DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
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Refer to: 14-3367GC, 15-0764GC

NOV 08 2016

Certified Mail

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

RE: Meridian Health 2006 Outlier Threshold Group
Meridian Health 2007 Outlier Threshold Group
Provider Nos. Various
FYEs 2006 and 2007
PRRB Case Nos. 14-3367GC and 15-0764GC

Dear Mr. Nash:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' October 10, 2016 request for expedited judicial review (EJR) (received October 11, 2016). The Board's decision with respect to the request for EJR is set forth below.

Issue Under Appeal

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

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

[1] *See* Providers' October 10, 2016 EJR request at 2, n.2.
[2] *Id.* at n.3.
[3] *Id.* at 2.

Providers' Request for EJR

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

The Providers note that from 1997 through 2003, a number of hospitals were reported to have inflated their charge–masters, an action which the Department of Justice (DOJ) termed "turbo-charging." This practice greatly inflated cost to charge ratios which greatly increased the cost per case. The DOJ termed this action a false claim and this also resulted in the Secretary greatly increasing the FLT so that payments for outliers would remain at 5.1 percent of DRG payments. More specifically, beginning in or around Federal fiscal year (FFY) 1998, the Secretary began making upward adjustments to the FLTs which were in excess of the rate of inflationary indices routinely used, such as the Consumer Price Index for medical care or the Medicare Market Basket.[8]

In 2002, the Secretary disclosed that he was aware of "turbo-charging" and that he would be amending the outlier regulations to fix "vulnerabilities" in the regulations.[9] In the March 5, 2003[10] and June 9, 2003[11] Federal Registers, the Secretary acknowledged three flaws in the outlier payment regulations and stated that the vulnerabilities would be subject to reconciliation.[12] The Providers maintain that the data used to correct the vulnerabilities had always been available and should have been used to calculate outlier reimbursement. The

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[4] *See* 42 U.S.C. § 1395ww(d)(5).
[5] Providers' October 10, 2016 EJR request at 3.
[6] *Id.* at 4, n.9, 42 U.S.C. § 1395ww(d)(3)(B) (Reducing for Value of Outlier Payments).
[7] Providers' October 10, 2016 EJR request at 4.
[8] *Id.* at 5.
[9] *Id.*
[10] 68 Fed. Reg. 10,420, 10,423 (Mar. 5, 2003) ("Recent analysis indicates that some hospitals have taken advantage of two vulnerabilities in our methodology to maximize their outlier payments . . . [1] the time lag between the current charges on a submitted bill and the cost-to-charge ratio taken from the most recently settled cost report [and 2] in some cases hospitals may increase their charges so far above costs that their cost-to-charge ratios fall below 3 standard deviations from the geometric mean of cost-to-charge ratios and a higher statewide average cost-to-charge ratio is applied.")
[11] 68 Fed. Reg. 34,494, 34,501 (June 9, 2003) ("[3] [e]ven though the final payment would reflect a hospital's true cost experience, there would still be the opportunity for a hospital to manipulate its outlier payments by dramatically increasing charges during the year in which the discharge occurs. In this situation, the hospital would receive excessive outlier payments, which, although the hospital would incur an overpayment and have to refund the money when the cost report is settled, would allow the hospital to obtain excess payments from the Medicare Trust Fund on a short-term basis.")
[12] Providers' October 10, 2016 EJR request at 6.

Secretary explained that although he has the authority to revise the outlier threshold given the manipulation of the outlier payments, he elected not to exercise this authority because of the relatively small difference between the current threshold and the revised estimate and the short amount of time remaining in the FFY.[13] The Providers allege that the Secretary was aware of the problem months before the final rule was published, as demonstrated by Provider Exhibit 9, a copy of an interim final rule submitted to the Office of Management and Budget on February 12, 2003.[14] In *Banner Health v. Sebelius*,[15] the D.C. District Court stated that the February 12, 2003 interim final rule was virtually identical to the final proposed rule, with the exception that the later proposed rule, published on March 5, 2003, did not recommend reduction of the FLT in the supporting analysis.[16]

The Providers state that they did not learn of the February 12, 2003 unpublished, interim final rule until their counsel obtained it through a Freedom of Information Act request made to the Office of Management and Budget in 2012. They believe the interim final rule for FYs 2007-2015 continues to be relevant because the Secretary's methodology for establishing each fiscal year's FLT regulation is necessarily a function of, and applies, the payment regulation. The Providers contend that the Secretary repeatedly set the FLT at levels which paid out significantly less than the agency's stated target of 5.1 percent of the total IPPS payments. As a result, they assert that providers did not receive the full amount of outlier payments to which they were entitled under the statute.[17]

Further, in the June 28, 2012 Office of Inspector General (OIG) report, the Inspector General noted that seven years after the 2003 publication of the regulation requiring reconciliation of outlier payments, CMS had not reconciled any of the cost reports screened and reported by Medicare Administrative Contractors (MACs).[18] In a later, 2013 report,[19] OIG noted that although nearly all hospitals receive outlier payments, a small percentage of hospitals receive a significantly higher proportion of payments. The hospitals receiving this higher portion of payments charged Medicare more for the same Medical Severity- -DRGs, yet had similar lengths of stay and cost-to-charge ratios. The Providers contend that this is another example of CMS' failure to correct the distribution of outlier payments.[20]

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

1) The FLTs, established by the FLT regulations, are substantively invalid because, both as written and implemented, they represent agency action that violated the Administrative Procedures Act in that it was arbitrary and

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[13] *Id.*
[14] The Providers furnished no evidence that this document was ever published in the Federal Register.
[15] 2013 U.S. Dist. Lexis 69889 (D.D.C. May 16, 2013).
[16] Providers' October 10, 2016 EJR request at 7, n.15.
[17] *Id.*
[18] *Id.* at 11. Providers' Exhibit 10, OIG Report: The Centers for Medicare & Medicaid Services Did Not Reconcile Medicare Outlier Payments in Accordance with Federal Regulations and Guidance, Report A-07-10-02764 at 7-9 (June 2012).
[19] *Id.* at 12. Providers' Exhibit 11, Medicare Hospital Outlier Payments Warrant Increased Scrutiny, Report OEI-06-10-00520 (Nov. 2013).
[20] *Id.* at 12.

capricious, exceeded statutory authority and frustrated the intent of Congress as reflected in the outlier statute.

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

   a) fails to "examine the relevant data and articulate a satisfactory explanation for its action including a rational connection between the facts found and the choice made," and/or ignored "new and better data." *Dist. Hosp. Partners v. Burwell,* 786 F.3d 46, 57-58 (D.C. Cir. 2015) (internal citations omitted).

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

   c) offers explanation(s) for its decision(s) that run counter to the evidence.[21]

The Providers believe EJR is appropriate because the Board is required to apply the outlier regulations establishing the FLT for the FYs at issue. The Providers assert that the Board lacks the authority to grant the relief sought: retroactive correction of the FLT.

Decision of the Board

The Board has reviewed the submissions of the Providers pertaining to the requests for hearing and expedited judicial review. 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permit expedited judicial review where the Board determines that it does not have the authority to decide a question of law, regulation or CMS ruling. In these cases, the Providers are challenging the validity of the outlier regulations, 42 C.F.R. §§ 412.80 through 412.86.[22] The Intermediaries did not oppose the request for EJR. The documentation shows that in each case the estimated amount in controversy exceeds $50,000 threshold for Board jurisdiction over group appeals, the appeals were timely filed and the Providers have preserved their right to claim dissatisfaction for the specific item at issue.[23]

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;

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[21] *Id.* at 14.
[22] *Id. at 2 n.* 2 (The Outlier Payment Regulations are the base regulations that establish the method for calculating a hospital's imputed costs for a patient case, which are set forth at 42 C.F.R. §§ 412.80 through 412.86. The Payment Regulations were first enacted in 1985 and have been revised periodically over the years . . . .).
[23] Consistent with *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988), it would be futile for the Providers to include a claim for the outlier payments in dispute as the MAC was barred by regulation from giving the Providers the relief sought.

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

3) it is bound by the regulations; and

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

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

FOR THE BOARD

Charlotte Benson for

Michael W. Harty
Chairman

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

cc: Bruce Snyder, Novitas (w/Schedules of Providers)
Wilson Leong, FSS (w/Schedules of Providers)

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Refer to: 15-1861GC, 15-3265GC, 16-0642GC

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Certified Mail

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RE: Meridian Health 2008 Outlier Threshold Group
Meridian Health 2009 Outlier Threshold Group
Meridian Health 2012Outlier Threshold Group
Provider Nos. Various
FYEs 2008, 2009, 2012
PRRB Case Nos. 15-1861GC, 15-3265GC, 16-0642GC

Dear Mr. Nash:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' October 10, 2016 request for expedited judicial review (EJR) (received October 11, 2016). The Board's decision with respect to the request for EJR is set forth below.

Issue Under Appeal

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

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

[1] *See* Providers' October 10, 2016 EJR request at 2, n.2.
[2] *Id.* at n.3.
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Providers' Request for EJR

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

The Providers note that from 1997 through 2003, a number of hospitals were reported to have inflated their charge–masters, an action which the Department of Justice (DOJ) termed "turbo-charging." This practice greatly inflated cost to charge ratios which greatly increased the cost per case. The DOJ termed this action a false claim and this also resulted in the Secretary greatly increasing the FLT so that payments for outliers would remain at 5.1 percent of DRG payments. More specifically, beginning in or around Federal fiscal year (FFY) 1998, the Secretary began making upward adjustments to the FLTs which were in excess of the rate of inflationary indices routinely used, such as the Consumer Price Index for medical care or the Medicare Market Basket.[8]

In 2002, the Secretary disclosed that he was aware of "turbo-charging" and that he would be amending the outlier regulations to fix "vulnerabilities" in the regulations.[9] In the March 5, 2003[10] and June 9, 2003[11] Federal Registers, the Secretary acknowledged three flaws in the outlier payment regulations and stated that the vulnerabilities would be subject to reconciliation.[12] The Providers maintain that the data used to correct the vulnerabilities had

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[11] 68 Fed. Reg. 34,494, 34,501 (June 9, 2003) ("[3] [e]ven though the final payment would reflect a hospital's true cost experience, there would still be the opportunity for a hospital to manipulate its outlier payments by dramatically increasing charges during the year in which the discharge occurs. In this situation, the hospital would receive excessive outlier payments, which, although the hospital would incur an overpayment and have to refund the money when the cost report is settled, would allow the hospital to obtain excess payments from the Medicare Trust Fund on a short-term basis.")
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always been available and should have been used to calculate outlier reimbursement. The Secretary explained that although he has the authority to revise the outlier threshold given the manipulation of the outlier payments, he elected not to exercise this authority because of the relatively small difference between the current threshold and the revised estimate and the short amount of time remaining in the FFY.[13] The Providers allege that the Secretary was aware of the problem months before the final rule was published, as demonstrated by Provider Exhibit 9, a copy of an interim final rule submitted to the Office of Management and Budget on February 12, 2003.[14] In *Banner Health v. Sebelius*,[15] the D.C. District Court stated that the February 12, 2003 interim final rule was virtually identical to the final proposed rule, with the exception that the later proposed rule, published on March 5, 2003, did not recommend reduction of the FLT in the supporting analysis.[16]

The Providers state that they did not learn of the February 12, 2003 unpublished, interim final rule until their counsel obtained it through a Freedom of Information Act request made to the Office of Management and Budget in 2012. They believe the interim final rule for FYs 2007-2015 continues to be relevant because the Secretary's methodology for establishing each fiscal year's FLT regulation is necessarily a function of, and applies, the payment regulation. The Providers contend that the Secretary repeatedly set the FLT at levels which paid out significantly less than the agency's stated target of 5.1 percent of the total IPPS payments. As a result, they assert that providers did not receive the full amount of outlier payments to which they were entitled under the statute.[17]

Further, in the June 28, 2012 Office of Inspector General (OIG) report, the Inspector General noted that seven years after the 2003 publication of the regulation requiring reconciliation of outlier payments, CMS had not reconciled any of the cost reports screened and reported by Medicare Administrative Contractors (MACs).[18] In a later, 2013 report,[19] OIG noted that although nearly all hospitals receive outlier payments, a small percentage of hospitals receive a significantly higher proportion of payments. The hospitals receiving this higher portion of payments charged Medicare more for the same Medical Severity- -DRGs, yet had similar lengths of stay and cost-to-charge ratios. The Providers contend that this is another example of CMS' failure to correct the distribution of outlier payments.[20]

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

1) The FLTs, established by the FLT regulations, are substantively invalid because, both as written and implemented, they represent agency action that violated the

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[14] The Providers furnished no evidence that this document was ever published in the Federal Register.
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Administrative Procedures Act in that it was arbitrary and capricious, exceeded statutory authority and frustrated the intent of Congress as reflected in the outlier statute.

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

   a) fails to "examine the relevant data and articulate a satisfactory explanation for its action including a rational connection between the facts found and the choice made," and/or ignored "new and better data." *Dist. Hosp. Partners v. Burwell,* 786 F.3d 46, 57-58 (D.C. Cir. 2015) (internal citations omitted).

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

   c) offers explanation(s) for its decision(s) that run counter to the evidence.[21]

The Providers believe EJR is appropriate because the Board is required to apply the outlier regulations establishing the FLT for the FYs at issue. The Providers assert that the Board lacks the authority to grant the relief sought: retroactive correction of the FLT.

Decision of the Board

The Board concludes that it lacks jurisdiction over the appeals because it is bound by the regulation 42 C.F.R. § 405.1835(a)(1)(ii) and dismisses the cases. Since jurisdiction over an appeal is a prerequisite to granting a request for EJR, the Providers' request for EJR is hereby denied. *See* 42 C.F.R. § 405.1842(a).

The regulation, 42 C.F.R. § 405.1835(a)(1)(ii), states that:

a) *Right to hearing on final contractor determination.* A provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, for specific items claimed for a cost reporting period covered by a final contractor or Secretary determination if—

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

[21] *Id.* at 14.

> (i) Including a claim for specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or
>
> (ii) Effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item(s) by following the applicable procedures for filing a cost report under protest, where the provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy (for example, if the contractor lacks discretion to award the reimbursement the provider seeks for the item(s)).

In these cases, the Providers received Notices of Program Reimbursement (NPRs) for cost reports that were filed after December 31, 2008. In the jurisdictional documents accompanying the Schedule of Providers, each Provider included a statement under Tab D that advising that:

> The provider did not self-disallow the outlier issue in its as-filed cost report. However, self-disallowance is not required. *See Banner Heart Hosp. v. Burwell*, [No. 14-CV-01195(APM), 2016 WL 4435174 (D.D.C. August 19, 2016)] ("under *Bethesda* [*Hospital Association v. Bowen*, 485 U.S. 399 (1988)]—and at *Chevron* Step One—the Secretary's self-disallowance regulation, as applied to the Plaintiffs' specific regulatory challenge, conflicts with the plain text of [42 U.S.C.] section 1395oo. The Board therefore erred in ruling that it lacked jurisdiction to hear the Plaintiff's challenge to the outlier regulations.") The *Banner Heart* decision invalidates "the [self-disallowance] regulation's application to providers who, like the Plaintiffs seek to assert a legal challenge to a regulation or policy than cannot be addressed by a fiscal intermediary."

However, the Court in *Banner* specifically addressed whether it was invalidating 42 C.F.R. § 405.1835(a)(1)(ii) in footnote 4 of the decision.[22] The D.C. District Court stated that:

> In their Complaint, Plaintiffs asked the court to "[i]nvalidat[e]" the self-disallowance regulation. Compl. At 20. The court, however, declines to do so, because its decision is limited only to the regulation's application to providers who, like Plaintiffs, seek to assert a legal challenge to a regulation or policy that cannot be addressed by a fiscal intermediary. The question is whether the self-disallowance regulation is lawful in all its applications is not

[22] No. 14-CV-01195(APM), 2016 WL 4435174 (D.D.C. August 19, 2016) at 10-11.

> before the court and, for that reason, the court will not vacate the regulation.

Since the Secretary has not taken action to remove the regulation from the Code of Federal Regulations, the Board is bound by the regulations by 42 C.F.R. § 405.1867. This regulation states that:

> In exercising its authority to conduct proceedings under this subpart, the Board must comply with all the provisions of Title XVIII of the Act and regulations issued thereunder, as well as CMS Rulings issued under the authority of the Administrator as described in § 401.108 of this subchapter. The Board shall afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS.

Although the D.C. District Court said its decision applied to Providers asserting a legal challenge to a regulation or policy that cannot be addressed by a fiscal intermediary, the Secretary has not acquiesced to this decision. Further, the Board is bound by 42 C.F.R. 405.1867 which requires the Board to comply with the regulations issued under Title XVIII of the Social Security Act, including 42 CFR 405.1835(a)(1)(ii).

Since this is the only issue under dispute in these appeals, the Board closes these cases. 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) and 42 C.F.R. §§ 405.1875 and 405.1877
Schedules of Providers

cc: Bruce Snyder, Novitas (w/Schedules of Providers)
Wilson Leong, FSS (w/Schedules of Providers)

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Suite 4900
Denver, CO 80202

RE: Meridian Health 2013 Outlier Threshold Group
Meridian Health 2014 Outlier Threshold Group
Provider Nos. Various
FYEs 2013 and 2014
PRRB Case Nos. 16-0242GC and 16-2437GC

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The Providers note that from 1997 through 2003, a number of hospitals were reported to have inflated their charge–masters, an action which the Department of Justice (DOJ) termed "turbo-charging." This practice greatly inflated cost to charge ratios which greatly increased the cost per case. The DOJ termed this action a false claim and this also resulted in the Secretary greatly increasing the FLT so that payments for outliers would remain at 5.1 percent of DRG payments. More specifically, beginning in or around Federal fiscal year (FFY) 1998, the Secretary began making upward adjustments to the FLTs which were in excess of the rate of inflationary indices routinely used, such as the Consumer Price Index for medical care or the Medicare Market Basket.[8]

In 2002, the Secretary disclosed that he was aware of "turbo-charging" and that he would be amending the outlier regulations to fix "vulnerabilities" in the regulations.[9] In the March 5, 2003[10] and June 9, 2003[11] Federal Registers, the Secretary acknowledged three flaws in the outlier payment regulations and stated that the vulnerabilities would be subject to reconciliation.[12] The Providers maintain that the data used to correct the vulnerabilities had always been available and should have been used to calculate outlier reimbursement. The

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[9] *Id.*
[10] 68 Fed. Reg. 10,420, 10,423 (Mar. 5, 2003) ("Recent analysis indicates that some hospitals have taken advantage of two vulnerabilities in our methodology to maximize their outlier payments . . . [1] the time lag between the current charges on a submitted bill and the cost-to-charge ratio taken from the most recently settled cost report [and 2] in some cases hospitals may increase their charges so far above costs that their cost-to-charge ratios fall below 3 standard deviations from the geometric mean of cost-to-charge ratios and a higher statewide average cost-to-charge ratio is applied.")
[11] 68 Fed. Reg. 34,494, 34,501 (June 9, 2003) ("[3] [e]ven though the final payment would reflect a hospital's true cost experience, there would still be the opportunity for a hospital to manipulate its outlier payments by dramatically increasing charges during the year in which the discharge occurs. In this situation, the hospital would receive excessive outlier payments, which, although the hospital would incur an overpayment and have to refund the money when the cost report is settled, would allow the hospital to obtain excess payments from the Medicare Trust Fund on a short-term basis.")
[12] Providers' October 10, 2016 EJR request at 6.

Secretary explained that although he has the authority to revise the outlier threshold given the manipulation of the outlier payments, he elected not to exercise this authority because of the relatively small difference between the current threshold and the revised estimate and the short amount of time remaining in the FFY.[13] The Providers allege that the Secretary was aware of the problem months before the final rule was published, as demonstrated by Provider Exhibit 9, a copy of an interim final rule submitted to the Office of Management and Budget on February 12, 2003.[14] In *Banner Health v. Sebelius*,[15] the D.C. District Court stated that the February 12, 2003 interim final rule was virtually identical to the final proposed rule, with the exception that the later proposed rule, published on March 5, 2003, did not recommend reduction of the FLT in the supporting analysis.[16]

The Providers state that they did not learn of the February 12, 2003 unpublished, interim final rule until their counsel obtained it through a Freedom of Information Act request made to the Office of Management and Budget in 2012. They believe the interim final rule for FYs 2007-2015 continues to be relevant because the Secretary's methodology for establishing each fiscal year's FLT regulation is necessarily a function of, and applies, the payment regulation. The Providers contend that the Secretary repeatedly set the FLT at levels which paid out significantly less than the agency's stated target of 5.1 percent of the total IPPS payments. As a result, they assert that providers did not receive the full amount of outlier payments to which they were entitled under the statute.[17]

Further, in the June 28, 2012 Office of Inspector General (OIG) report, the Inspector General noted that seven years after the 2003 publication of the regulation requiring reconciliation of outlier payments, CMS had not reconciled any of the cost reports screened and reported by Medicare Administrative Contractors (MACs).[18] In a later, 2013 report,[19] OIG noted that although nearly all hospitals receive outlier payments, a small percentage of hospitals receive a significantly higher proportion of payments. The hospitals receiving this higher portion of payments charged Medicare more for the same Medical Severity--DRGs, yet had similar lengths of stay and cost-to-charge ratios. The Providers contend that this is another example of CMS' failure to correct the distribution of outlier payments.[20]

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

1) The FLTs, established by the FLT regulations, are substantively invalid because, both as written and implemented, they represent agency action that violated the Administrative

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[13] *Id.*
[14] The Providers furnished no evidence that this document was ever published in the Federal Register.
[15] 2013 U.S. Dist. Lexis 69889 (D.D.C. May 16, 2013).
[16] Providers' October 10, 2016 EJR request at 7, n.15.
[17] *Id.*
[18] *Id.* at 11. Providers' Exhibit 10, OIG Report: The Centers for Medicare & Medicaid Services Did Not Reconcile Medicare Outlier Payments in Accordance with Federal Regulations and Guidance, Report A-07-10-02764 at 7-9 (June 2012).
[19] *Id.* at 12. Providers' Exhibit 11, Medicare Hospital Outlier Payments Warrant Increased Scrutiny, Report OEI-06-10-00520 (Nov. 2013).
[20] *Id.* at 12.

Procedures Act in that it was arbitrary and capricious, exceeded statutory authority and frustrated the intent of Congress as reflected in the outlier statute.

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

   a) fails to "examine the relevant data and articulate a satisfactory explanation for its action including a rational connection between the facts found and the choice made," and/or ignored "new and better data." *Dist. Hosp. Partners v. Burwell,* 786 F.3d 46, 57-58 (D.C. Cir. 2015) (internal citations omitted).

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

   c) offers explanation(s) for its decision(s) that run counter to the evidence.[21]

The Providers believe EJR is appropriate because the Board is required to apply the outlier regulations establishing the FLT for the FYs at issue. The Providers assert that the Board lacks the authority to grant the relief sought: retroactive correction of the FLT.

Decision of the Board

PRRB Case Number 16-0242GC

#1 Jersey Shore University Medical Center ("Jersey Shore") (provider number 31-0073), FYE 12/31/2013 and #2 Ocean Medical Center ("Ocean") (provider number 31-0052), FYE 12/31/2013

These Providers' appeals in case number 16-0242GC, were filed under the provisions of 42 C.F.R. § 405.1835(c)(2014). This regulation permits providers which have not received final determinations to file appeals with the Board where:

(1) A final contractor determination for the provider's cost reporting period is not issued **(through no fault of the provider)** within 12 months after the date of receipt by the contractor of the provider's perfected cost report or amended cost report (as specified in §

[21] *Id.* at 14.

> 413.24(f) of this chapter). The date of receipt by the contractor of the provider's perfected cost report or amended cost report is presumed to be the date the contractor stamped "Received" on such cost report unless it is shown by a preponderance of the evidence that the contractor received the cost report on an earlier date.
>
> (2) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the expiration of the 12 month period for issuance of the final contractor determination (as determined in accordance with paragraph (c)(1) of this section); and
>
> (3) The amount in controversy (as determined in accordance with § 405.1839) is $10,000 or more. (emphasis added)

Similarly, the Provider Reimbursement Manual (PRM) (CMS Pub. 15-1) §§ 2920 and 2905.1, reiterates the requirement that the provider may not be the cause of the delay in the issuance of a final determination. Section 2920 states that a provider may file an appeal with the Board where a "[MAC] has failed to issue an Notice of Program Reimbursement (NPR) within 12 months of receiving your [i.e. the provider's] perfected (final) or amended cost report, and **the cause of the days was not occasioned by you** [i.e., the provider], but was due to the [MAC's] failure to act timely." Section 2905.1 permits appeal in the same circumstances where "**the cause of such delay does not lie with the provider.**"

In this case, Jersey Shore filed cost reports that were received by the MAC on October 31, 2014, and December 12, 2014, and were accepted on November 6 and December 17, 2014, respectively. Ocean filed three cost reports received on May 28, 2014, October 2, 2014, and August 6, 2015, and were accepted on June 2, 2014, December 5, 2014, and September 3, 2015.

The Board concludes that Jersey Shore and Ocean caused the delay in issuing the NPR of the appealed cost reports within 12 months because prior to the expiration of the 12 month period of the submission of the first cost report, the Providers filed amended cost reports which were accepted by the MAC. Accordingly, the appeals for Jersey Shore University Medical Center (provider 31-0073) and Ocean Medical Center (provider number 31-0052) were premature when filed with the Board. Since the appeals did not comply with the requirements of 42 C.F.R. § 405.1835(d)(2014), the Board hereby dismisses the Providers from the case number 16-0242GC. Further, jurisdiction over a provider is a prerequisite to granting a request for EJR; consequently, the request for EJR for Jersey Shore University Medical Center and Ocean

Medical Center for the FYE December 31, 2013, is hereby denied. *See* 42 C.F.R. § 405.1842(a). The Providers may file an appeal with the Board upon receipt of their respective NPRs.

Request for EJR

The Board has reviewed the submissions of the remaining Providers pertaining to the requests for hearing and expedited judicial review. 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permit expedited judicial review where the Board determines that it does not have the authority to decide a question of law, regulation or CMS ruling. In these cases, the Providers are challenging the validity of the outlier regulations, 42 C.F.R. §§ 412.80 through 412.86.[22] The Intermediaries did not oppose the request for EJR. The documentation shows that in each case the estimated amount in controversy exceeds $50,000 threshold for Board jurisdiction over group appeals and the appeals were timely filed.[23]

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

3) it is bound by the regulations; and

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

Accordingly, the Board finds that the outlier issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the remaining Providers' request for expedited judicial review for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. The Board's jurisdictional decision is subject to review under the prov
isions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877. Since this is the only issue under dispute, the Board hereby closes the cases.

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

[23] With the exception of Bayshore Community Hospital in case number 16-0242GC, all of the Providers in case numbers 16-0242GC and 16-2437GC filed under the provisions of 42 C.F.R. § 405.1835(c)(2014). Bayshore Community Hospital timely filed from the issuance of an NPR and protested the FLT issue as required by 42 C.F.R. § 405.1835(a)(1)(ii).

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FOR THE BOARD

Charlotte Benson for

Michael W. Harty
Chairman

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

cc: Bruce Snyder, Novitas (w/Schedules of Providers)
Wilson Leong, FSS (w/Schedules of Providers)

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RE: St. Mary Medical Center – Long Beach
Provider No.: 05-0191
FYE: 6/30/10
PRRB Case No.: 14-1786

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 is set forth below.

Background

The Provider submitted a request for hearing on January 16, 2014, based on a Notice of Program Reimbursement ("NPR") dated July 23, 2013. The hearing request included twenty-one issues,[1] ten of which were subsequently transferred to group appeals[2] and seven of which were subsequently withdrawn.[3] Four issues remain in the appeal as follows:

- Issue No. 2 – Medicare Bad Debt
- Issue No. 5A – Medicare Disproportionate Share Hospital (DSH) Payments – Additional Medicaid Eligible Days
- Issue No. 5B – Medicare Rehabilitation Low Income Patient (LIP) Payments – Additional Medicaid Eligible Days
- Issue No. 10B – Medicare Rehabilitation Low Income Patient (LIP) Payments – Code 2 and 3 Medicaid Eligible Days

The Medicare Contractor submitted a jurisdictional challenge on Issue No. 5B and Issue No. 10B on August 18, 2015.[4] The Provider filed a responsive brief on May September 10, 2015.

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[1] The Provider's hearing request listed nineteen issues; Issue Nos. 5 and 10 and actually contained two issues each, bringing the total to twenty-one.

[2] Six issues were transferred via a letter dated September 3, 2014, one issue was transferred via a letter dated September 24, 2014, and three issues were transferred via requests dated October 14, 2016.

[3] One issue was withdrawn in the Provider's Jurisdictional Challenge Response dated September 9, 2015 and six issues were withdrawn in the Provider's Final Position Paper dated October 21, 2015.

[4] The Medicare Administrative Contractor challenged six issues in total, but the other issues have been transferred to group appeals or withdrawn.

Medicare Contractor's Position

The Medicare Contractor contends that the language of 42 U.S.C. § 1395ww(j)(8)(B)[5] unambiguously precludes administrative and judicial review of the Inpatient Rehabilitation Facility-Prospective Payment ("IRF-PPS") rates established under 42 U.S.C. § 1395ww(j)(3)(A). The Medicare Contractor maintains that, because the IRF-PPS rate is comprised of both the general federal rate based on historical costs and adjustments to that federal rate (including but not limited to the LIP adjustment at issue), the statute prohibits administrative and judicial review of the LIP adjustment.[6] Accordingly, the Medicare Contractor argues that the Board is divested of jurisdiction to hear the Provider's appeal because it must comply with all of the provisions of the Medicare Act and the regulations issued thereunder.[7]

Provider's Position

The Provider contends that the NPR issued on July 23, 2013 constitutes a final determination by the Medicare Contractor with respect to the provider's cost report. In 42 C.F.R. § 405.1801(a)(2), it defines a final determination as follows: "An intermediary determination is defined as a "determination of the total amount of payment due to the hospital, pursuant to § 405.1803 following the close of the hospital's cost reporting period…"[8]

The Provider contends that in this case the Provider's claims that the Medicare Contractor has jurisdictionally challenged were either contained in the body of the as-filed cost report, and such claims were adjusted by the Contractor, and such claims were self-disallowed as protested amounts in the filed cost report, giving way to appeal rights. The Provider contends the Medicare Contractor made an adjustment that revised the LIP Medicaid Eligible Days from 170 to 227 and IRF LIP SSI ratio from 0.1614 to 0.1637 per audit adjustment numbers 11 an 67. The Medicare Contractor also made an adjustment that eliminated $208,573 of the as-filed protested amount related to LIP payment issues. These adjustments allow the Provider an avenue to pursue a correction to their DSH entitlement via the PRRB appeal process.[9]

The Provider contends that the LIP adjustment is not a component of the IRF-PPS rate described in § 1395ww(j)(3)(A) (*i.e.*, the unadjusted federal rates) because LIP is calculated as a current cost reporting period add-on payment to the IRF-PPS federal payment and it is reported on a separate line within the Medicare cost report.[10] The Provider argues that it is only disputing the accuracy of the provider-specific data elements used by the Medicare Contractor, not the establishment or methodology for development of the federal IRF prospective payments.[11] The Provider contends that § 1395ww(j)(8) does not prohibit its challenge as to whether CMS and its agents utilized the proper data elements in executing that formula. The Provider maintains that, while § 1395ww(j)(8) prohibits administrative or

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[5] Formerly designated at paragraph (7). Section 3004(b) of the Affordable Care Act addressed the IRF PPS program and reassigned the previously-designated section 1886(j)(7) of the Act [42 U.S.C. § 1395ww(j)(7)] to section 1886(j)(8) [42 U.S.C. § 1395ww(j)(8)] and inserted a new section 1886(j)(7), which contains new requirements for the Secretary to establish a quality reporting program for IRFs.
[6] Medicare Contractor's jurisdictional challenge at 4.
[7] 42 C.F.R. § 405.1867. *Id.* at 5.
[8] Provider's jurisdictional response at 3 (Emphasis included).
[9] *Id.* at 4-5.
[10] *Id.* at 5.
[11] *Id.* at 6.

judicial review for certain aspects of the establishment of the IRF payments, there is no specific language within § 1395ww(j)(8) prohibiting administrative or judicial review as it pertains to the establishment of LIP.[12]

Board's Decision

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 jurisdictional issue presented here is whether or not this hospital has preserved its right to claim dissatisfaction with the amount of Medicare payment. "A provider. . . has a right to a Board hearing . . . only if – (1) the provider has preserved its right to claim dissatisfaction.....by.....[i]ncluding a claim for specific item(s) on its cost report...or...self-disallowing the specific item(s) by.....filing a cost report under protest.....[13]

The Board finds that there is evidence in the record that the Provider's reported Rehabilitation Unit Part A protested amount included estimated $7,985 amounts related to LIP – Additional Medicaid Eligible Days and LIP – Code 2 and 3 Eligible Days. The LIP – Additional Medicaid Eligible Days protested amount was described as follows:

> Understated LIP payments pending receipt of State of California Medicaid eligibility verification. The State of California's Medicaid Eligibility Branch maintains a policy of not processing Medicaid eligibility verification until 13 months after the Provider's fiscal year end. Consequently, the Provider is unable to report a Medicaid eligible day count that was verified by the State of California's Medicaid Eligibility Branch.[14]

The LIP – Code 2 and 3 Eligible Days protested amount was described as follows:

> Understated LIP payments due to the exclusion of Code 2 & 3 Medicaid Days without an aid code returned from the State of California's Medicaid Eligibility Branch.[15]

As such, the Board concludes that it has jurisdiction over these issues as they were properly protested in the Provider's as-filed cost report.

Additionally, in reviewing this matter, the Board first looked to the statutory provision prohibiting certain judicial and administrative review. 42 U.S.C. § 1395ww(j)(8) specifies:

> There shall be no administrative or judicial review . . . of the *establishment* of—

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[12] *Id.*
[13] 42 C.F.R. § 405.1835(a).
[14] *See* Listing of Issues Filed Under Protest in Exhibit 4 of Provider's jurisdictional response.
[15] *Id.*

> (A) case mix groups, of the methodology for the classification of patients within such groups, and the appropriate weighting factors thereof under paragraph (2),
>
> (B) the prospective payment rates under paragraph (3),
>
> (C) outlier and special payments under paragraph (4), and
>
> (D) area wage adjustments under paragraph (6).[16]

The United States District Court for the District of Columbia in *Mercy Hosp., Inc. v. Burwell ("Mercy")*, No. 15-1236 (JDB), 2016 WL 4007072, at *8 (D.D.C. July 25, 2016), recently concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's interpretation of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates. The Board in *Mercy* had previously held that it had jurisdiction to review the Medicare Contractor's determination of the LIP adjustment.[17] The Administrator of CMS vacated the Board's decision concluding that the Board had lacked authority to hear the hospital's appeal in light of 42 U.S.C. § 1395ww(j)(8).[18] *Mercy* appealed to the United States District Court for the District of Columbia who affirmed the Administrator's decision.

The Board notes the text of § 1395ww(j)(8) prohibits administrative or judicial review of "*the establishment* of" the items listed in Subparagraphs (A) to (D). The Board finds the use of the word "establishment" in the statute significant.[19] St. Mary Medical Center – Long Beach is not challenging "the *establishment* of" either the federal rates or "the *establishment* of" the LIP adjustment to those rates, since this appeal challenges no part of the August 2001 Final Rule in which the Secretary established the LIP adjustment itself (*i.e.*, the formula used to calculate the adjustment). Rather, St. Mary Medical Center – Long Beach is challenging whether the Medicare Contractor properly executed the LIP adjustment, specifically whether the Medicare Contractor's calculation of the LIP adjustment used the proper provider-specific data elements in that calculation. The Board finds no prohibition in 1395ww(j)(8) to administrative or judicial review of *"the calculation of"* the LIP adjustment where the focus is on the accuracy of the provider-specific data elements being used in the LIP adjustment calculation.

In this case, the Provider is disputing two separate and distinct issues related to the LIP payment. Issue No. 5B relates to additional LIP Medicaid Eligible Days and issue No. 10B relates to additional Code 2 and 3 LIP Medicaid Eligible Days. The Board finds both issues relate to specific scenarios cited by the United States District Court for the District of Columbia in *Mercy* when responding to *Mercy's* argument that if the limitation on review were as broad as the Secretary urges, then there would be nothing for inpatient rehabilitation providers to challenge.[20] The court stated:

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[16] (emphasis added)
[17] *Mercy Hospital v. First Coast Service Options, Inc.*, PRRB Dec. No. 2015-D7, 2013 WL 10381780, at *1 (Apr. 3, 2015).
[18] *Mercy Hospital v. First Coast Service Options, Inc.*, Review of PRRB Dec. 2015-D7, 2015 WL 3760091, at *11 (June 1, 2015).
[19] 42 U.S.C. § 1395ww(j)(8).
[20] *Mercy*, 2016 WL 4007072 at *7.

> [b]ut the Secretary's interpretation does not leave inpatient rehabilitation providers with nothing to appeal. Suppose that a contractor failed to account for a number of patients altogether, proposing reimbursement for 475 Medicare beneficiaries instead of the 600 Medicare beneficiaries that the provider believed it had treated. A challenge to the contractor's decision to exclude those 125 patients would ***not*** be a challenge to the prospective payment rates, and so would not be barred by paragraph (8)'s limitation on review. (Emphasis added).

Likewise, St. Mary's is not challenging the establishment of the prospective payment rates but instead is challenging the accuracy of the Medicare Contractor's calculation of the provider-specific data elements being used in the LIP adjustment calculation. Specifically, the underlying data used in the calculation of the number of Medicaid Eligible Days and Code 2 & 3 Days. The dispute does not resolve around whether these categories of days should be included, only if the correct number of days was included. As articulated by the U.S. District Court, this is not a challenge to the prospective payment rates and as such would not be barred by paragraph (8)'s limitation on review.

The Board notes however, even in the absence of this exception articulated by the court which is applicable in the instant case, that it respectfully disagrees with the U.S. District Court for the District of Columbia's decision in *Mercy* which found that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the contractor's interpretation of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates. The Board has been clear on its decision in regards to this issue.[21] The Board continues to stand by its conclusion that it has jurisdiction to review the Medicare Contractor's determination of the LIP adjustment including the understatement of the Medicaid Days and the Code 2 and 3 Days.

As noted above, the Administrator in *Mercy* and the U.S. District Court for the District of Columbia affirming the Administrator, reversed the Board's decision that it had jurisdiction over the LIP payment factors. The Administrator and the U.S. District Court restated the Medicare Contractor's assertion that administrative and judicial review of the LIP adjustment is precluded because § 1395ww(j)(8) precludes review of the prospective payment rate under paragraph (3) as well as *all* adjustments articulated in subsequent paragraphs. The Board, however, remains unconvinced, and continues to disagree with the Administrator and the U.S. District Court for the District of Columbia's overly broad interpretation.

This case is scheduled for a live hearing on December 7, 2016. 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.

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[21] See the Board's decision in *Mercy*; See also, the Board's latest decision in *St. Joseph Hospital of Eureka v. Noridian Healthcare Solutions*, PRRB Dec. No. 2016-D4, 2016 WL 10371515 (December 2, 2015).

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RE: Providence Health 2007-2009 SSI CIRP Group
Provider Nos.: 50-0024; 50-0014; 50-0054; 50-0077
FYE: 12/31/2009
PRRB Case No.: 12-0068GC

Dear Mr. Nord and Mr. Ward,

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

Background

On December 2, 2011, the Board received the Common Issue Related Party ("CIRP") Group Appeal Request. All of the Providers appealed based on the Medicare Contractor's failure to timely issue Notices of Program Reimbursement ("NPR"). On September 10, 2012, the group representative, Quality Reimbursement Services, Inc. ("QRS"), attempted to add the 2007, 2008 and some 2009 cost reporting periods to the CIRP Group, based upon the publishing of the SSI percentage on the Center for Medicare and Medicaid Services' website on March 16, 2012. The Board issued a decision dismissing this appeal on January 29, 2013, based on its finding that the publication of the SSI Ratios is not a final determination from which Providers can appeal to the Board.

The Board received Model Form E requests to join this appeal, Case No. 12-008GC, from Providers appealing from NPRs on April 29, 2013. On June 19, 2013, the Board established QRS Providence Health 2007-2009 CIRP Group II, Case No.: 13-2348GC, a separate CIRP Group for Providence Providers filing from a final determination.

The Board then reinstated this appeal, Case No.: 12-0068GC, in order to address the participants that initially filed the subject group appeal based on the Medicare Contractor's failure to timely issue a final determination. On December 31, 2013, the Medicare Contractor submitted its Jurisdictional Brief, and on January 14, 2014, QRS sent correspondence agreeing that appeals from non-issuance of NPRs were not timely filed.

Medicare Contractor's Contentions

Timeliness

This case was reinstated by the Board on July 3, 2013 to address four Providers that initially filed the group appeal on the basis that the Medicare Contractor failed to issue final determinations.[1] The Medicare Contractor contends that none of the appeal requests were filed timely pursuant to 42 C.F.R. § 405.1835(a)(3)(ii) and all of the cost reports were received on May 28, 2010 and all of the hearing requests were received on December 1, 2013.[2] The Medicare Contractor argues that there are 187 days between the expiration of the 12 month period for issuance of the Medicare Contractor's determination and the receipt of the hearing requests. Therefore, the Medicare Contractor argues that the Providers did not timely appeal from the non-issuance of NPRs.

LIP – SSI Issue

As defined by the Providers, the issue is whether the SSI percentage used in the Medicare DSH calculation accurately and correctly accounts for all patient days that must be included as part of the SSI percentage. However, an adjustment to the SSI percentage used in the LIP payment for a rehabilitation subprovider was included in the jurisdictional documents and listed as one of the determinations under appeal for the Provider – Providence St. Peter Hospital (Provider No.: 51-0024).[3] The Medicare Contractor contends that the LIP SSI should not be part of this appeal as the LIP adjustment for rehabilitation services is governed by a different regulation than the one governing hospital DSH payments.

Dissatisfaction Requirement

The Medicare Contractor finds that there are jurisdictional impediments for Participants 1 and 2 in this group because those Providers did not meet the dissatisfaction requirement for jurisdiction.

According to the Medicare Contractor, all four of the Providers in this group had the SSI percentages adjusted to those published on the CMS website for use in cost reports beginning in Federal fiscal year 2009. The Medicare Contractor does not consider those adjustments sufficient to establish hearing rights pursuant to the regulation at 42 C.F.R. § 405.1835(a)(1) which states:

> (1) The Provider has preserved its right to claim dissatisfaction with amount of Medicare payment for the specific item(s) at issue by either –
>
> (i) Including a claim for specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy

[1] Medicare Contractor's Review of Schedule of Providers and Findings on Jurisdiction, Exhibit I-3, Page 3.
[2] *Id.* at Exhibit I-2.
[3] *Id.* at Exhibit I-1, Adjustment 36.

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

The Medicare Contractor contends that none of the Providers meet the first option as the regulation requires CMS to determine the SSI percentage. The Providers question whether CMS has properly determined that percentage. The regulation prohibits the Providers from claiming additional days in the SSI percentage that are not in accordance with Medicare policy. The Providers are challenging Medicare policy and are precluded from that policy, as well as by manual instructions, from claiming the days in dispute via its own internally determined SSI percentage. The Medicare Contractor also suggests that if the Board decides to grant jurisdiction, it may be more efficient to move any provider with appeal rights to Case No.: 13-2438GC, which was established for related CIRP providers appealing from NPR issuances.[4]

The Medicare Contractor maintains that in all but one of the cost reports in the group, the adjustment actually increased the SSI percentage filed on the cost report. In addition, the Medicare Contractor does not have the discretion to award the reimbursement that the Providers seek for this issue. The only allowable SSI percentage is the one CMS determines, the regulations do not provide for the Medicare Contractor to calculate the SSI percentage. Therefore, the only way for the Providers to preserve their right to claim dissatisfaction with those determinations is to follow the procedures for filing a cost report under protest.

Provider's Contentions

Timeliness

The Provider states that the Medicare Contractor is correct with respect to its reading of the regulation at 42 C.F.R § 405.1835(a)(3)(ii). The Provider states that upon review of this regulation the appeals were filed 188 days after the 12 month anniversary of when the cost reports were initially filed. However, each of the hospitals included in the group has now received their NPRs and are within the 180 days appeal filing timeframe.

LIP – SSI Issue

The Provider contends that mandatory CIRP groups are required for related party providers. The acute and rehab areas of the hospital definitely qualify as being related providers. Additionally, SSI percentages are determined in an identical manner for both acute and rehab facilities. The only difference is the provider number itself. The arguments related to the recognition of "entitled" days are identical as well. Thus, for judicial efficiency the Provider requests that the Board permit both acute and rehab units to be addressed in the same CIRP group.

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[4] *Id.* at Exhibit I-3, Page 2.

Dissatisfaction Requirement

The Providers contend that pursuant to 42 U.S.C. § 1395oo(a), a provider (or group of providers) does not have to protest issues to establish Board jurisdiction. The Providers argue that the requirement of dissatisfaction is met when the provider is dissatisfied with the amount of Medicare payment or when "the provider is unable to determine whether the Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment."[5] The Providers also contend that the Medicare Contractor did adjust the SSI percentages for each of the Providers included in the CIRP group.

The Provider also contend that once the Board's jurisdiction is properly invoked, the Board may exercise its jurisdiction over any other matter covered by the cost report, even if the dissatisfaction requirement has not been satisfied as to the particular matter.

The Providers conclude that the 180-day deadline was exceeded with respect to the establishment of appeal rights due to the Medicare Contractor's failure to issue NPRs within 12 months of having received the cost reports. Accordingly, the Providers concur that the Board does not have proper jurisdiction over this group appeal. However, the Providers request that the jurisdictional decision be based upon this sole reason – that the appeal was not timely filed because it believes it is proper to include acute care and rehab units in the same related party group appeal and that the adjustments to the SSI percentage are adequate determinations from which SSI systemic issues can be addressed.

Board's Decision

Timeliness

The Board finds that it does not have jurisdiction over this group appeal because the four Providers in the group did not timely file their appeal requests.

Pursuant to 42 C.F.R. § 1395oo(a) and 42 C.F.R § 405.1835 – 405.1841, a provider has a right to hearing before the Board with respect to costs claimed on a timely filed cost report if is it dissatisfied with the final determination of the Medicare Contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the day of the NPR.

As the Medicare Contractor pointed out and the Provider representative concurred, all of the Providers filed appeals from the non-issuance of the NPRs late. Though the Providers eventually received NPRs and appealed from those final determinations into this group, the Board established a separate group, PRRB Case No.: 13-2348GC, for those appeals. The Board has also already addressed the fact that the publishing of the SSI ratios is not a final determination from which Providers can appeal.

All of the cost reports were received by the Medicare Contractor on May 28, 2010 and all of the

[5] Provider's Jurisdictional Findings of Noridian Administrative Services; *see also* 42 C.F.R. § 405.1835(b)(2)(i).

hearing requests were received by the Board on December 2, 2013. There are 188 days between the Medicare Contractor's failure to issue a final determination and the receipt of the hearing requests. Therefore, the Board finds that it does not have jurisdiction over the group because the Providers did not timely file their appeals. The Board hereby dismisses Case No. 12-0068GC.

LIP – SSI Issue

The Providers argue in their jurisdictional brief that, although the appeals were not timely filed, the Board should include in its jurisdictional decision that the DSH and Low Income Patient ("LIP") issues can be pursued in the same group appeal. The Board rejects this argument. DSH and LIP Providers cannot be in the same group because the DSH-SSI percentage and the LIP-SSI percentage issue are two distinct legal issues.

Furthermore, the Board finds that the LIP SSI percentage issue was not raised as an issue in this group. The issue statement for this group appeal states, "whether the SSI percentage used in the Medicare DSH calculation by the Medicare Contractor accurately and correctly accounts for all patient days that must be included in the numerator and the denominator of the SSI calculation." The Board finds that only the DSH SSI percentage issue is raised by this issue statement.

Summary

The Board finds that the Providers did not timely file this group appeal from the non-issuance of NPRs. In addition, the Board rejects the Providers' request that the Board find that DSH and LIP SSI percentage issues can be pursued in the same group appeal and confirms that the appeal contains only the DSH-SSI percentage issue. Case No.: 12-0086GC is hereby dismissed.

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

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

FOR THE BOARD

Charlotte Benson for

Michael W. Harty
Chairman

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

cc: Wilson C. Leong, Esq., CPA, FSS

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

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Refer to: 16-1070
Certified Mail

NOV 30 2016

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

RE: Antelope Valley Hospital
Provider No. 05-0056
FYE 6/30/2016
PRRB Case No. 16-1070

Dear Mr. Kramer:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's October 28, 2016 request for expedited judicial review (EJR) (received October 31, 2016). The decision of the Board is set forth below.

Issue under Dispute

Whether the provision in the FY [Fiscal Year] 2015 IPPS [Inpatient Prospective Payment System] Final Rule [("Final Rule")] that imposes a .02 [sic .2][percent] decrease in the IPPS rates for all IPPS hospitals for each of FYs 2014 - 2018 is procedurally invalid, arbitrary and capricious, and outside the statutory authority of [the Secretary[1]].[2]

Statutory and Regulatory Background

In the final IPPS rule for 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[3] 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] of the Department of Health and Human Services.
[2] Provider's October 28, 2016 EJR Request at 3.
[3] 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).

impact on Medicare beneficiaries who may incur greater financial liability than they would if they were admitted to the hospital as inpatients.[4]

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.[5]

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).[6]

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[7] 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.[8]

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[4] 78 Fed. Reg. 50,496, 50,907 (Aug. 19, 2013).
[5] *Id.*
[6] *Id.*
[7] CMS Pub. 100-02, Chapter 6, §20.6 and Chapter 1, §10.
[8] 78 Fed. Reg. at 50,907-08.

In the FFY 2014 IPPS proposed rule,[9] 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).[10]

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.[11]

As a result of the number of these administrative adjudications, the CMS Administrator issued Ruling CMS-1455-P[12] (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.[13] The 1-year deadline for filing claims remained unchanged and the Secretary stated that she was

[9] *See generally* 78 Fed. Reg. 27,486 (May 10, 2013).
[10] 78 Fed. Reg. 50,908.
[11] *Id.*
[12] *See* 78 Fed. Reg. 16,614 (Mar. 18, 2013)
[13] 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.[14]

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.[15]

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).[16] The Secretary maintains that she has consistently provided physicians with a time-based admission framework to effectuate appropriate inpatient hospital admission decisions.[17]

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

[14] *Id.* at 50,927.
[15] *Id.* at 50,944.
[16] *Id.*
[17] *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.[18] 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.[19] 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.[20]

Provider's Request for EJR

The Provider has requested EJR over the 0.2 percent reduction to IPPS rates because it does not believe the Board has the authority to declare the reduction invalid. The regulation, 42 C.F.R. § 405.1867 requires that the Board comply with all provisions of Title XVIII of the Social Security Act and the regulation thereunder. Consequently, the Providers assert, the Board lacks the authority to decide whether the Final Rule is procedurally invalid, arbitrary, capricious, and outside the statutory authority of CMS.[21]

The Provider notes that in *Shands Jacksonville Medical Center, Inc. et al. v. Burwell*[22] *(Shands)* the Court found that the Secretary did not give the public an adequate opportunity to comment on the [2014] IPPS final rule because the proposed rule did not explain the methodology for predicting that there would be a net shift of 40,000 cases from outpatient to inpatient.[23] As a result of the Court order in *Shands*, the Secretary published a notice in the December 1, 2015 Federal Register[24] repromulgating the final rule with an opportunity for comment. In the April 27, 2016 proposed IPPS Rule for FFY 2017, the Secretary announced that the 0.2 percent payment reduction was being abandoned. In addition, they propose an increase to the payment rates in FFY 2017 by 0.2 percent, as well as to make a one-time positive adjustment of 0.6 percent in order to reverse the effect of the 0.2 percent payment cut for FYs 2014, 2015 and 2017 [sic 2016]. The Provider believes that even if finalized, it will not necessarily make providers whole for the reduction in their IPPS payments caused by the 2-midnight rule.[25]

Decision of the Board

The Board has reviewed the Provider's requests for hearing and EJR. The regulation at 42 C.F.R. § 405.1842(a) permits the Board to consider 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

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[18] *Id.* at 50,952-53.
[19] *Id.* at 50,990.
[20] 79 Fed. Reg. 49,854, 50,382-83 (Aug. 22, 2014).
[21] Provider's October 28, 2016 EJR request at 17.
[22] 139 F.Supp.3d 240 (D.D.C. 2015).
[23] *Id.* at 265.
[24] 80 Fed. Reg. 75107 (Dec. 1, 2015)
[25] Provider's October 28, 2016 EJR request at 12.

conduct a hearing under the provisions of 42 C.F.R. §§ 405.1835 and 405.1840(a). The Board concludes that the Provider timely filed its request for hearing[26] from the issuance of the August 17, 2015 Federal Register[27] and the amount in controversy exceeds the $10,000 threshold necessary for an individual appeal.[28] Consequently, the Board has determined that it has jurisdiction over Provider's appeal. This issue involves a challenge to the application of the 0.2 percent reduction, for which the background regarding its promulgation 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 valid; 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

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 for expedited judicial review on for the issue and the subject year. The Provider has 60 days from the receipt of this decision to institute

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[26] The hearing request was received in the Board's office on Tuesday, February 16, 2016, the 183rd day after publication of the Federal Register notice. The 180th day after publication fell on Saturday and the appeal received on the next business day (Monday, February 15, 2016 was Presidents' Day when Federal offices are closed). This complies with the requirements of 42 C.F.R. § 405.1801(d)(3).

[27] *Washington Hospital Center v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986) ([A] year end cost report is not a report necessary in order for the Secretary to make PPS payments, and the appeals provisions 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 Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 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).

[28] *See* 42 C.F.R. § 405.1835.

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
Jack Ahern, MBA

FOR THE BOARD:

Michael W. Harty
Chairman

Enclosure: 42 U.S.C. § 1395oo(f)(1)

cc: Evaline Alcantara, Noridian Healthcare Solutions
Wilson Leong, FSS