No, Dual Elig. Schedule only
33-0047	St. Mary's	07-0064 (closed 01.14.08)	Yes, both Dual Elig. and Part C
27-0049	St. Vincent	05-2146 (closed 12.04.07)	No, Dual Elig. Schedule only

[3] St. John was not included on either Schedule of Providers and will not be addressed.
[4] *See* Case Management Plan Letter, Jun. 3, 2013.
[5] *See* Bifurcation Letter, Aug. 30, 2013; *see also* Schedule of Providers, Aug. 30, 2013.
[6] *Id.* at 1.

01-0113	Mobile Infirmary	05-2140 (closed 12.14.07)	Yes, both Dual Elig. and Part C

Board Determination on Bifurcation

The Board has granted the bifurcation request regarding the Dual Eligible issue into two groups:

(1) Dual Eligible Exhausted Benefits days
(2) Part C days

The Board's decision rests on the framing of the group issue and the regulations and Board Rules applicable at the time the group appeal was filed.

Prior to the 2008 revisions, the regulations required that, for a group appeal, "[t]he matters at issue involve a common question of fact or interpretation of law, regulations, or CMS Rulings."[7] Here, the group "matter at issue" is described as Dual Eligible days. The group clearly defines Dual Eligible days as "dually eligible" for Medicaid and Medicare with exhausted benefits and "dually eligible" for Medicaid and Medicare Part C. Seemingly, the group appealed multiple issues, since the group's definition of Dual Eligible days is viewed as two separate issues by the Board (i.e. Exhausted Benefits days and Part C days). However, the Board has decided to treat the "multi-component" issue as a valid appeal because of the way "Dual Eligible days" were defined in the 2004 group appeal request. The Board concludes that it will grant the bifurcation of Dual Eligible days, as long as all other jurisdictional requirements are met.

Board Determination on Jurisdiction

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Board finds that, although Albemarle Hospital, Kaleida Health, Kootenai Medical Center, Memorial Medical Center, Mobile Infirmary Medical Center, and St. Mary's Healthcare requested bifurcation of the Part C days issue, these providers did not originally raise the sub-issue of Part C days in their respective original appeals. However, the request to transfer the "DE days" issue occurred prior to the 2008 regulation change, which limited the ability to add issues to an open appeal. Prior to the regulatory change, providers would regularly (and simultaneously) add issues to individual appeals and transfer those issues to group appeals. Therefore, the Board will deem the "transfers" of the Dual Eligible days issue as an "add/transfer" of the Part C days issue for each of these providers. The Board finds that the group that the providers were transferring to explicitly defined the issue under appeal as including the Part C days component. Further, the Board will grant Kaleida's request to join the

[7] 42 C.F.R. § 405.1837(a)(2) (2003).

fully formed group.

Butler Memorial Hospital will also join the new Part C days group appeal. Butler was one of the original providers used to establish the instant group appeal, which means that Butler's issue statement matches the group's issue statement. The Board finds that Butler validly raised Part C days. The Part C days appeal will continue for the four providers in Case No. 15-3296G.

Finally, the Board finds that it has jurisdiction over the providers in Case No. 05-2253G who requested to appeal Dual Eligible days from original NPRs. These providers established the instant group appeal or timely filed individual appeals and were properly added and/or transferred to this group appeal. All eleven providers: Butler Memorial Hospital, Albemarle Hospital, East Liverpool City Hospital, Kootenai Medical Center, Wilson Medical Center, Kaleida Health, Memorial Medical Center, St. Joseph Hospital Elmira, St. Mary's Healthcare, St. Vincent Hospital, and Mobile Infirmary Medical Center will be remanded under separate cover pursuant to CMS Ruling 1498-R.

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

cc: Sharon L. Keyes, BCBSA (Enclosure)

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CERTIFIED MAIL

SEP 14 2015

Thomas P. Knight
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Concord, CA 94520-2546

RE: Mission Hospital Regional Medical Center, Provider No. 05-0567, FYE 06/30/06, as a participant in "St. Joseph Health System 2006 LIP Code 2 & 3 Eligible Days CIRP Group" PRRB Case No.: 15-2901GC

Dear Mr. Knight:

The Provider Reimbursement Review Board (Board) has reviewed the Schedule of Providers and the associated jurisdictional documents for case number 15-2901GC. The Board dismisses Mission Hospital Regional Medical Center from case number 15-2901GC as the LIP Code 2 & 3 eligible days issue was not appealed in the individual appeal nor timely added to the individual appeal. As such, the LIP Code 2 & 3 eligible days issue could not be transferred to the group appeal, case number 15-2901GC.

Background

On June 8, 2007, the Medicare Contractor issued a Notice of Program Reimbursement (NPR) to Mission Hospital Regional Medical Center, provider number 05-0567, for the cost reporting period ending June 30, 2006. On November 30, 2007, Mission Hospital Regional Medical Center filed an appeal of the NPR challenging disproportionate share hospital (DSH) and low income patient (LIP) Medicaid eligible days, DSH dual eligible days, DSH Code 2 & 3 eligible days, DSH elimination of labor and delivery room days, DSH labor/ delivery/ recovery/post-partum unit days, DSH SSI ratio and budget neutrality. The Board assigned case number 08-0318 to the appeal.

On April 1, 2008, Mission Hospital Regional Medical Center (along with 2 other providers[1]) requested to establish the St. Joseph's Health System 2006 DSH Code 2 & 3 eligible days group. The Board assigned case number 08-1741GC to the appeal. Mission Hospital Regional Medical Center requested to transfer the DSH Code 2 & 3 eligible days issue from its individual appeal case number 08-0318, to case number 08-1741GC. On July 9, 2015, the Board bifurcated Mission Hospital Regional Medical Center and Queen of the Valley Medical Center[2], from case number 08-0741GC, and formed group appeal, case number 15-2901GC, to address the LIP Code 2 & 3 eligible days issue appealed by the Providers. The Board found that the group appeal, case number

[1] Queen of the Valley Medical Center (Provider No. 05-0009, fiscal year end (FYE) 6/30/06) and Santa Rosa Memorial Hospital (Provider No. 05-0174, FYE 6/30/06).
[2] Provider No. 05-0009, FYE 6/30/06.

08-1741GC, contained both acute care hospitals which received the DSH adjustment and inpatient rehabilitation facilities which received the LIP adjustment; and that the DSH and LIP adjustments were separate issues that required separate group appeals.

Decision of the Board

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 ($50,000 for a group) and the request for a hearing is filed within 180 days of the NPR.[3]

Mission Hospital Regional Medical Center did not appeal the LIP Code 2 & 3 eligible days issue in its individual appeal, case number 08-0318, and did not timely request to add the LIP Code 2 & 3 eligible days issue to its individual appeal. Mission Hospital Regional Medical Center requested to transfer the DSH Code 2 & 3 eligible days issue from its individual appeal, case number 08-0318, to case number 08-1741GC. At the Provider's request, the Board thereafter bifurcated Mission Hospital Regional Medical Center and Queen of the Valley Medical Center for fiscal year end (FYE) 2006 from case number 08-1741GC and formed group appeal, case number 15-2901GC, to address the alleged LIP Code 2 & 3 eligible days issue appealed. However, upon review of the Schedule of Providers and the associated jurisdictional documents, the Board has determined that the LIP Code 2 & 3 eligible days issue was neither appealed in Mission Hospital Regional Medical Center's individual appeal nor timely added to its individual appeal. As such, the LIP Code 2 & 3 eligible days issue could not be transferred from case number 08-1741GC to case number 15-2901GC for this Provider. The Board hereby dismisses, Provider 1, Mission Hospital Regional Medical Center, Provider No. 05-0567, FYE June 30, 2006, from group appeal, case number 15-2901GC.

As only one provider remains in case number 15-2901GC,[4] the Board converts case number 15-2901GC from a common issue related party (CIRP) group appeal to an individual appeal with the same issue being, the challenge to the LIP Code 2 & 3 eligible days.[5] The appeal number for the individual appeal is case number 15-2901. Case number 15-2901 will be used for all future correspondences regarding Queen of the Valley Medical Center.

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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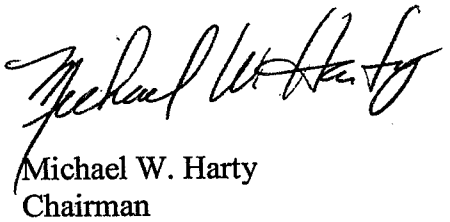
[3] 42 U.S.C. § 1395oo(a)(2007) and 42 C.F.R. §§ 405.1835-1841(2007).
[4] Queen of the Valley Medical Center (Provider no. 05-0009, FYE 6/30/06)
[5] The original individual appeal for Queen of the Valley Medical Center (FYE 6/30/06), case number 08-1116, was reopened on August 12, 2015, to transfer the LIP dual eligible days issue from a group appeal (case number 08-1742G) back to this individual appeal. The LIP dual eligible days issue has already been scheduled for hearing. As such, the Board will not transfer the LIP Code 2 & 3 eligible days issue back to this individual appeal.

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

For the Board:



Michael W. Harty
Chairman

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

cc: Darwin San Luis, Noridian Healthcare Solutions
Sharon L. Keyes, Blue Cross and Blue Shield Association

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Refer to: 05-1900G

CERTIFIED MAIL SEP 15 2015

Joanne B. Erde, P.A.
Duane Morris
200 South Biscayne Boulevard
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Kyle Browning
Appeals Lead
National Government Services
MP: INA102 - AF42
P. O. Box 6474
Indianapolis, IN 46206-6474

Re: **Duane Morris/McKay Consulting DSH DE Days Bifurcation to (1) Part A Non-Covered/Exhausted Benefits Days and (2) Part C Days**
PRRB Case No.: 05-1900G
FYE: 1999

Dear Ms. Erde:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal regarding the bifurcation of Dual Eligible days into (1) Exhausted Benefits days and (2) Part C days. The Board determined that, for providers deemed eligible (see below), it will grant the bifurcation request. The Part C days issue will be adjudicated in Case No. 15-3270G, Duane Morris 1999 II National Part C Days Group.[1] If the Board finds jurisdiction over providers appealing Part A Non-Covered and Exhausted Benefit days, those providers will be remanded pursuant to CMS Ruling 1498-R.

Background

The instant group appeal, established in 2005, framed the issue as follows:

> Is the [Medicare Administrative Contractor's] exclusion from the Medicaid percentage of all days of care rendered to dually eligible patients who were eligible for reimbursement under the State's Medicaid plan and either whose Medicare Part A benefits were exhausted or who received Part C benefits correct?[2]

[1] This letter will serve as the Acknowledgement Letter normally sent via e-mail. The parties will be informed of new position paper deadlines in a Notice of Hearing.
[2] Group Request for Hearing at 1-2, Jul. 25, 2005.

The initial appeal request included two providers, Mercy Hospital of Buffalo (Prov. No. 33-0297)[3] and Alamance Regional Medical Center (Prov. No. 34-0070). Subsequent to the establishment of the instant case, other providers transferred into this group appeal.

On June 3, 2013, the Provider Representative, Duane Morris, submitted a Case Management Plan for the "McKay Consulting Appeals," including the instant case, which adopted new deadlines for the Schedule of Providers.[4] On August 30, 2013, the Board received the Schedule of Providers from McKay Consulting ("McKay") for both Part C days and "Dual Eligible," or Exhausted Benefits, days, along with a letter addressing the bifurcation of the Dual Eligible days issue.[5] McKay wrote that it determined that "... each of the group appeals ... challenges the exclusion of both non-covered and Medicare part [*sic*] C dual eligible patients from the numerator of the DSH Medicaid fraction."[6] However, not every provider was listed on both the Exhausted Benefits and Part C days' Schedules of Providers.

The list of providers for Case No. 05-1900G is in the table below.

Provider Number	Provider Name	Original Case Number	Request for Bifurcation?
34-0070	Alamance Regional Medical Center	05-2298 (closed 02.21.06); original provider in group	Yes, both Dual Elig. and Part C
34-0030	Duke University Health System	06-2345 (closed 12.13.06)	No, Dual Elig. Schedule only
39-0256	Hershey Medical Center	02-0968 (closed 09.04.07)	No, Dual Elig. Schedule only
33-0005	Kaleida Health – 1998	08-1474 (closed 04.26.11)	Yes, Dual Elig. and Part C
33-0005	Kaleida Health – 1999	08-1475 (closed 07.01.14)	Yes, Dual Elig. and Part C
33-0005	Kaleida Health – RNPR	Direct Add	No, Dual Elig. Schedule only
33-0230	St. Vincent's Midtown Hospital	06-0049 (closed 07.11.06)	Yes, Dual Elig. and Part C
33-0226	Unity Hospital	06-0129 (closed 03.20.06)	Yes, Dual Elig. and Part C

Board Determination on Bifurcation

The Board has granted the bifurcation request regarding the Dual Eligible issue into two

[3] Mercy was not included on either Schedule of Providers and will not be addressed here.
[4] *See* Case Management Plan Letter, Jun. 3, 2013.
[5] *See* Bifurcation Letter, Aug. 30, 2013; *see also* Schedule of Providers, Aug. 30, 2013 (however, it should be noted that the Group Representative failed to include a cover page for the Dual Eligible days Schedule of Providers).
[6] *Id.* at 1.

groups:

(1) Dual Eligible Exhausted Benefits days
(2) Part C days

The Board's decision rests on the framing of the group issue and the regulations and Board Rules applicable at the time the group appeal was filed.

Prior to the 2008 revisions, the regulations required that, for a group appeal, "[t]he matters at issue involve a common question of fact or interpretation of law, regulations, or CMS Rulings."[7] Here, the group "matter at issue" is described as Dual Eligible days. The group clearly defines Dual Eligible days as "dually eligible" for Medicaid and Medicare with exhausted benefits and "dually eligible" for Medicaid and Medicare Part C. Seemingly, the group appealed multiple issues, since the group's definition of Dual Eligible days is viewed as two separate issues by the Board (i.e. Exhausted Benefits days and Part C days). However, the Board has decided to treat the "multi-component" issue as a valid appeal because of the way "Dual Eligible days" were defined in the 2004 group appeal request. The Board concludes that it will grant the bifurcation of Dual Eligible days, as long as all other jurisdictional requirements are met.

Board Determination on Jurisdiction

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

Regarding appeals from revised Notices of Program Reimbursement ("RNPR"), the applicable regulations explain that a RNPR is considered a separate and distinct determination, and, depending on when the RNPR was issued, the issue on appeal must have been either reviewed[8] or revised[9] as a prerequisite for Board jurisdiction. The 2002 Board Rules also provide:

> 3. Revised NPR - The Board accepts jurisdiction over appeals from a [RNPR] where the issue(s) in dispute were specifically adjusted by that [RNPR]. The Board typically follows the courts by limiting the scope of such an appeal to only the revised issue(s).[10]

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[7] 42 C.F.R. § 405.1837(a)(2) (2003).
[8] 42 C.F.R. § 405.1885, 1889; *see also HCA Health Services v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994) (holding 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).
[9] 42 C.F.R. § 405.1889 (2004), "When a revision is made in a determination or decision . . . after such determination or decisions has been reopened as provided in § 405.1885, such revision shall be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1835, 405.1875 and 405.1877 are applicable."
[10] Board Rule B.I.a.3 at 3, Mar. 1, 2002 (citation omitted).

The Board finds that multiple providers failed to meet jurisdictional requirements and must be dismissed from both the Dual Eligible Exhausted Benefits days and the Part C days appeals. Kaleida Health (Prov. No. 33-0005) appealed its March 13, 2012 RNPR by requesting to join the existing group appeal.[11] Kaleida Health only appealed Dual Eligible days and not Part C days in that appeal request. The Board finds that there is no evidence that Kaleida Health's Dual Eligible days were revised in its RNPR as required. In fact, the work papers specifically state that, "[Dual Eligible] Days have not been considered during the current review." St. Vincent's Midtown Hospital (Prov. No. 27-0049) timely appealed Dual Eligible days from its April 14, 2005 RNPR. St. Vincent subsequently requested to transfer its Dual Eligible days to the instant group appeal. The adjustment referenced by St. Vincent adjusted Medicaid Eligible days, not Dual Eligible or Part C days. Specifically, the Medicare Contractor noted, "[a]djustment to remove the labor and delivery days from Medicaid and Total per reopening findings."[12] St. Vincent admits that Dual Eligible days were not adjusted: "[t]he fact that the [Contractor] made no adjustment to Medicaid eligible non-covered and [P]art C days in the DSH calculation does not deprive the Board of jurisdiction."[13] The Board disagrees; the Board finds that St. Vincent failed to prove that both Dual Eligible days and Part C days were specifically revised in its RNPR. Unity Hospital timely appealed from its RNPR and transferred Dual Eligible days to the instant case. Unity referenced an adjustment entered, "[t]o adjust reported Medicaid Eligible Days per audit review."[14] Unity argued that:

> In accord with longstanding Board precedent in effect for the period at issue . . . the adjustment to some Medicaid days in the [RNPR] opens all aspects of the Medicaid days issue to appeal from the [RNPR], including subcomponents of the issue that were not adjusted, such as the Medicaid-eligible patient days at issue in this appeal for patients who were dually-eligible for Medicaid and Medicare.[15]

The Board finds that Unity's assertion that an adjustment to some Medicaid Eligible days allows the Board to take jurisdiction over Dual Eligible and Part C days is incorrect. The regulation requires a separate revision to the appealed days, which is absent in this case. The Board concludes that it lacks jurisdiction over Kaleida Health, St. Vincent, and Unity's RNPR appeals and hereby dismisses these providers.

Additionally, the Board finds that, although Kaleida Health, for fiscal years 1998 and 1999 (Prov. No. 33-0005), requested bifurcation of the Part C days issue, it did not originally raise the sub-issue of Part C days in its original appeals. However, the request to transfer the issue occurred prior to the 2008 regulation change, which limited the ability to add issues to an open appeal. Prior to the regulatory change, providers would regularly (and simultaneously) add issues to individual appeals and transfer those issues to group appeals. Therefore, the Board will

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[11] Kaleida's Request to Join Existing Appeal, Sep. 6, 2012.
[12] *See* St. Vincent's Audit Adjustment Report *attached at* Dual Eligible Schedule of Providers Tab 7D.
[13] St. Vincent's Statement of Jurisdiction *attached at* Dual Eligible Schedule of Providers Tab 7D.
[14] Unity's Audit Adjustment Report *attached at* Dual Eligible Schedule of Providers Tab 8D.
[15] Unity's Statement of Jurisdiction *attached at* Dual Eligible Schedule of Providers Tab 8D.

grant Kaleida's request to join the fully formed group and deem the "transfer" of the Dual Eligible days issue as an "add/transfer" of the Part C days issue. The Board finds that the group that the providers were transferring to explicitly defined the issue under appeal as including the Part C days component.

Alamance (Prov. No. 34-0070) will also join the new Part C days group appeal. Alamance was one of the original providers used to establish the instant group appeal, which means that Alamance's issue statement matches the group's issue statement. The Board finds that Alamance validly raised Part C days. The Part C days appeal will continue in Case No. 15-3270G.

Finally, the Board finds that it has jurisdiction over the providers in Case No. 05-1900G who requested to appeal Dual Eligible days from original NPRs. These providers either established the instant group appeal or timely filed individual appeals and were properly transferred to this group appeal. All five providers, Alamance (Prov. No. 34-0070), Duke (Prov. No. 34-0030), Hershey (Prov. No. 39-0256), Kaleida – 1998 (Prov. No. 33-0005) and Kaleida – 1999 (Prov. No. 33-0005), will be remanded under separate cover pursuant to CMS Ruling 1498-R.

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

cc: Sharon L. Keyes, BCBSA (Enclosure)

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CERTIFIED MAIL

SEP 16 2015

Kenneth R. Marcus
Honigman Miller Schwartz & Cohn
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Detroit, MI 48226-3506

RE: Baptist Memorial Hospital-North Mississippi, Provider No. 25-0034, FYE 09/30/06, as a participant in "BMHCC 2004-2006 LIP SSI% CIRP Group"
PRRB Case No.: 11-0121GC

Dear Mr. Marcus:

The Provider Reimbursement Review Board (Board) has reviewed the Schedule of Providers and the associated jurisdictional documents for case number 11-0121GC. The Board dismisses Baptist Memorial Hospital-North Mississippi from case number 11-0121GC as the LIP SSI percentage issue was not appealed in the individual appeal nor timely added to the individual appeal. As such, the LIP SSI percentage issue could not be transferred from the individual appeal to the current group appeal.

Background

On March 12, 2008, the Medicare Contractor issued a Notice of Program Reimbursement (NPR) to Baptist Memorial Hospital-North Mississippi, Provider No. 25-0034, for the cost reporting period ending September 30, 2006. On September 5, 2008, Baptist Memorial Hospital-North Mississippi filed an appeal of the NPR challenging disproportionate share hospital (DSH) Medicaid eligible days and inpatient rehab low income patient (LIP) Medicaid eligible days. The Board assigned case number 08-2859 to the appeal. On November 22, 2010, Baptist Memorial Hospital-North Mississippi requested to transfer the LIP supplemental security income (SSI) percentage issue from case number 08-2859, to the current group appeal, case number 11-0121GC.

Decision of the Board

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 ($50,000 for a group) and the request for a hearing is filed within 180 days of the NPR.[1]

Effective August 21, 2008, new Board regulations went into effect that limited the addition of issues to appeals. 42 C.F.R. § 405.1835 provides in relevant part:

[1] 42 U.S.C. § 1395oo(a)(2008) and 42 C.F.R. §§ 405.1835-1840(2008).

(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:

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(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.

Baptist Memorial Hospital-North Mississippi did not appeal the LIP SSI percentage issue in its individual appeal, case number 08-2859, and did not timely request to add the LIP SSI percentage issue to its individual appeal. The Lip SSI percentage issue clearly is a separate and distinct issue from the LIP Medicaid eligible days issue as they are reported on separate cost report worksheets and the SSI percentage issue is published by the Centers for Medicare & Medicaid Services (CMS), while the Medicaid eligible days data is accumulated by the Provider. Baptist Memorial Hospital-North Mississippi may have requested to transfer the LIP SSI percentage issue from its individual appeal, case number 08-2859, to the current group appeal, case number 11-0121GC, however, as the LIP SSI percentage issue was not appealed in the individual appeal nor timely added to the individual appeal,[2] the LIP SSI percentage issue could not be transferred to the current group appeal. As such, the Board dismisses, Provider 3, Baptist Memorial Hospital-North Mississippi, Provider No. 25-0034, fiscal year end (FYE) September 30, 2006, from the current group appeal, case number 11-0121GC.

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
Jack Ahern, MBA

For the Board:

Michael W. Harty
Chairman

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

cc: Beth Wills, Cahaba GBA c/o National Government Services
Sharon L. Keyes, Blue Cross and Blue Shield Association

[2] Baptist Memorial Hospital-North Mississippi had until November 12, 2008, to add the LIP SSI percentage issue to its appeal. The Provider did not add the LIP SSI percentage issue to the appeal by this date.

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Refer to:

14-2469GC

SEP 17 2015

Certified Mail

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Bill Tisdale
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Pittsburgh, PA 15219

RE: Texas Health Partners FFY 2014 0.2% IPPS Rate Reduction Group
Provider Nos. Various
FFY 2014
PRRB Case No. 14-2469GC
EJR Determination

Dear Messrs. Polston and Tisdale:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' comments agreeing that own motion expedited judicial review (EJR) is appropriate for the issue under dispute. The decision of the Board with respect to EJR is set forth below.

Background

Issue Under Appeal

Whether the Secretary's adjustment to the Medicare hospital inpatient prospective payment system (IPPS) standardized amount to account for the adoption of the "two-midnight" rule was lawful; and if it was lawful, whether the adjustment (-0.2 percent) was . . . the correct amount or should it have been less of a reduction or an increase in the standardized amount?[1]

Statutory and Regulatory Background

In the final inpatient prospective payment system (IPPS) rule for Federal fiscal year (FFY) 2014, the Secretary of Health and Human Services (Secretary) indicated that she had expressed concern in the proposed calendar year (CY) Outpatient PPS (OPPS) rule[2] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving observation services.

[1] Providers' February 14, 2014 Hearing Request, Tab 2.
[2] 77 Fed. Reg. 45,061, 45,155-57 (July 30, 2012) and the final rule with comment period, 77 Fed. Reg. 68,210, 68,426-33 (Nov. 15, 2012).

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

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

In response to this concern, the Secretary proposed clarifications and changes regarding hospital payment under both Part A and Part B. The Secretary proposed to revise the Part B inpatient payment policy to allow payment under Part B for all reasonable and necessary hospital services furnished if the beneficiary had been treated as a hospital outpatient, rather than admitted as an inpatient. This policy would apply when a Medicare Part A hospital inpatient claim was denied or when a hospital determines after a discharge that the inpatient visit was not reasonable and necessary. The timely filing restrictions for Part B billing were not changed (claims must be filed within one year from the date of service).[5]

Medicare Part A

In addition, the Secretary reviewed hospital inpatient status criteria to improve CMS' policies governing when a Medicare beneficiary should be admitted as an inpatient and how hospitals should be paid for associated costs. The Medicare Benefit Policy Manual[6] states that the typical decision to admit a beneficiary as an inpatient should be made within 24 to 48 hours after observation care and that an overnight stay may be a factor in the admission decision. Physicians should use the 24-hour or overnight period as a benchmark, i.e., patients who are expected to need care for 24 hours or overnight should be admitted. Generally, a beneficiary is considered an inpatient if formally admitted with the expectation that he or she will remain in the hospital overnight, regardless of whether there is a later transfer or discharge resulting in no overnight patient stay. Only rarely and in exceptional cases do reasonable and necessary observation services span more than 48 hours. Length of stay is not the sole basis for payment, it is the physician responsible for patient care who determines if the patient should be admitted.[7]

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[3] 78 Fed. Reg. 50,496, 50,907 (Aug. 19, 2013).
[4] *Id.*
[5] *Id.*
[6] CMS Pub. 100-02, Chapter 6, § 20.6 and Chapter 1, § 10.
[7] 78 Fed. Reg. at 50,907-08.

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

Medicare Part B

In the final IPPS rule, the Secretary noted there had been an increasing number of hospitals appealing Part A inpatient claim denials in which it was determined the inpatient admissions were not reasonable or necessary. These claims received partial favorable treatment by the Medicare Appeals Council or Administrative Law Judges (ALJs). In those cases, the Medicare review contractor determinations that the inpatient admission was not reasonable or necessary was upheld, however, the Medicare Appeals Council and ALJ decisions ordered payment of the services as if they were rendered in an outpatient or observation level of care. These decisions effectively required Medicare to issue payment for all Part B services that would have been payable had the patient been treated as an outpatient (rather than an inpatient). In addition, payments were made regardless of whether or not the subsequent hospital claims were within the applicable time limit for filing Part B claims. The Secretary pointed out that this was contrary to longstanding polices that permitted billing for only a limited list of Part B inpatient services and required that the services be billed within specific timeframes.[10]

As a result of the number of these administrative adjudications, the CMS Administrator issued Ruling CMS-1455-P[11] (the Ruling) which established a standard process for effectuating the decisions granting Part B coverage. Among other things, where the administrative adjudicator had issued an order for payment under Medicare Part B, the request for Part B payment would not be rejected if more than one year had elapsed (the time period for filing Part B claims), if the Part A claim had been submitted timely. The Ruling was to remain in effect until the effective date of regulations that finalized "Medicare Program; Part B Billing in Hospitals." In the August 19, 2013 Federal Register, the Secretary revised the Part B inpatient payment policy to allow payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require outpatient status.[12] The 1-year deadline for filing claims remained unchanged and the Secretary stated that she was

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[8] *See generally* 78 Fed. Reg. 27,486 (May 10, 2013).
[9] 78 Fed. Reg. 50,908.
[10] *Id.*
[11] *See* 78 Fed. Reg. 16,614 (Mar. 18, 2013), http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings.html.
[12] 78 Fed. Reg. at 50,909.

not creating an exception to this requirement (as found in 42 C.F.R. §§ 424.44(b)(1)-(4)) even though the contractor claims review and appeal process could exceed the 1-year filing period.[13]

The 2-Midnight Rule

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

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

The Secretary's actuaries estimated that the 2-midnight rule would increase IPPS expenditures by approximately $220 million. These additional expenditures would result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving from OPPS to IPPS and some encounters of less than 2 midnights moving from IPPS to OPPS. The actuaries estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient from the approximately 11 million encounters paid under IPPS. This shift of 40,000 net encounters represents an increase of approximately 1.2 percent in the number of shorter stay hospital inpatient encounters paid under IPPS. This additional expenditure would be partially offset by reduced expenditures from the shift of shorter stay hospital inpatient encounters to hospital outpatient encounters. The actuaries estimated that, on average, the per encounter payments for these hospital outpatient encounters would be approximately 30 percent of the per encounter payments for the inpatient encounters. In light of the impact of the 2-midnight rule on IPPS and the systematic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, the Secretary decided it was appropriate

[13] *Id.* at 50,927.
[14] *Id.* at 50,944.
[15] *Id.*
[16] *Id.* at 50,945.

to use her exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i) to offset the $220 million in additional IPPS expenditures associated with the 2-midnight policy. Consequently, the standardized amount was reduced by 0.2 percent.[17] The Secretary made the same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[18]

Providers' Position

The Providers contend that the Secretary's decision to apply a downward 0.2 percent adjustment to the operating IPPS standardized amount, the capital Federal payment rate, and sole community hospitals' and Medicare dependent hospitals' hospital specific rates for the FFY 2014 as set forth in the Federal Register[19] was unlawful and should be reversed because:

- The adjustment exceeds the Secretary's statutory authority to adjust PPS standardized amounts;
- The amount of the adjustment is unsupported by data and is arbitrary and capricious; and
- The Secretary violated [the] Administrative Procedure Act's notice and comment rule-making requirements because of insufficient discussion of the data and assumptions purporting to support the amount of the adjustment and failing to address or take into account public comments to the proposed rule.

The Providers contend that CMS' adoption of the IPPS payment reduction is arbitrary and capricious and violated its rulemaking obligations under the Administrative Procedure Act. In the proposed rule, the CMS [sic the Secretary] estimated the number of prior patient encounters from FFY 2009 through FFY 2011 that would have changed from inpatient to outpatient (and vice-versa) under the new two-midnight policy. CMS estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient. The net effect of the two-midnight rule, according to CMS, would be 40,000 inpatient admissions payable under Medicare Part A rather than Part B.[20] CMS estimated that the 40,000 new admissions would increase Part A expenditures by $220 million or 0.2 percent of annual IPPS payments.[21]

The Providers do not believe that CMS' calculations are supported by the data the Secretary cites, and the agency has disregarded comments identifying errors in the agency's reasoning.

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[17] *Id.* at 50,952-53.
[18] *Id.* at 50,990.
[19] 78 Fed. Reg. 50,496 (Aug. 19, 2013).
[20] *Id.* at 50952-54.
[21] *Id.*

Commenters indicated in the final PPS rule that, using publicly available files, they would not replicate CMS' calculations and argued that the adoption of the 0.2 percent payment reduction would be improper and not supported by data. The Commenters noted that under the two-midnight rule, nearly all of those inpatient stays would shift to outpatient encounters.[22]

The Providers contend that CMS' decision to adopt a 0.2 percent downward adjustment to IPPS violates section 706(2) of the Administrative Procedure Act,[23] as an arbitrary and capricious agency action. First, the Providers allege that because CMS adopted a proposal that runs counter to the data upon which it relied, the Agency action must be set aside. Second, CMS altogether failed to respond to commenters' analysis in the final IPPS rule which undermines the public's ability to meaningfully comment on a rule. Third, the agency failed to articulate a rational connection between the facts found and the choice made. The Providers believe the agency failed to examine the relevant data and articulate a satisfactory explanation for its action. Finally, the Providers assert the Secretary did not have the authority under 42 U.S.C. § 1395ww(d)(5)(I)(i), or any other provision of the law, to make a downward adjustment in the rates set under § 1395ww(d).[24]

Decision of the Board

The Board has reviewed the Providers' request for hearing and comments regarding the proposed own motion EJR determination. The regulation, 42 C.F.R. § 405.1842(c), permits the Board to consider on its own motion whether it lacks the authority to decide a legal question relevant to the matter at issue once it has made a finding that it has jurisdiction to conduct a hearing under the provisions of 42 C.F.R. § 405.1840(a). With respect to jurisdiction, the Board concludes that each of the Providers in the case referenced above timely filed their requests for hearing from the issuance of the August 19, 2013 Federal Register.[25] The amount in controversy exceeds the $50,000 threshold necessary for a group appeal.[26] Consequently, the Board has determined that it has jurisdiction over the appeal. Further the Board finds that it lacks the authority to decide the legal question of whether the 0.2 percent adjustment to IPPS is appropriate; therefore, EJR is appropriate for the issue under dispute in this case.

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[22] Providers' February 14, 2014 Hearing Request, Tab 2, pp. 3-5.
[23] 5 U.S.C. § 706(2).
[24] Providers' February 14, 2014 Hearing Request, Tab 2, pp. 6-9.
[25] *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986) ("[A] year-end cost report is *not* a report which is necessary in order for the Secretary to make PPS payments, and the appeals provision applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal") and *District of Columbia Hosp. Ass'n Wage Index Group Appeal*, HCFA Adm'r Dec., Medicare & Medicaid Guide (CCH) ¶ 41,025 (Jan. 15, 1993) (publication of the wage index in the Federal Register is a final determination which can be appealed to the Board).
[26] *See* 42 C.F.R. § 405.1837(a)(3).

The Board finds that:

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

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

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

4) it is without the authority to decide the legal question of whether the Secretary's 0.2 percent reduction to the standardized amount, the hospital specific rate for the issue, is valid.

Accordingly, the Board finds that the 0.2 percent reduction issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants expedited judicial review on its own motion for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

Board Members Participating

Michael W. Harty
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 Schedule of Providers

cc: Sharon L. Keyes, BCBSA (w/Schedule of Providers)

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Refer to: 13-0413

CERTIFIED MAIL

SEP 17 2015

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 Audit & Reimbursement
CGS Administrators
P.O. Box 20020
Nashville, TN 37202

RE: Akron General Medical Center
Provider No.: 36-0027
FYE: 12/31/2007
PRRB Case No.: 13-0413

Dear Ms. Goron and Ms. Cummings:

The above-referenced case involves a provider's appeal of its Medicare reimbursement for the fiscal year ending ("FYE") on December 31, 2007. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the jurisdictional documents in this appeal and determined that it has jurisdiction over Akron General Medical Center's ("Akron's") appeal of its Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") fraction issues with respect to its SSI percentage and Medicare Managed Care Days[1] issues but does not have jurisdiction over Akron's Dual Eligible Days issues in either the Medicare/SSI fraction or Medicaid fraction.

Pertinent Facts

On December 28, 2012, the Board received Akron's timely filed request for hearing ("RFH") based on Akron's October 23, 2012 Notice of Program Reimbursement ("NPR"). Within its RFH, Akron appeals two issues: DSH/SSI and Rural Floor Budget Neutrality Adjustment ("RFBNA").[2] For its first issue, DSH/SSI, Akron claims that "[t]he Secretary [i]mproperly calculated the Provider's DSH/SSI percentage" because (1) the Secretary improperly included Medicare Advantage days in the SSI fraction, and (2) the Secretary failed to adhere to the required notice and comment procedures when she adopted her policy on Medicare Advantage ("MA") and Exhausted Benefit ("EB") days.

Following Akron's submission of its preliminary position paper, BlueCross and BlueShield Association ("BCBSA") filed a jurisdictional challenge with the Board on October 28, 2013. BCBSA argues that Akron improperly expanded its appeal request by briefing the dual eligible days issue in its preliminary paper. On March 26, 2014, the Board received Akron's response ("Response") to BCBSA's jurisdictional challenge.

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[1] Medicare Managed Care days are also referred to as "Medicare Advantage" ("MA") or "Medicare Part C" ("Part C") days.

[2] Akron's RFBNA issue was granted expedited judicial review as part of a multi-provider plaintiff group.

On July 31, 2014, the Board received Akron's five "Request to Transfer Issue to a Group Appeal" forms in which Akron requests to split and transfer its DSH/SSI issue into the following five sub-issues and groups:

1. DSH/SSI Percentage to Case No. 14-0365G;
2. DSH SSI Fraction Dual Eligible Days to Case No. 14-3519G;
3. DSH Medicaid Fraction Dual Eligible Days to Case No. 14-0366G;
4. DSH SSI Fraction Medicare Managed Care Days to Case No. 14-3518G; and
5. DSH Medicaid Fraction Medicare Managed Care Days to Case No. 14-0369G.

BCBSA's Jurisdictional Challenge

BCBSA states that the Board does not have jurisdiction over either of Akron's "Dual Eligible Days" issues (SSI Fraction or Medicaid Fraction) because Akron did not properly appeal these issues and that Akron improperly "expand[ed] upon the appeal request issues" by briefing the dual eligible days issues in its preliminary position paper. BCBSA argues that Akron did not specifically identify these issues in its RFH, as required under the applicable regulations and Board Rules, and that Akron's "impact calculation" did not include any impact calculations for the dual eligible days.

Akron's Response

Akron claims that the Board has jurisdiction over its appeal of its dual eligible days issues because the issues were part of five "distinct sub-issues" contained within its DSH/SSI issue. Akron states that "based on discussions with the Board," it "broke out the sub-issues" and briefed them separately in its preliminary position paper. Akron also claims that the dual eligible days issues were "timely appealed in the appeal request."

Board's Analysis and Decision

A timely filed RFH that meets the applicable jurisdictional and procedural requirements set out under 42 C.F.R. § 405.1835(a)[3] must also 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

[3] A provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if the provider is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more and the request for a hearing is filed within 180 days of the provider's receipt of its final determination.

> 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.[4]
> . . .

The Board's 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.)

For Akron to successfully appeal its five DSH issues—DSH/SSI Percentage, DSH SSI Fraction Dual Eligible Days, DSH Medicaid Fraction Dual Eligible Days, DSH SSI Fraction Medicare Managed Care Days and DSH Medicaid Fraction Medicare Managed Care Days—the Board must have jurisdiction over the issues. In order for the Board to have jurisdiction over the issues, Akron must have either complied with the above-listed specificity requirements within its RFH with respect to the five issues or timely added the issues to its appeal. The Board did not receive a request to add issues to this appeal from Akron and, therefore, the Board's analysis of Akron's RFH issue statements and accompanying documentation is set forth below.

Akron lists two issues in its RFH: "Issue 1: Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI")" and "Issue 2: Rural Floor Budget Neutrality Adjustment." In support of its appeal, Akron also filed two impact calculation documents along with its RFH: one that describes the "TOTAL ESTIMATED MEDICARE ADVANTAGE DAYS IMPACT ON DSH," and one that describes the "Estimated Impact of 1.100% (3) increase in Rural Floor Budget Neutrality Adjustment."

Medicare Managed Care Days/MA Days Issue

Within its RFH documentation, Akron provides additional detail regarding its issues. Beneath its first issue, DSH/SSI, Akron's issue statement states that the Secretary improperly calculated the Provider's DSH/SSI percentage for two reasons that Akron has underlined: (1) the Secretary improperly included MA days in the SSI fraction ("first argument"), and (2) the Secretary failed to adhere to required notice and comment rulemaking procedures in adopting "its" policy on MA and EB days ("second argument"). Then, under its first argument, Akron specifically describes

[4] 42 C.F.R. § 405.1835(b) (2012).

its dissatisfaction with the Medicare Contractor's treatment of its MA days in both its SSI/Medicare Fraction and Medicaid Fraction within the DSH calculation.

Based on these facts, the Board finds that Akron has described both of its DSH MA days issues in its RFH with the specificity required by the applicable rules and regulations, thus, the Board has jurisdiction over these two issues and acknowledges the transfer of these issues to Case Nos. 14-3518G (SSI/Medicare Fraction) and 14-0369G (Medicaid Fraction).

Dual Eligible Days Issue

Within its preliminary position paper, Akron describes two of its DSH issues as falling under the category of "Calculation of Exhausted Benefit ("EB") and Medicare Second Payor ("MSP") days." Akron refers to this issue as "Dual Eligible Days." In its Response to BCBSA's claim that Akron did not include the "Dual Eligible Days" issue in its RFH, Akron claims that it is a sub-issue of DSH/SSI and, thus, was timely appealed in its RFH documentation. However, in its RFH, Akron only uses the term "dual eligible" in terms of its MA days issue when it is describing patients that are "dually eligible" for MA and Medicaid. In fact, Akron only refers to EB days in its RFH generally when it describes its second argument that states that, without appropriate warning, the Secretary reversed her position with respect to the treatment of EB and MA days in the DSH calculation. Other than this general argument, there is only one other mention of EB days and only one reference at all to MSP days in Akron's RFH:

> The Provider contends that CMS 1498-R, issued April 28, 2012, is not applicable to this appeal. CMS 1498-R is applicable to appeals challenging the exclusion of EB and MSP days from the Medicaid fraction only when the patient days at issue occurred prior to October 1, 2004. However, all of the patient days at issue in this case occurred subsequent to that date.

While Akron does generally reference EB and MSP days in this paragraph, it never refers to them collectively as the "Dual Eligible Days" issue; never specifically describes this issue, as it does when describing its MA days issue; and never includes these days as any part of its impact calculations, as it does with its MA days.

As noted prior, Board Rule 8 states that each item in dispute must be specifically identified and appealed as a separate issue. Board Rule 8 also states that the DSH issue is an issue made up of multiple components and even cites "dual eligible" as an example of a component. Akron states that it only broke out its five sub-issues after discussions with the Board, but these instructions are clear and were in effect at the time that Akron filed its appeal. Akron appears to have been aware of these instructions as it followed them when, in its RFH, it specifically described its dissatisfaction with the Medicare Contractor's treatment of its MA days with respect to its DSH calculation.

In BCBSA's jurisdictional challenge, BCBSA argues that Akron's dual eligible days issues were not specifically identified in its appeal request and that Akron is trying to improperly add the issues in its preliminary position paper. As additional evidence of this assertion, BCBSA points

to the fact that Akron submitted an impact calculation document for the MA days issues but failed to do so for its dual eligible days issues. In its Response, Akron fails to explain away this discrepancy and, in fact, provides no support at all for its claim that all its issues were timely appealed, other than the statement that it only "broke out the sub-issues" based on "discussions with the Board." Akron also fails to address why, if its DSH/SSI issue was generally stated in its RFH, it specifically identified and described two of its "sub-issues" related to MA days but failed to do the same for its dual eligible days issues.

The Board finds that Akron did not properly include its two dual eligible days issues in its RFH, nor did Akron add these issues to its present appeal. Therefore, the Board does not have jurisdiction over these issues and the issues are dismissed from the appeal. Accordingly, the Board is denying Akron's request to transfer these issues to Case Nos. 14-3519G and 14-0366G.

DSH/SSI Percentage

In its RFH, Akron lists its first issue as "Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI")." Akron's "Description of the Issue" asks "[w]hether the Medicare Administrative Contractor, CGS Administrators, LLC, ("MAC") used the correct SSI percentage in the DSH calculation." Akron then states its issue as "[t]he Secretary [i]mproperly calculated the Provider's DSH/SSI percentage for the following reasons . . ." Finally, within its second argument under this issue, Akron claims that "CMS 1498 is also inapplicable to the portion of this appeal challenging the SSI matching methodology." Akron goes on to argue that the Centers for Medicare & Medicaid Services ("CMS") already used its revised matching methodology when computing Akron's SSI percentage, and, therefore, remanding this appeal would serve "no possible purpose." These statements, when viewed together, appear to identify and describe DSH/SSI percentage as an issue in this appeal and explain that Akron's dissatisfaction with its DSH/SSI percentage is CMS' current SSI matching methodology.

Although Akron did not separately break this issue out in its appeal, the Board finds that Akron identified and described its dissatisfaction with this issue sufficiently to allow the Board to assume jurisdiction over this issue and acknowledges the transfer of this issue to Case No. 14-0365G.

Summary

The Board finds that it has jurisdiction over Akron's following issues (as described by Akron): DSH/SSI Percentage, DSH SSI Fraction Medicare Managed Care Days and DSH Medicaid Fraction Medicare Managed Care Days. As such, the Board hereby acknowledges Akron's issue transfers—Akron's DSH/SSI Percentage Issue to Case No. 14-0365G, Akron's DSH SSI Fraction Medicare Managed Care Days Issue to Case No. 14-3518G, and Akron's DSH Medicaid Fraction Medicare Managed Care Days to Case No. 14-0369G.

However, the Board finds that it does not have jurisdiction over either of Akron's Dual Eligible Days Issues, namely, DSH SSI Fraction Dual Eligible Days and DSH Medicaid Fraction Dual

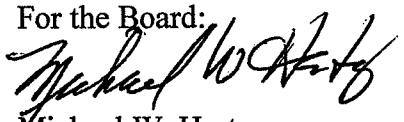
Eligible Days. Accordingly, the Board hereby denies the transfer of these issues into Case Nos. 14-3519G and 14-0366G and dismisses the issues from the present appeal.

As Akron's sole remaining issue in the present appeal, the DSH SSI Issue, has been sub-divided and transferred or dismissed as explained above, there are no remaining issues in Case No. 13-0413 and the Board is hereby closing this case and removing it from the docket.

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

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

For the Board:



Michael W. Harty
Chairman

cc: Sharon L. Keyes, Executive Director, Blue Cross and Blue Shield Association

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SEP 17 2015

CERTIFIED MAIL

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

RE: Sutter Auburn Faith Hospital, Provider No. 05-0498, FYEs 12/31/04 and 12/31/05, PRRB Case Nos.: 08-0933 and 08-0943

Dear Mr. Jaeger:

The Provider Reimbursement Review Board (Board) has reviewed the Schedule of Providers and the associated jurisdictional documents for case numbers 08-0933 and 08-0943. The Board dismisses the LIP dual eligible days issue from case numbers 08-0933 and 08-0943 as the Provider's listings of days under appeal ties to the number of days it received on its final settled cost report. There are no additional LIP dual eligible days in dispute.

Background

On September 11, 2007, and September 19, 2007, the Medicare Contractor issued Notice of Program Reimbursements (NPRs) to Sutter Auburn Faith Hospital, provider number 05-0498, for the cost reporting periods ending December 31, 2004 and 2005. On February 19, 2008, Sutter Auburn Faith Hospital filed appeals of the NPRs challenging Medicare bad debts, disproportionate share hospital (DSH) dual eligible days, DSH SSI ratio, DSH elimination of labor and delivery room days, low income patient (LIP) SSI ratio, LIP dual eligible days, and rural floor budget neutrality. The Board assigned case numbers 08-0933 and 08-0943 to the appeals.

On November 24, 2008, a revised NPR was issued to Sutter Auburn Faith Hospital for the fiscal year end (FYE) December 31, 2005. On May 11, 2009, Sutter Auburn Faith Hospital filed an appeal of the revised NPR challenging the DSH SSI ratio and the DSH SSI ratio realignment. The Board incorporated the appeal of the revised NPR into case number 08-0933. All issues with the exception of the LIP SSI ratio and LIP dual eligible days have been transferred to group appeals.

Decision of the Board

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

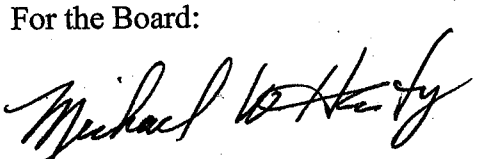
Contractor, the amount in controversy is $10,000 or more ($50,000 for a group) and the request for a hearing is filed within 180 days of the NPR.[1]

Sutter Auburn Faith Hospital in its initial appeal request for case numbers 08-0933 and 08-0943 requested an additional 25 LIP dual eligible days. On July 31, 2015, the Board requested a listing from Sutter Auburn Faith Hospital of the LIP dual eligible days in dispute. On August 24, 2015, Sutter Auburn Faith Hospital provided the Board with a listing of 158 Medicaid eligible days for case number 08-0943 and a listing of 141 Medicaid eligible days for case number 08-0933. These are the exact number of days in Sutter Auburn Faith Hospital's final settled cost reports for fiscal years (FYs) 2004 and 2005. Sutter Auburn Faith Hospital does not have any additional dual eligible days in dispute for either year. Although Sutter Auburn Faith Hospital has posed a legal challenge to CMS' policy of not counting dual eligible days in the Medicaid fraction, they themselves cannot claim "dissatisfaction" with the final determinations as they have *no* denied dual eligible days for the years under appeal. As such, the Board dismisses the dual eligible days issue from case numbers 08-0933 and 08-0943.

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

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

For the Board:



Michael W. Harty
Chairman

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

cc: James Lowe, Cahaba Safeguard Administrators, LLC
Sharon L. Keyes, Blue Cross and Blue Shield Association

[1] 42 U.S.C. § 1395oo(a)(2007) and 42 C.F.R. §§ 405.1835-1841(2007).

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Refer to:

CERTIFIED MAIL

SEP 17 2015

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

RE: Jurisdictional Decision – on revised NPR appeals for
NYU Hospitals Center (33-0214), FYEs 12/31/2000 and 12/31/2001

As participants in NYU Healthcare System 2000-9/30/2004 Dual Eligible Days CIRP Group, PRRB Case No.: 09-0926GC

Dear Mr. Blumberg:

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced common issue related party (CIRP) group appeal which is subject to CMS Ruling 1498-R. The Board notes an impediment to jurisdiction over two of the participants in the group. The background and the Board's jurisdictional determination are set forth below.

Background

NYU Hospitals Center (Participant 1)

The Provider was issued a Notice of Program Reimbursement (NPR) on May 26, 2006. The Provider filed an individual appeal on November 3, 2006 to which the Board assigned case number 07-0247. On May 1, 2009 the Provider requested the transfer of the Dual Eligible Days issue to the subject group appeal.

The Provider was issued a revised Notice of Program Reimbursement (RNPR) on February 3, 2012. On August 2, 2012 the Provider filed a Model Form E/Direct Appeal From Final Determination to Existing Group.

The Representative supplied a copy of the audit adjustment page referencing audit adjustment 4 which was an adjustment "To include SSI %, revised T-19 days and include revised DSH payment as a result of DSH appeal review." The Representative did not supply any of the other documentation (workpapers) required to support an adjustment to Dual Eligible Days on the RNPR.

NYU Hospitals Center (Participant 2)

The Provider was issued a NPR on March 25, 2008. The Provider filed an individual appeal on July 31, 2008 to which the Board assigned case number 08-2481. On March 23, 2009 the Provider requested the transfer of the Dual Eligible Days issue to the subject group appeal.

The Provider was issued a RNPR on March 15, 2010. On September 13, 2010 the Provider filed a Model Form E/Direct Appeal From Final Determination to Existing Group.

The Representative supplied a copy of the audit adjustment page referencing audit adjustment 1, which adjusted Medicaid eligible and paid days by removing 420 eligible days from the partial paid listing and adjustment 2 which was an adjustment DSH. The Representative did not supply any of the other documentation (workpapers) required to support an adjustment to Dual Eligible Days on the RNPR.

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.

Although the Intermediary did not file a jurisdictional challenge the Board, nonetheless, finds that it does not have jurisdiction over NYU Hospitals' RNPR appeals.

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).

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

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.

(b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.

(b)(2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

In this case, the documentation is not sufficient to support that Dual Eligible Days were revised for Participants 1 and 2. Therefore, the Board hereby dismisses NYU Hospitals' RNPR appeals from case number 09-0926GC.

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.

Enclosed, please find a Standard Remand of Medicare Dual Eligible Days Under CMS Ruling CMS-1498-R for the remaining participants in the group.

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
Standard Remand of Medicare Dual Eligible Days Under CMS Ruling CMS-1498-R
Schedule of Providers

cc: Sharon L. Keyes, Executive Director, BCBSA (w/enclosures)
Kyle Browning, National Government Services (w/enclosures)

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Refer to: 14-4020GC

SEP 21 2015

CERTIFIED MAIL

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

RE: PRRB Decision
Request for Expedited Judicial Review
Squire Patton Boggs 2012 Medicare Outliers – Lee Memorial CIRP Group
PRRB Case No. 14-4020GC

Dear Mr. Nash:

The Provider Reimbursement Review Board's ("PRRB or Board") decision with respect to the above referenced request is set forth below.

Background

The Providers filed their request for a Common Issue Related Party (hereinafter "CIRP") group appeal on August 25, 2014. The sole issue in the appeal is whether or not the Providers received the proper amount of supplemental Medicare outlier payments to which they are entitled. All of the Providers claim a right to a hearing based upon the fact they did not receive a timely final determination, or Notice of Program Reimbursement (hereinafter "NPR"), from the Medicare contractor. The Providers notified the Board that this CIRP group appeal was complete on July 28, 2015.[1]

On August 24, 2015, the Providers filed a request for expedited judicial review (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[2] and the fixed loss threshold ("FLT") Regulations[3] (collectively, the "Medicare Outlier Regulations")

[1] One Provider, Cape Coral Hospital (Provider No. 10-0244), has also appealed the same outlier issue from its NPR dated September 11, 2014, and the appeal of the outlier issue from that NPR was consolidated or merged into this appeal.
[2] *See* Providers' August 21, 2015 EJR request, Page 2, n. 2.
[3] *Id.* at n. 3.

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

Providers' Request for EJR

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

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

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

The Providers contend, in its later investigations of hospitals it believed had engaged in charge inflation, the DOJ alleged that the practice of "turbo-charging" led directly to inflated claims for payments under the Medicare outlier program, which the DOJ characterized as "false claims."

[4] 42 U.S.C. § 1395ww(d)(5)(A)(i)-(iv).
[5] 42 U.S.C. § 1395ww(d)(3)(B).
[6] *See, e.g.*, *Amicus Curiae Mem.* of U.S.A in Resp. to Tenet Healthcare Corp's Mot. to Dismiss, *Boca Raton Cmty. Hosp.*, ECF No. [49], at 4 (S.D. Fla. May 17, 2005).
[7] *Id.* at 4-5.
[8] Providers' EJR Req. at 4-5.

The Providers argue these and other inflated claims led HHS to increase the FLTs at a precipitous rate in an attempt to ensure that the total amount of outlier payments made for discharges in the fiscal years at issue would remain at 5.1 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year.[9]

The Providers maintain beginning in or around federal fiscal year (FFY) 1998, HHS began making substantial upward adjustments to the FLTs. These adjustments were at a rate far in excess of the rate of growth of inflationary indices routinely used by HHS, such as the CPI-Medical Index or the Medicare Market Basket. For instance, from 1997 through 2003, HHS increased the FLTs by more than 246%, when by its own admission there was modest cost inflation (of between 22% and 26%) for the same period. The Providers assert although the Secretary purported to calibrate the FLT adjustments to historical inflation data, the actual increase in FLTs bore no discernible relationship to cost inflation; in fact they were more than 10 times higher.[10]

The Providers contend in late 2002, HHS disclosed that it was aware of "turbo charging" and that it would be amending the outlier payment regulations to fix the vulnerabilities in the same.[11] The Providers assert in its previous promulgating and amending the outlier payment regulations, HHS had variously represented there were no critical flaws in its outlier payment regulations, that it had always used the best available data, and that it would not make retroactive corrections to outlier payments. Then in March 2003, in the process of amending the outlier payment regulations, CMS did an about face on all three of these points, admitting that there were three critical flaws in its outlier payment regulations, that other data, which had always been available and was better, should be used and that the outliers case payments would now be subject to reconciliation.[12]

The Providers argue while the agency was in the process of reversing its position on each of these points, HHS had the opportunity (if not the statutory and/or fiduciary obligation) to reset its FLT to correct for what it openly acknowledged had been the improper redistribution of the Medicare funds allocated for outlier case payments—literally billions of dollars of improper payments made to a few "turbo charging" hospitals, at the expense of the many. Instead, after reviewing hundreds of public comments, most urging HHS to lower the FLT, the agency announced that it would leave the threshold where it was, $33,560.[13]

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[9] *Medicare Outlier Payments to Hospitals: Hearing Before a Subcomm. of the S. Comm. on Appropriations*, 108th Cong. 3-17 (2003) (statement by Thomas A. Scully Administrator, Centers for Medicare and Medicaid Services, Department of Health and Human Services).
[10] Providers' EJR Req. at 5.
[11] *See* CMS *Program Memorandum*, Transmittal A-02-122 (Dec. 3, 2002); CMS *Program Memorandum*, Transmittal A-02-126 (Dec. 20, 2002); CMS *Program Memorandum Intermediaries*, Transmittal A-03-058, July 3, 2003; and CMS Manual System, Pub. 100-04 Medicare Claims Processing, Transmittal 707, October 12, 2005, Change Request 3966.
[12] *See* 68 Fed. Reg. 34,494, 34,496 and 34,501 (June 9, 2003).
[13] Providers' EJR Req. at 6.

The Providers assert HHS did not disclose that the agency had known six months earlier how to fix the problems engendered by its earlier flawed regulations and believed it was obligated to do so immediately. The Providers contend HHS also did not disclose in that rulemaking that then-HHS Secretary Thompson and then-Administrator Scully had cleared and signed an interim final regulation (the IFR) and submitted the IFR to the Office of Management and Budget (OMB) for presumptive approval on February 12, 2003.[14] The Providers maintain the IFR contained facts and analysis on the basis of which HHS concluded it was required, mid-year, to lower its fiscal year (FY) 2003 FLT to $20,760 (from $33,560) (*i.e.*, that the 2003 FLT was approximately 62% higher than it should have been) in order to comply with the outlier statute's mandates and the intent of Congress.[15] The Providers contend in stark contrast, HHS' subsequent rulemakings, beginning with the proposed regulation published on February 28, 2003 (March 5, 2003, in the Federal Register),[16] omitted key data, facts, analysis and conclusions. The Providers argue HHS failed to mention, amongst other key information, the agency's considered analysis quantifying the impact of the "turbo-charging" hospitals on its FLT adjustments, the need and method to remove the "turbo-charged" data and what HHS believed to be its statutory obligation to lower the FLT.

The Providers argue contrasting the data, other facts, and analysis set forth in the IFR with HHS' subsequent published rulemakings, it is clear that HHS used corrupted data, and knowingly disregarded its own concurrent provider-favorable conclusions and alternatives in setting the FLTs for fiscal year end (FYEs) 2003-2010. The Providers maintain they did not learn of the IFR until 2012 – and then only through a Freedom of information Act (FOIA) request that through their counsel, submitted to OMB's Office of Information and Regulatory Affairs (OIRA) for various documents related to the Medicare outlier program. The Provider contends as for FYEs 2007-2011, the IFR continued to be relevant because HHS still had not accounted for the impact of the "turbo-charging" data, still relied on hyper-inflated data in projecting the FLTs, and still had not returned the FLTs anywhere close to the levels dictated by analysis set forth in the IFR. Instead, HHS repeatedly set the FLTs at levels which paid out significantly less than the agency's stated target of 5.1% of total IPPS payments. As a result, the Providers argue they did not receive the full amount of the outlier case payments to which they are entitled under the outlier statute.[17]

The Providers allege on June 28, 2012, HHS Office of Inspector General (OIG) issued a report with results from its review of CMS' outlier reconciliation process (the 2012 OIG Report). The 2012 OIG Report reveals the inaccuracy of (and the key information omitted from) HHS' stated reason for not considering the impact of reconciliation, in establishing the FLTs for FYEs 2004-2011. The Providers maintain the Inspector General noted that seven years after the 2003

[14] Providers' EJR Req. at 6-7.
[15] *Id.* at 7.
[16] *See* 68 Fed. Reg. 10,420 (March 5, 2003).
[17] Providers' EJR Req. at 9-10.

publication of the regulation requiring reconciliation of outlier payments, CMS had not reconciled any of the cost reports screened and reported by Medicare Administrative Contractors (MACs). The Providers contend in a later 2013 OIG Report, OIG noted that although nearly all hospitals received some outlier payments, a small percentage of hospitals received a significantly higher proportion (almost 6 times higher) of outlier payments than others. These high-outlier hospitals charged Medicare substantially more for the same Medical Severity Diagnostic Related Groups (MS-DRGs), even though their patients had similar lengths of stay as the average in all other hospitals. The Providers argue HHS failed to notice and correct this unusual distribution of outlier payments.[18]

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

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

2.) The Secretary has violated well-settled principles of judicial review of agency action in that CMS has not used the best available data, and in fact, has used faulty data when establishing FLTs even when admonished by hospitals. Also, the FLTs established by CMS have borne no discernible, much less logical, relationship to CMS' published "inflationary factors."[19]

3.) The FLTs themselves, as calculated pursuant to HHS published criteria, have been (and continue to be) invalid because CMS used data that was not the best available data, used formulas or criteria that CMS knew to be flawed (and did so when CMS knew information was available that would have resulted in a more accurate process), and/or were not supported by substantial evidence (or were contrary to the same).[20]

4.) In disregard of the repeated suggestions of commenters, HHS has refused to make mid-year corrections to the FLTs in order to achieve greater accuracy.[21]

5.) The Medicare outlier regulations (and its companion Program Transmittals) are substantively invalid, as implemented because, in late 2002, when CMS began to realize that its Medicare outlier regulations were flawed, CMS began a process of

[18] *Id.* at 11-12.
[19] *Id.* at 14-15.
[20] *Id.* at 17.
[21] *Id.* at 21.

"selective" administration of the Medicare outlier statute through an effort to correct (and recoup) overpayments but with no corresponding effort to correct underpayments.[22]

6.) HHS' failure to follow its own regulations to conduct reconciliation contributed to HHS's failure to detect a small percentage of hospitals receiving an abnormally high concentration and amount of outlier payments, which caused HHS to underpay most hospitals.[23]

7.) The Medicare outlier regulations are both substantively and procedurally invalid because, as written and as implemented, their actual effect has been to frustrate the intent of Congress, and to deprive the Providers of the "catastrophic loss" protection that Congress intended the outlier statute to provide. The agency action described above has consistently violated the outlier statute, and in the absence of adequate explanation, has also violated the Administrative Procedure Act ("APA") as an arbitrary and capricious, and therefore invalid rule-making, and should be set aside.[24]

8.) The Medicare outlier regulations are procedurally invalid because, when HHS amended the outlier payment regulations, it failed to disclose the alternatives set forth in the IFR, alternatives that it had not only considered, but had signed, cleared for distribution outside the agency, and sent to OMB for presumptive approval in the form of an emergency Interim Final Rule. HHS failed to provide any explanation for why it abandoned this alternative. Indeed, it did not even mention the alternative of removing "turbo-charging" data from its future analysis of setting FLTs.[25]

Analysis and Decision

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.

[22] *Id.* at 22.
[23] *Id.* at 24.
[24] *Id.*
[25] *Id.* at 24-25.

Jurisdiction

Pursuant to 42 U.S.C. § 1395oo(a), 42 C.F.R. § 405.1837, and 42 C.F.R. § 405.1835(c),[26] the Board has jurisdiction to conduct a hearing on a specific cost item at issue if the provider has not received its final determination from the Medicare contractor on a timely basis, the amount in controversy is $50,000 or more (group appeals), and the provider has filed a request for hearing within 180 days after its final determination would have been timely received. An provider has a right to a hearing if it has not timely received its final determination if –

> 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 the provider's perfected cost report or amended cost report…"[27]

The Board finds it has jurisdiction to conduct a hearing on the specific matter at issue in this appeal. The Providers have timely requested a hearing within 180 days after the providers failed to timely receive a contractor determination (12 months after the Medicare contractor's receipt of the Providers' cost reports) and the amount in controversy has been met.

Board Authority to Decide Legal Question

Pursuant to 42 C.F.R. § 405.1867, the Board must comply with Title XVIII of the Act and its supporting regulations. The Providers' allege the Medicare outlier regulations are substantively and procedurally invalid for a variety of reasons, and the Board finds it lacks the authority to examine this legal question.

Conclusion

With regards 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;

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[26] At the time the Providers filed this appeal, the right to appeal the failure to timely receive an NPR was found at 42 C.F.R. § 405.1835(a). The regulation was revised and moved to 42 C.F.R. § 405.1835(c) effective October 1, 2014, with the revisions retroactively applicable to appeals pending or filed on or after August 21, 2008. *See* 79 Fed. Reg. 49,854, 50200 to 50201 (August 22, 2014).
[27] 42 C.F.R. § 405.1835(c).

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.

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
Jack Ahern, MBA

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: Federal Specialized Services
Wilson C. Leong, Esq., CPA
PRRB Appeals
1701 S. Racine Avenue
Chicago, IL 60608-4058

First Coast Service Options, Inc. - FL
Geoff Pike
Provider Audit and Reimbursement Dept.
532 Riverside Avenue
Jacksonville, FL 32231-0014

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

FAX: 410-786-5298
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Refer to: 14-3500G

SEP 21 2015

CERTIFIED MAIL

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

RE: PRRB Decision
Request for Expedited Judicial Review
Patton Boggs 2012 Medicare Outliers Group
PRRB Case No. 14-3500G

Dear Mr. Nash:

The Provider Reimbursement Review Board's ("PRRB or Board") decision with respect to the above referenced request is set forth below.

Background

The Providers filed their request for a group appeal on May 20, 2014. The sole issue in the appeal is whether or not the Providers received the proper amount of supplemental Medicare outlier payments to which they are entitled. All twelve Providers claim a right to a hearing based upon the fact they did not receive a timely final determination or Notice of Program Determination (hereinafter "NPR") from the Medicare contractor. Four of the twelve Providers have subsequently received their NPRs, and they have appealed the same outlier issue in Case No. 15-1605G.

On August 24, 2015, the Providers filed a request for expedited judicial review (EJR) with respect to the following legal question:

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

[1] *See* Providers' August 21, 2015 EJR request, Page 2, n. 2.
[2] *Id.* at n. 3.

Providers' Request for EJR

The Providers assert despite the anticipated virtues of the inpatient prospective payment system (IPPS), Congress recognized that health-care providers would inevitably care for some patients whose hospitalizations would be extraordinarily costly or lengthy. To insulate hospitals from bearing a disproportionate share of these atypical costs, Congress authorized HHS to make supplemental outlier case payments. During the year at issue, the outlier payment provisions were set forth in four clauses of the Medicare statute.[3]

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

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

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Department of Health and Human Services).

[9] Providers' EJR Req. at 5.

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

[12] Providers' EJR Req. at 6.

[13] Providers' EJR Req. at 6-7.

basis of which HHS concluded it was required, mid-year, to lower its fiscal year (FY) 2003 FLT to $20,760 (from $33,560) (*i.e.*, that the 2003 FLT was approximately 62% higher than it should have been) in order to comply with the outlier statute's mandates and the intent of Congress.[14] The Providers contend in stark contrast, HHS' subsequent rulemakings, beginning with the proposed regulation published on February 28, 2003 (March 5, 2003, in the Federal Register),[15] omitted key data, facts, analysis and conclusions. The Providers argue HHS failed to mention, amongst other key information, the agency's considered analysis quantifying the impact of the "turbo-charging" hospitals on its FLT adjustments, the need and method to remove the "turbo-charged" data and what HHS believed to be its statutory obligation to lower the FLT.

The Providers argue contrasting the data, other facts, and analysis set forth in the IFR with HHS' subsequent published rulemakings, it is clear that HHS used corrupted data, and knowingly disregarded its own concurrent provider-favorable conclusions and alternatives in setting the FLTs for fiscal year end (FYEs) 2003-2010. The Providers maintain they did not learn of the IFR until 2012 – and then only through a Freedom of information Act (FOIA) request that through their counsel, submitted to OMB's Office of Information and Regulatory Affairs (OIRA) for various documents related to the Medicare outlier program. The Provider contends as for FYEs 2007-2011, the IFR continued to be relevant because HHS still had not accounted for the impact of the "turbo-charging" data, still relied on hyper-inflated data in projecting the FLTs, and still had not returned the FLTs anywhere close to the levels dictated by analysis set forth in the IFR. Instead, HHS repeatedly set the FLTs at levels which paid out significantly less than the agency's stated target of 5.1% of total IPPS payments. As a result, the Providers argue they did not receive the full amount of the outlier case payments to which they are entitled under the outlier statute.[16]

The Providers allege on June 28, 2012, HHS Office of Inspector General (OIG) issued a report with results from its review of CMS' outlier reconciliation process (the 2012 OIG Report). The 2012 OIG Report reveals the inaccuracy of (and the key information omitted from) HHS' stated reason for not considering the impact of reconciliation, in establishing the FLTs for FYEs 2004-2011. The Providers maintain the Inspector General noted that seven years after the 2003 publication of the regulation requiring reconciliation of outlier payments, CMS had not reconciled any of the cost reports screened and reported by Medicare Administrative Contractors (MACs). The Providers contend in a later 2013 OIG Report, OIG noted that although nearly all hospitals received some outlier payments, a small percentage of hospitals received a significantly higher proportion (almost 6 times higher) of outlier payments than others. These high-outlier hospitals charged Medicare substantially more for the same Medical Severity Diagnostic Related Groups (MS-DRGs), even though their patients had similar lengths of stay as the average in all other hospitals. The Providers argue HHS failed to notice and correct this unusual distribution of outlier payments.[17]

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

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

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

2.) The Secretary has violated well-settled principles of judicial review of agency action in that CMS has not used the best available data, and in fact, has used faulty data when establishing FLTs even when admonished by hospitals. Also, the FLTs established by CMS have borne no discernible, much less logical, relationship to CMS' published "inflationary factors."[18]

3.) The FLTs themselves, as calculated pursuant to HHS published criteria, have been (and continue to be) invalid because CMS used data that was not the best available data, used formulas or criteria that CMS knew to be flawed (and did so when CMS knew information was available that would have resulted in a more accurate process), and/or were not supported by substantial evidence (or were contrary to the same).[19]

4.) In disregard of the repeated suggestions of commenters, HHS has refused to make mid-year corrections to the FLTs in order to achieve greater accuracy.[20]

5.) The Medicare outlier regulations (and its companion Program Transmittals) are substantively invalid, as implemented because, in late 2002, when CMS began to realize that its Medicare outlier regulations were flawed, CMS began a process of "selective" administration of the Medicare outlier statute through an effort to correct (and recoup) overpayments but with no corresponding effort to correct underpayments.[21]

6.) HHS' failure to follow its own regulations to conduct reconciliation contributed to HHS's failure to detect a small percentage of hospitals receiving an abnormally high concentration and amount of outlier payments, which caused HHS to underpay most hospitals.[22]

7.) The Medicare outlier regulations are both substantively and procedurally invalid because, as written and as implemented, their actual effect has been to frustrate the intent of

[18] *Id.* at 14-15.
[19] *Id.* at 17.
[20] *Id.* at 21.
[21] *Id.* at 22.
[22] *Id.* at 24.

Congress, and to deprive the Providers of the "catastrophic loss" protection that Congress intended the outlier statute to provide. The agency action described above has consistently violated the outlier statute, and in the absence of adequate explanation, has also violated the Administrative Procedure Act ("APA") as an arbitrary and capricious, and therefore invalid rule-making, and should be set aside.[23]

8.) The Medicare outlier regulations are procedurally invalid because, when HHS amended the outlier payment regulations, it failed to disclose the alternatives set forth in the IFR, alternatives that it had not only considered, but had signed, cleared for distribution outside the agency, and sent to OMB for presumptive approval in the form of an emergency Interim Final Rule. HHS failed to provide any explanation for why it abandoned this alternative. Indeed, it did not even mention the alternative of removing "turbo-charging" data from its future analysis of setting FLTs.[24]

Analysis and Decision

Consolidation of Four Providers from Case No. 15-1605G

The Board generally consolidates or merges appeals from final determinations for the same cost reporting periods.[25] Additionally, a provider may not appeal an issue from a final determination in more than one appeal.[26] Four of the twelve Providers in this appeal have subsequently received their NPRs, and they have appealed the same outlier issue and fiscal year ends in Case No. 15-1605G. The Board is merging the following four Providers from Case No. 15-1605G into this appeal:

Name	Provider #	Fiscal Year End	Final Determination Date
Billings Clinic	27-0004	06/30/2012	08/28/2014
Halifax Medical Center	10-0017	09/30/2012	02/28/2013
Good Samaritan Hospital	05-0471	08/31/2012	01/29/2013
Bozeman Deaconess Hospital	27-0057	12/31/2012	09/26/2014

Expedited Judicial Review

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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[23] *Id.*
[24] *Id.* at 24-25.
[25] *See* PRRB Rule 6.
[26] *See* PRRB Rule 4.

Jurisdiction

Pursuant to 42 U.S.C. § 1395oo(a), 42 C.F.R. § 405.1837 and 42 C.F.R. § 405.1835(c)[27], the Board has jurisdiction to conduct a hearing on a specific cost item at issue if the provider has not received its final determination from the Medicare contractor on a timely basis, the amount in controversy is $50,000 or more, and the provider has filed a request for hearing within 180 days after its final determination would have been timely received. An provider has a right to a hearing if it has not timely received its final determination if –

> 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 the provider's perfected cost report or amended cost report..."[28]

The Board finds it has jurisdiction to conduct a hearing on the specific matter at issue in this appeal. All twelve Providers have timely requested a hearing within 180 days after the providers failed to timely receive a contractor determination (12 months after the Medicare contractor's receipt of the Providers' cost reports) and the amount in controversy has been met.

Board Finding Regarding Authority

Pursuant to 42 C.F.R. § 405.1867, the Board must comply with Title XVIII of the Act and its supporting regulations. The Providers' allege the Medicare outlier regulations are substantively and procedurally invalid for a variety of reasons. The Board finds it lacks the authority to examine this legal question.

Conclusion

With regards to the Providers' request for EJR for the outlier reimbursement issue, the Board finds that:

1) Provider Nos. 1, 6, 11, and 12, which have NPR appeals in Case No. 15-1605G for the same Providers, issue and fiscal year ends, are merged from Case No. 15-1605G into this appeal;

2) for all twelve Providers in Case No. 14-3500G

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[27] At the time the Providers filed this appeal, the right to appeal the failure to timely receive an NPR was found at 42 C.F.R. § 405.1835(a). The regulation was revised and moved to 42 C.F.R. § 405.1835(c) effective October 1, 2014, with the revisions retroactively applicable to appeals pending or filed on or after August 21, 2008. *See* 79 Fed. Reg. 49,854, 50200 to 50201 (August 22, 2014).
[28] 42 C.F.R. § 405.1835(c).

a. the Board has jurisdiction over the matter for the subject years and the Providers are entitled to a hearing before the Board under 42 C.F.R. § 405.1835(c);

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

c. the Board is bound by the regulations; and

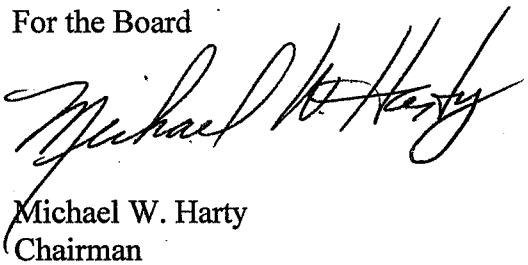
d. the Board is without the authority to decide the legal question of whether the outlier regulations are valid.

Accordingly, the Board finds that the outlier issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and grants the Providers request for EJR for all twelve Providers in Case no. 14-3500G.

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
Jack Ahern, MBA

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,
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Refer to: 15-0391GC

SEP 21 2015

CERTIFIED MAIL

Stephen P. Nash
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RE: PRRB Decision
Request for Expedited Judicial Review
Squire Patton Boggs Allina Health 2012 Medicare Outliers CIRP Group
PRRB Case No. 15-0391GC

Dear Mr. Nash:

The Provider Reimbursement Review Board's ("PRRB or Board") decision with respect to the above referenced request is set forth below.

Background

The Providers filed their request for a Common Issue Related Party (hereinafter "CIRP") group appeal on November 14, 2014. The sole issue in the appeal is whether or not the Providers received the proper amount of supplemental Medicare outlier payments to which they are entitled. All of the Providers claim a right to a hearing based upon the fact they did not receive a timely final determination from the Medicare contractor. The Providers notified the Board that this CIRP group appeal was complete on July 28, 2015.

On August 24, 2015, the Providers filed a request for expedited judicial review (EJR) with respect to the following legal question:

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

[1] *See* Providers' August 21, 2015 EJR request, Page 2, n. 2.
[2] *Id.* at n. 3.

Providers' Request for EJR

The Providers assert despite the anticipated virtues of the inpatient prospective payment system (IPPS), Congress recognized that health-care providers would inevitably care for some patients whose hospitalizations would be extraordinarily costly or lengthy. To insulate hospitals from bearing a disproportionate share of these atypical costs, Congress authorized HHS to make supplemental outlier case payments. During the year at issue, the outlier payment provisions were set forth in four clauses of the Medicare statute.[3]

The Providers maintain, traditionally, the Secretary has read paragraph (5)(A)(iv) of the statute to mean that prior to the start of each fiscal year, the Secretary must establish a FLT beyond which hospitals will qualify for outlier case payments, at levels resulting in outlier case payments totaling between 5-6% of projected diagnosis related group (DRG) payments for that year. The Providers contend outlier payments are made from the "outlier pool," which is a regulatory set aside or subset of the Medicare Part A Trust Fund, maintained by the government to pay for outliers (Medicare outlier pool). The Medicare outlier pool is, in effect, funded by all of the acute care hospitals participating in Medicare IPPS, in that each such hospital's ordinary IPPS payments are reduced (between 5% and 6%) and those moneys are credited to the Medicare outlier pool.[4]

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

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

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[3] 42 U.S.C. § 1395ww(d)(5)(A)(i)-(iv).
[4] 42 U.S.C. § 1395ww(d)(3)(B).
[5] *See, e.g., Amicus Curiae Mem.* of U.S.A in Resp. to Tenet Healthcare Corp's Mot. to Dismiss, *Boca Raton Cmty. Hosp.*, ECF No. [49], at 4 (S.D. Fla. May 17, 2005).
[6] *Id.* at 4-5.
[7] Providers' EJR Req. at 4-5.

be made based on DRG prospective payment rates for discharges in that year.[8]

The Providers maintain beginning in or around federal fiscal year (FFY) 1998, HHS began making substantial upward adjustments to the FLTs. These adjustments were at a rate far in excess of the rate of growth of inflationary indices routinely used by HHS, such as the CPI-Medical Index or the Medicare Market Basket. For instance, from 1997 through 2003, HHS increased the FLTs by more than 246%, when by its own admission there was modest cost inflation (of between 22% and 26%) for the same period. The Providers assert although the Secretary purported to calibrate the FLT adjustments to historical inflation data, the actual increase in FLTs bore no discernible relationship to cost inflation; in fact they were more than 10 times higher.[9]

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

The Providers argue while the agency was in the process of reversing its position on each of these points, HHS had the opportunity (if not the statutory and/or fiduciary obligation) to reset its FLT to correct for what it openly acknowledged had been the improper redistribution of the Medicare funds allocated for outlier case payments—literally billions of dollars of improper payments made to a few "turbo charging" hospitals, at the expense of the many. Instead, after reviewing hundreds of public comments, most urging HHS to lower the FLT, the agency announced that it would leave the threshold where it was, $33,560.[12]

The Providers assert HHS did not disclose that the agency had known six months earlier how to fix the problems engendered by its earlier flawed regulations and believed it was obligated to do

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[8] *Medicare Outlier Payments to Hospitals: Hearing Before a Subcomm. of the S. Comm. on Appropriations*, 108th Cong. 3-17 (2003) (statement by Thomas A. Scully Administrator, Centers for Medicare and Medicaid Services, Department of Health and Human Services).
[9] Providers' EJR Req. at 5.
[10] *See* CMS *Program Memorandum*, Transmittal A-02-122 (Dec. 3, 2002); CMS *Program Memorandum*, Transmittal A-02-126 (Dec. 20, 2002); CMS *Program Memorandum Intermediaries*, Transmittal A-03-058, July 3, 2003; and CMS Manual System, Pub. 100-04 Medicare Claims Processing, Transmittal 707, October 12, 2005, Change Request 3966.
[11] *See* 68 Fed. Reg. 34,494, 34,496 and 34,501 (June 9, 2003).
[12] Providers' EJR Req. at 6.

so immediately. The Providers contend HHS also did not disclose in that rulemaking that then-HHS Secretary Thompson and then-Administrator Scully had cleared and signed an interim final regulation (the IFR) and submitted the IFR to the Office of Management and Budget (OMB) for presumptive approval on February 12, 2003.[13] The Providers maintain the IFR contained facts and analysis on the basis of which HHS concluded it was required, mid-year, to lower its fiscal year (FY) 2003 FLT to $20,760 (from $33,560) (*i.e.*, that the 2003 FLT was approximately 62% higher than it should have been) in order to comply with the outlier statute's mandates and the intent of Congress.[14] The Providers contend in stark contrast, HHS' subsequent rulemakings, beginning with the proposed regulation published on February 28, 2003 (March 5, 2003, in the Federal Register),[15] omitted key data, facts, analysis and conclusions. The Providers argue HHS failed to mention, amongst other key information, the agency's considered analysis quantifying the impact of the "turbo-charging" hospitals on its FLT adjustments, the need and method to remove the "turbo-charged" data and what HHS believed to be its statutory obligation to lower the FLT.

The Providers argue contrasting the data, other facts, and analysis set forth in the IFR with HHS' subsequent published rulemakings, it is clear that HHS used corrupted data, and knowingly disregarded its own concurrent provider-favorable conclusions and alternatives in setting the FLTs for fiscal year end (FYEs) 2003-2010. The Providers maintain they did not learn of the IFR until 2012 – and then only through a Freedom of information Act (FOIA) request that through their counsel, submitted to OMB's Office of Information and Regulatory Affairs (OIRA) for various documents related to the Medicare outlier program. The Provider contends as for FYEs 2007-2011, the IFR continued to be relevant because HHS still had not accounted for the impact of the "turbo-charging" data, still relied on hyper-inflated data in projecting the FLTs, and still had not returned the FLTs anywhere close to the levels dictated by analysis set forth in the IFR. Instead, HHS repeatedly set the FLTs at levels which paid out significantly less than the agency's stated target of 5.1% of total IPPS payments. As a result, the Providers argue they did not receive the full amount of the outlier case payments to which they are entitled under the outlier statute.[16]

The Providers allege on June 28, 2012, HHS Office of Inspector General (OIG) issued a report with results from its review of CMS' outlier reconciliation process (the 2012 OIG Report). The 2012 OIG Report reveals the inaccuracy of (and the key information omitted from) HHS' stated reason for not considering the impact of reconciliation, in establishing the FLTs for FYEs 2004-2011. The Providers maintain the Inspector General noted that seven years after the 2003 publication of the regulation requiring reconciliation of outlier payments, CMS had not reconciled any of the cost reports screened and reported by Medicare Administrative Contractors (MACs). The Providers contend in a later 2013 OIG Report, OIG noted that although nearly all

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[13] Providers' EJR Req. at 6-7.
[14] *Id.* at 7.
[15] *See* 68 Fed. Reg. 10,420 (March 5, 2003).
[16] Providers' EJR Req. at 9-10.

hospitals received some outlier payments, a small percentage of hospitals received a significantly higher proportion (almost 6 times higher) of outlier payments than others. These high-outlier hospitals charged Medicare substantially more for the same Medical Severity Diagnostic Related Groups (MS-DRGs), even though their patients had similar lengths of stay as the average in all other hospitals. The Providers argue HHS failed to notice and correct this unusual distribution of outlier payments.[17]

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

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

2.) The Secretary has violated well-settled principles of judicial review of agency action in that CMS has not used the best available data, and in fact, has used faulty data when establishing FLTs even when admonished by hospitals. Also, the FLTs established by CMS have borne no discernible, much less logical, relationship to CMS' published "inflationary factors."[18]

3.) The FLTs themselves, as calculated pursuant to HHS published criteria, have been (and continue to be) invalid because CMS used data that was not the best available data, used formulas or criteria that CMS knew to be flawed (and did so when CMS knew information was available that would have resulted in a more accurate process), and/or were not supported by substantial evidence (or were contrary to the same).[19]

4.) In disregard of the repeated suggestions of commenters, HHS has refused to make mid-year corrections to the FLTs in order to achieve greater accuracy.20

5.) The Medicare outlier regulations (and its companion Program Transmittals) are substantively invalid, as implemented because, in late 2002, when CMS began to realize that its Medicare outlier regulations were flawed, CMS began a process of "selective" administration of the Medicare outlier statute through an effort to

[17] *Id.* at 11-12.
[18] *Id.* at 14-15.
[19] *Id.* at 17.
[20] *Id.* at 21.

correct (and recoup) overpayments but with no corresponding effort to correct underpayments.[21]

6.) HHS' failure to follow its own regulations to conduct reconciliation contributed to HHS's failure to detect a small percentage of hospitals receiving an abnormally high concentration and amount of outlier payments, which caused HHS to underpay most hospitals.[22]

7.) The Medicare outlier regulations are both substantively and procedurally invalid because, as written and as implemented, their actual effect has been to frustrate the intent of Congress, and to deprive the Providers of the "catastrophic loss" protection that Congress intended the outlier statute to provide. The agency action described above has consistently violated the outlier statute, and in the absence of adequate explanation, has also violated the Administrative Procedure Act ("APA") as an arbitrary and capricious, and therefore invalid rule-making, and should be set aside.[23]

8.) The Medicare outlier regulations are procedurally invalid because, when HHS amended the outlier payment regulations, it failed to disclose the alternatives set forth in the IFR, alternatives that it had not only considered, but had signed, cleared for distribution outside the agency, and sent to OMB for presumptive approval in the form of an emergency Interim Final Rule. HHS failed to provide any explanation for why it abandoned this alternative. Indeed, it did not even mention the alternative of removing "turbo-charging" data from its future analysis of setting FLTs.[24]

Analysis and Decision

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.

[21] *Id.* at 22.
[22] *Id.* at 24.
[23] *Id.*
[24] *Id.* at 24-25.

Jurisdiction

Pursuant to 42 U.S.C. § 1395oo(a), 42 C.F.R. § 405.1837 and 42 C.F.R. § 405.1835(c),[25] the Board has jurisdiction to conduct a hearing on a specific cost item at issue if the provider has not received its final determination from the Medicare contractor on a timely basis, the amount in controversy is $50,000 or more, and the provider has filed a request for hearing within 180 days after its final determination would have been timely received. An provider has a right to a hearing if it has not timely received its final determination if –

> 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 the provider's perfected cost report or amended cost report…"[26]

The Board finds it has jurisdiction to conduct a hearing on the specific matter at issue in this appeal. The Providers have timely requested a hearing within 180 days after the providers failed to timely receive a contractor determination (12 months after the Medicare contractor's receipt of the Providers' cost reports) and the amount in controversy has been met.

Board Authority to Decide Legal Question

Pursuant to 42 C.F.R. § 405.1867, the Board must comply with Title XVIII of the Act and its supporting regulations. The Providers' allege the Medicare outlier regulations are substantively and procedurally invalid for a variety of reasons, and the Board finds it lacks the authority to examine this legal question.

Conclusion

With regards 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

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[25] 42 C.F.R. § 405.1835(c) was revised effective October 1, 2014, with the revisions retroactively applicable to appeals pending or filed on or after August 21, 2008. *See* 79 Fed. Reg. 49,854, 50200 to 50201 (August 22, 2014).
26 42 C.F.R. § 405.1835(c).

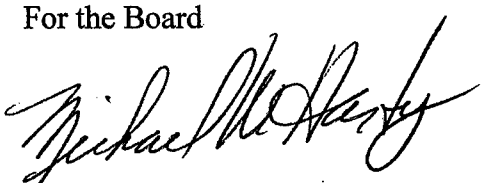
Case No.: 15-0391GC

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

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
Jack Ahern, MBA

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

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SEP 25 2015

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RE: St. Elizabeth Health Center
Provider No.: 36-0064
FYEs: 12/31/04 and 12/31/06
PRRB Case Nos.: 07-1236 and 09-1229

Dear Ms. Densmore and Ms. Cummings:

The Provider Reimbursement Review Board ("Board") has reviewed jurisdiction in the above-captioned appeals in response to the Medicare Contractor's challenges. The jurisdictional decision of the Board is set below.

Background

CN 07-1236 FYE 12/31/04

The Provider submitted a request for hearing dated March 14, 2007, based on a Notice of Program Reimbursement ("NPR") dated September 22, 2006. The hearing request included two issues: 1) DSH/SSI and 2) Rural Floor Budget Neutrality Adjustment. The Provider subsequently submitted a request to transfer the DSH/SSI issue to PRRB Case No. 03-1254G – Campbell Wilson 93-04 SSI Group on June 18, 2007.

On October 17, 2008, the Provider submitted a request to add three issues to the appeal[1]: 1) DSH-Medicaid Eligible Days, 2) DSH – Ohio HCAP Days, and 3) DSH – Dual Eligible Days. On July 29, 2009, the Provider submitted a request to transfer the DSH – Dual Eligible Days issue to PRRB Case No. 09-2085GC – CHP 2002-2006 DSH Dual Eligible Days CIRP Group.

The Provider submitted its Final Position Paper on September 4, 2012, wherein it briefed the DSH – Medicaid Eligible Days issue. The Provider also briefed for the first time the Inpatient Rehabilitation Facility ("IRF") Low Income Patient ("LIP") adjustment Medicaid Eligible Days issue. The DSH – Ohio HCAP Days and Rural Floor Budget Neutrality Adjustment issues were not briefed.

[1] The Issues were numbered as 4, 5, and 6 in the request, though there is no evidence the Provider ever raised/added Issue #3.

The Medicare Contractor filed a jurisdictional challenge on the DSH – Medicaid Eligible Days and the IRF LIP – Medicaid Eligible Days issues on April 26, 2013. The Provider did not file a responsive brief.

Blumberg Ribner, Inc. filed a response to Board Alert 10 on the Provider's behalf on July 16, 2014, however, Blumberg Ribner, Inc. is not the Provider's authorized representative in this appeal.

CN 09-1229 FYE 12/31/06

The Provider submitted a request for hearing on March 23, 2009, based on an NPR dated September 29, 2008. The hearing request included five issues: 1) DSH – Medicaid Eligible Days, 2) DSH/SSI, 3) DSH – Dual Eligible Days, 4) Rural Floor Budget Neutrality Adjustment, and 5) DSH – Ohio HCAP Days.

The Provider submitted a request to transfer the DSH – Dual Eligible Days and DSH/SSI issues to PRRB Case No. 09-2085GC – CHP 2002-2006 DSH Dual Eligible Days CIRP Group and PRRB Case No. 09-2201GC – CHP 2006 DSH SSI Percentage Group on July 29, 2009 and November 30, 2009 respectively. On November 24, 2009, Hall Render submitted a request to transfer the Rural Floor Budget Neutrality Adjustment issue to PRRB Case No. 09-1748GC – Catholic Health Partners 2007 Standardized Amount CIRP Group (II). However, Hall Render was never designated as an authorized representative for the Provider. Case No. 09-1748GC was eventually withdrawn on June 7, 2012.

The Provider submitted its Final Position Paper on September 4, 2012, wherein it briefed only The DSH – Medicaid Eligible Days issue. The Provider did not specifically raise LIP days in its narrative or a calculation of reimbursement impact for the Rehab unit, but did include listings of Rehab days in dispute at Exhibits P-5 and P-6. The Rural Floor Budget Neutrality Adjustment and DSH – Ohio HCAP Days issues were not briefed.

The Medicare Contractor filed a jurisdictional challenge on the DSH – Medicaid Eligible Days and the IRF LIP – Medicaid Eligible Days issues on April 26, 2013. The Provider did not file a responsive brief.

Blumberg Ribner, Inc. filed a response to Board Alert 10 on the Provider's behalf on July 16, 2014, however Blumberg Ribner, Inc. is not the Provider's authorized representative in this appeal.

Medicare Contractor's Position

DSH – Medicaid Eligible Days

The Medicare Contractor contends that the Provider did not claim the additional Medicaid Eligible Days on its cost reports, nor did it claim those days as a protested item. Therefore, no adjustments were made to the cost reports in relation to the additional Medicaid Eligible Days.[2]

The Medicare Contractor argues that 42 C.F.R. § 405.1835 limits the PRRB's jurisdiction to the review of the Intermediary's final determination for which the Provider is dissatisfied. The Medicare Contractor explains that 42 C.F.R. § 405.1801(a)(1) (2005) defines an intermediary's determination as a determination of the amount of total reimbursement due the provider following the close of the provider's cost reporting period. In these appeals, the Medicaid Eligible Days disputed by the Provider were not previously claimed or reported on the as-filed cost reports. Therefore, the Medicare Contractor did not propose any adjustments in the NPR that would have impacted the days disputed by the Provider. Accordingly, the Provider has no right to a PRRB hearing for those items pursuant to 42 C.F.R. § 405.1835 (2005 version).[3]

The Medicare Contractor contends that the Supreme Court's decision regarding the *Bethesda Hospital*[4] that allows an appeal of self-disallowed costs, does not apply in these cases. For these cases, the Provider failed to claim the additional Medicaid Eligible Days at issue. The Contractor also argues that its jurisdictional challenge is consistent with the Administrator's decision in *Norwalk Hospital v. BlueCross BlueShield Ass'n/Nat'l Gov't Serv., Inc.*.[5]

IRF LIP – Medicaid Eligible Days

The Medicare Contractor contends that the Provider did not include the IRF LIP – Medicaid Eligible Days issue in its initial requests for hearing and it was not added to the appeals in a timely manner. In addition, the IRF LIP issue is lack of subject matter jurisdiction because Section 1886(j)(8)(B) of the Medicare Act specifically prohibits and precludes administrative and judicial review of prospective payment rates established under Section 1886(j)(3) of the Medicare Act. Therefore, the Board does not have jurisdiction in regards to the Provider's appeals of the IRF LIP - Medicaid Eligible Days issue.[6]

Provider's Position

The Provider did not file a responsive brief for either appeal.

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[2] For fiscal year 12/31/04 the Medicare Contractor proposed an adjustment to increase the Medicaid days by 847 days in Adjustment #13. Therefore, the Medicare Contractor did not remove any Medicaid days during the review.
[3] Medicare Contractor's Jurisdictional Briefs at 2-3.
[4] *Bethesda Hospital Ass'n v. Bowen,* 485 U.S. 399 (1988).
[5] PRRB Dec. No. 2012-D14 (Mar. 19, 2012).
[6] Medicare Contractor's Jurisdictional Briefs at 6.

Board's Decision

DSH – Medicaid Eligible Days

Pursuant to 42 U.S.C. §1395oo(a) and 42 C.F.R. §§ 405.1835 – 1841(2007), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more ($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. 42 U.S.C. §1395oo(a) provides, in relevant part:

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

In *Barberton Citizens Hosp. vs. CGS Administrators*, PRRB Dec. No. 2015-D5 (March 19, 2015)("*Barberton*"), the Board stated "pursuant to the concept of futility in *Bethesda*, the Board has jurisdiction of a hospital's appeal of additional Medicaid eligible days for the DSH adjustment calculation if that hospital can establish a "practical impediment" as to why it could not claim these days at the time that it filed its cost report."[7]

In the instant cases, the Board finds that the Provider neither responded to the Medicare Contractor's jurisdictional challenge nor submitted any additional arguments and/or documentation in response to Board Alert 10.[8]

The Board finds that it does not have jurisdiction under 42 U.S.C. § 1395oo(a) to hear the claim for additional Medicaid eligible days in these appeals 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 these days with the State prior to the filing of the cost report. Therefore, the Board dismisses the DSH – Medicaid Eligible Days issue from the appeals.

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[7] *Barberton* at 4.

[8] The Board disregards the Alert 10 response submitted by Blumberg Ribner, Inc. as Blumberg Ribner, Inc. was never the Provider's authorized representative in these appeals.

IRF LIP – Medicaid Eligible Days

The Board finds that it does not have jurisdiction to hear the IRF LIP - Medicaid Eligible Days issue because it was not properly added to the appeals. 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.

For appeals already pending when this regulation was promulgated, Providers were given 60 days from the date that the new regulations took effect, August 21, 2008, to add issues to their appeals. In practice this means that issues had to be added to pending appeals by October 20, 2008.[9]

As PRRB Case No. 07-1236 FYE 12/31/04 was pending when the regulation was promulgated, the IRF LIP – Medicaid Eligible Days issue should have been added by October 20, 2008. First mention of the issue was made in the Provider's Final Position Paper submitted on September 4, 2012.

As PRRB Case No. 09-1229 FYE 12/31/06 was filed in 2009, the Provider was required to file any additional issues no later than June 1, 2009. However, there is nothing in the record documenting the addition of the IRF LIP – Medicaid Eligible Days issue to the appeal.

Rural Floor Budget Neutrality and DSH – Ohio HCAP Days Issues

The Board dismisses the DSH – Ohio HCAP Days and Rural Floor Budget Neutrality Adjustment[10] issues from both appeals as the issues were never briefed in the Provider's final position papers.

PRRB Rules also elaborate on requirements for acceptable final position papers:

> If your position paper does not explain the facts or make any arguments about an issue in accordance with the following guidelines, the Board may find that the position paper submitted for this issue is unacceptable. In this case, it will dismiss the issue from the appeal. If you fail to address an issue, the Board will dismiss it from your appeal.[11]

As there are no issues remaining in the appeals, the Board hereby closes the cases and removes them from the Board's docket.

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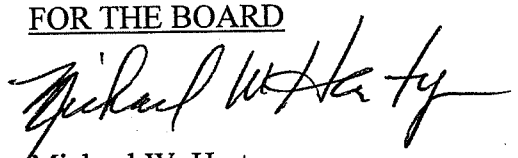
[9] *See* 73 FR 30,234 (May 23, 2008).
[10] The transfer of the Rural Floor Budget Neutrality issue in Case No. 09-1229 to a group appeal was improper since the transfer request was not submitted by the Provider's authorized representative.
[11] PRRB Rules (2002), Part II § B.IV.

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

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: Federal Specialized Services
Wilson C. Leong, Esq., CPA
PRRB Appeals
1701 S. Racine Avenue
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CERTIFIED MAIL SEP 25 2015

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National Government Services, Inc.
Danene Hartley, Appeals Lead
MP INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206 6474

RE: Reed Smith 2006 SSI Group
PRRB Case No. 09-0821G

Specifically:
San Antonio Community Hospital (05-0099) for FYEs 12/31/2006 & 12/31/2007

Dear Mr. Rotella and Ms. Hartley:

The Provider Reimbursement Review Board (the Board) has reviewed the jurisdictional documentation submitted in the above captioned case and finds that it lacks jurisdiction over two of the participants in the group. The pertinent facts with regard to these Providers and the Board's jurisdiction decision are set forth below.

Pertinent Facts

Participant 10, San Antonio Community Hospital, Prov. No. 05-0099, FYE 12/31/2006:

This Provider received a revised Notice of Program Reimbursement (NPR) on 6/11/2009 and filed an individual appeal on 12/7/2009. The appeal request submitted for this participant behind tab 1B, however, does not include the SSI Percentage issue, nor is there proof that the issue was timely added to the individual appeal prior to transferring it to the group on 7/9/2010. In addition, the audit adjustment pages submitted behind tab 1D do not appear to be from the revised NPR.

Participant 11, San Antonio Community Hospital, Prov. No. 05-0099, FYE 12/31/2007:

This Provider received an NPR on 8/10/2009 and filed an appeal request on 1/29/2010. Based on a review of the appeal request, the Provider did not appeal the SSI Percentage issue in the original appeal request, nor does it have proof that the issue was properly added to the individual appeal prior to transferring it to the group on 7/9/2010.

Board Decision

The Board finds that it does not have jurisdiction over San Antonio Community Hospital for FYEs 12/31/2006 and 12/31/2007 (participants 10 and 11).

Pursuant to 42 U.S.C. §1395oo(a) and 42 C.F.R. §§405.1835-405.1840(2006), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if (1) it is dissatisfied with the final determination of the MAC, (2) the amount in controversy is $10,000 or more (or $50,000 for a group), and (3) the request for a hearing is filed within 180 days of the date the notice of the intermediary's determination was mailed to the provider.

Further guidance and requirements for filing an appeal with the Board are outlined in the PRRB Rules (July 1, 2009). PRRB Rule 16.1 requires a provider who is transferring an issue from an individual appeal to a group appeal to provide documentation that the issue being transferred is "currently apart of the individual appeal from which it is being transferred."

Regulation 42 C.F.R. §405.1835(c) provides that an issue may be added to the original appeal request "no later than 60 days after the expiration of the 180-day period" following the Provider's receipt of its NPR.

After reviewing the jurisdictional documentation submitted with the Schedule of Providers the Board finds that San Antonio Community Hospital did not provide proof that the SSI Percentage issue was properly appealed for FYEs 12/31/2006 and 12/31/2007prior to transferring to the group.

As noted, San Antonio's appeal for FYE 12/31/2006 was filed from a revised NPR. 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).

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

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the

provisions of 42 C.F.R. §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.

(b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.

(b)(2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

The Board finds that San Antonio Community Hospital did not provide evidence that the SSI Percentage issue was adjusted on the revised NPR for FYE 12/31/2006.

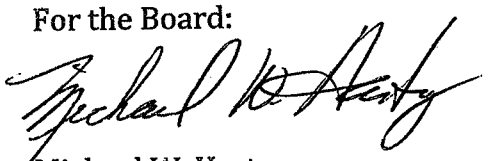
Therefore, the Board hereby dismisses participants 10 and 11 from case number 09-0821G.

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

Enclosed, please find the Board's Standard Remand of the SSI fraction under CMS Ruling CMS-1498-R for the remaining participants in the group.

Board Members Participating:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Anderson, 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
Standard Remand of the SSI fraction under CMS Ruling CMS-1498-R
Schedule of Providers

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services (w/enclosure)

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CERTIFIED MAIL

SEP 28 2015

Kenneth R. Marcus
Honigman Miller Schwartz & Cohn
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Detroit, MI 48226-3506

RE: Baptist Memorial Hospital-North Mississippi, Provider No. 25-0034, FYE 09/30/06, as a former participant in "BMHCC 2004-2006 LIP SSI% CIRP Group"
PRRB Case No.: 11-0121GC

Dear Mr. Marcus:

The Provider Reimbursement Review Board (Board) has reviewed your September 24, 2015 correspondence requesting that the Board reconsider and reverse its September 16, 2015 jurisdictional decision dismissing Provider 3, Baptist Memorial Hospital-North Mississippi, provider number 25-0034, fiscal year end (FYE) September 30, 2006, from case number 11-0121GC. The Board's decision is set forth below.

Background

On September 16, 2015, the Board dismissed Baptist Memorial Hospital-North Mississippi, provider number 25-0034, FYE September 30, 2006, from case number 11-0121GC because the low income patient (LIP) supplemental security income (SSI) percentage issue was not appealed by the Provider in its individual appeal, case number 08-2859, nor timely added to its individual appeal (the Provider appealed DSH and LIP Medicaid eligible days in its individual appeal). The Board determined that the LIP SSI percentage issue therefore could not be transferred from case number 08-2859 to case number 11-0121GC for this Provider.

Provider's Contention

The Provider contends that its reference to the LIP Medicaid eligible days issue in its individual appeal request was a typographical error. In support of its contention the Provider points out that its individual appeal request references Audit Adjustment No. 30, which specifically references the LIP SSI percentage adjustment. The Provider maintains that there was no audit adjustment for LIP Medicaid eligible days; in the absence of an audit adjustment for LIP Medicaid eligible days, it was not the Provider's intention to appeal LIP Medicaid eligible days.

The Provider further contends review of the records in its individual appeal, case number 08-2859, and in case number 11-0121GC shows that subsequent to its request for the

individual appeal, every single pleading filed by the Provider and the Medicare Contractor referenced the LIP SSI percentage issue; it never again referenced the LIP Medicaid eligible days issue. Thus, the Provider requests that the Board find that it possesses jurisdiction over the Provider in case number 11-0121GC.

Decision of the Board

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 ($50,000 for a group) and the request for a hearing is filed within 180 days of the NPR.[1]

The Board reverses its prior September 16, 2015 decision dismissing Provider 3, Baptist Memorial Hospital-North Mississippi, provider number 25-0034, FYE September 30, 2006, from case number 11-0121GC. The Board grants jurisdiction and reinstates Baptist Memorial Hospital-North Mississippi into case number 11-0121GC as the Provider referenced Audit Adjustment No. 30 in its individual appeal request; Audit Adjustment No. 30 specifically referenced the LIP SSI percentage issue not the LIP Medicaid eligible days issue. As such, the Board finds that the Provider's intent was to appeal the LIP SSI percentage issue not the LIP Medicaid eligible days issue.

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
Jack Ahern, MBA

For the Board:

Charlotte Benson for

Michael W. Harty
Chairman

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

cc: Beth Wills, Cahaba GBA c/o National Government Services
Wilson C. Leong, Esq., Federal Specialized Services

[1] 42 U.S.C. § 1395oo(a)(2014) and 42 C.F.R. §§ 405.1835-1840(2014).