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

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

Refer to: 16-2228

JAN 0 9 2017

CERTIFIED MAIL

Paul Evers
Lubaway, Masten & Company, Ltd.
510 Highland Avenue
Milford, MI 48381

Byron Lamprecht
Wisconsin Physicians Service
Cost Report Appeals
2525 N. 117th Avenue, Suite 200
Omaha, NE 68164

RE: Jurisdictional Decision
Oakland Physician Medical Center (d/b/a Pontiac General Hospital)
Provider No.: 23-0013
FYE: 12/31/2011
PRRB Case No.: 16-2228

Dear Mr. Evers and Mr. Lamprecht,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above-referenced appeal. The Board finds that the appeal was not timely filed and does not qualify for a good cause extension. The Board's decision is set forth below.

Background

On November 17, 2014, Pontiac General Hospital was issued its original Notice of Program Reimbursement ("NPR") for fiscal year end ("FYE") 12/31/2010. The Provider filed its appeal request with the Board 634 days later, on August 12, 2016.

Provider's Position

The Provider requests that the Board find that there is "good cause" for its delay in filing an NPR appeal. The Provider asserts that good cause should be found because:

1. When the NPR was issued, the Provider was in serious financial distress, ultimately resulting in the need for the Provider to seek bankruptcy protection, from which the Provider had only recently emerged. During this period of financial distress and bankruptcy, the Provider did not have total control of the management of its business and financial affairs.

2. The Provider relied on the Medicare Contractor's issuance of a reopening letter and on that basis did not file an appeal within the initial 180 days.

3. The Medicare Contractor issued a notice of reopening on February 16, 2015. The Provider believed at that time the discrepancy with the Full Time Equivalent (FTE) would be resolved.

4. The FTE issue was not resolved during the reopening process. Rather, the Provider received correspondence dated April 27, 2016 from WPS closing this fiscal year based on a Settlement Agreement.

5. The Provider believes that the Medicare Contractor's interpretation of the Settlement Agreement is inaccurate and has requested reconsideration.

6. The Provider is not appealing to the Board the Medicare Contractor's reopening denial for 2009. The Provider notes, however, that if the Medicare Contractor denies the Provider's request to reopen this year, the Provider's only legal remedy is for the Board to grant this request for an appeal.

Board's Decision

The Board finds that it does not have jurisdiction over this appeal because the Provider did not timely file its appeal and does not qualify for a good cause extension.

Pursuant to 42 C.F.R. § 405.1835(a)(3), unless the Provider qualifies for a good cause extension, the Board must receive a Provider's hearing request no later than 180 days after the date of receipt of the final determination, with a five-day presumption for mailing. Pursuant to 42 C.F.R. § 405.1801(a) and PRRB Rule 21, for appeal requests filed after August 21, 2008, the date of filing is the date of receipt by the Board, or the date of delivery by a nationally-recognized next-day courier.

The regulation at 42 C.F.R. § 405.1836(b) explains when the Board may find good cause to extend the time for filing. The regulation states in pertinent part:

> The Board may find good cause to extend the time limit only if the provider demonstrates in writing it [could] not reasonably be expected to file timely due to extraordinary circumstances beyond its control (such as a natural or other catastrophe, fire, or strike), and the provider's written request for an extension is received by the Board within a reasonable time (as determined by the Board under the circumstances) after the expiration of the applicable 180-day limit specified in § 405.1835(a)(3).

In the instant appeal, the Board finds that the Provider's reasons for not timely filing its appeal do not rise to the level of a good cause extension of the time limit to file an appeal. The Provider apparently knew of some FTE discrepancy because of a 2011 settlement agreement, even though it argues that its decision not to file an appeal was based on the Notice of Reopening issued in

2015.[1] Based on these facts, the Board finds that the Provider did not provide any documentation explaining why it did not or could not file sooner and therefore is at fault for not timely filing an appeal. Case number 16-2228 is hereby closed and removed 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
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA (recused)
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

cc: Wilson Leong, Esq., CPA, Federal Specialized Services

[1] Provider's Appeal Request at Exh. 3.

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CERTIFIED MAIL

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510 Highland Avenue
Milford, MI 48381

Byron Lamprecht
Wisconsin Physicians Service
Cost Report Appeals
2525 N. 117th Avenue, Suite 200
Omaha, NE 68164

RE: Jurisdictional Decision
Oakland Physician Medical Center (d/b/a Pontiac General Hospital)
Provider No.: 23-0013
FYE: 12/31/2010
PRRB Case No.: 16-2231

Dear Mr. Evers and Mr. Lamprecht,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above-referenced appeal. The Board finds that the appeal was not timely filed and does not qualify for a good cause extension. The Board's decision is set forth below.

Background

On October 17, 2014, Pontiac General Hospital was issued its original Notice of Program Reimbursement ("NPR") for fiscal year end ("FYE") 12/31/2010. The Provider filed its appeal request with the Board 665 days later, on August 12, 2016.

Provider's Position

The Provider requests that the Board find that there is "good cause" for its delay in filing an NPR appeal. The Provider asserts that good cause should be found because:

1. When the NPR was issued, the Provider was in serious financial distress, ultimately resulting in the need for the Provider to seek bankruptcy protection, from which the Provider had only recently emerged. During this period of financial distress and bankruptcy, the Provider did not have total control of the management of its business and financial affairs.

2. The Provider relied on the Medicare Contractor's issuance of a reopening letter and on that basis did not file an appeal within the initial 180 days.

3. The Medicare Contractor issued a notice of reopening on February 16, 2015. The Provider believed at that time the discrepancy with the Full Time Equivalent (FTE) would be resolved.

4. The FTE issue was not resolved during the reopening process. Rather, the Provider received correspondence dated April 27, 2016 from WPS closing this fiscal year based on a Settlement Agreement.

5. The Provider believes that the Medicare Contractor's interpretation of the Settlement Agreement is inaccurate and has requested reconsideration.

6. The Provider is not appealing to the Board the Medicare Contractor's reopening denial for 2009. The Provider notes, however, that if the Medicare Contractor denies the Provider's request to reopen this year, the Provider's only legal remedy is for the Board to grant this request for an appeal.

Board's Decision

The Board finds that it does not have jurisdiction over this appeal because the Provider did not timely file its appeal and does not qualify for a good cause extension.

Pursuant to 42 C.F.R. § 405.1835(a)(3), unless the Provider qualifies for a good cause extension, the Board must receive a Provider's hearing request no later than 180 days after the date of receipt of the final determination, with a five-day presumption for mailing. Pursuant to 42 C.F.R. § 405.1801(a) and PRRB Rule 21, for appeal requests filed after August 21, 2008, the date of filing is the date of receipt by the Board, or the date of delivery by a nationally-recognized next-day courier.

The regulation at 42 C.F.R. § 405.1836(b) explains when the Board may find good cause to extend the time for filing. The regulation states in pertinent part:

> The Board may find good cause to extend the time limit only if the provider demonstrates in writing it [could] not reasonably be expected to file timely due to extraordinary circumstances beyond its control (such as a natural or other catastrophe, fire, or strike), and the provider's written request for an extension is received by the Board within a reasonable time (as determined by the Board under the circumstances) after the expiration of the applicable 180-day limit specified in § 405.1835(a)(3).

In the instant appeal, the Board finds that the Provider's reasons for not timely filing its appeal do not rise to the level of a good cause extension of the time limit to file an appeal. The Provider apparently knew of some FTE discrepancy because of a 2011 settlement agreement, even though it argues that its decision not to file an appeal was based on the Notice of Reopening issued in

2015.[1] Based on these facts, the Board finds that the Provider did not provide any documentation explaining why it did not or could not file sooner and therefore is at fault for not timely filing an appeal. Case number 16-2231 is hereby closed and removed 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
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA (recused)
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

cc: Wilson Leong, Esq., CPA, Federal Specialized Services

[1] Provider's Appeal Request at Exh. 3.

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Refer to: 15-2728

JAN 0 9 2017

CERTIFIED MAIL

Steven R. Price, Sr., Esq.
Wyatt, Tarrant & Combs, LLP
500 West Jefferson Street, Suite 2800
Louisville, KY 40202-2898

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

RE: Jurisdictional Decision
King's Daughters Medical Center
FYE: 9/30/2008
PRRB Case No.: 15-2728

Dear Mr. Price and Ms. Cummings,

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

Background

King's Daughters Medical Center ("King's" or "the Provider") was issued an original Notice of Program Reimbursement ("NPR") on March 13, 2013 for fiscal year end ("FYE") 9/30/2008. On the same day this original NPR was issued, the Medicare Contractor issued a Notice of Intent to Reopen Cost Report for the same FYE. The letter stated:

> In the event of an unfavorable final nonappealable decision in Allina Health Services v. Sebelius, the cost report will be reopened to adjust the Disproportionate Share payment calculation.

On October 16, 2014, the Provider is issued another Notice of Intent to Reopen Cost Report. This letter indicated that the cost report was being reopened for the following reasons:

> To include additional inpatient and outpatient traditional, charity and crossover bad debts after MAC review.
>
> To include additional SNF traditional and charity bad debts after MAC review.

The Provider was issued a revised NPR for FYE 9/30/2008 on December 8, 2014. On June 5, 2015, the Board received the Provider's individual appeal request in which it appealed one issue: Part C days in the Medicare and Medicaid fractions. The Provider's appeal request states that it is

appealing from the revised NPR, but references an NPR days of March 13, 2013 and all of the audit adjustments cited and included are from the original NPR.

Medicare Contractor's Position

The Medicare Contractor has challenged the Board's jurisdiction over this appeal for two reasons. First, it argues that the appeal was not timely filed from the Provider's original NPR. Second, the Medicare Contractor argues that the Provider's revised NPR did not specifically adjust Part C days, therefore the Board does not have jurisdiction over the issue in accordance with 42 C.F.R. § 405.1889.

In its response to the jurisdictional challenge, the Provider requested that the "FI provider clarification as to whether the cost report is still being held open on this issue and whether the FI intends to issue another RNPR." The Medicare Contractor explained that CMS has not yet issued guidance on how to deal with Part C days after the Court of Appeals for the District of Columbia issued its decision in *Allina Health Serv's v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014). Therefore, the Medicare Contractor has not yet issued a revised NPR addressing Part C days.

Board's Decision

The Board finds that it does not have jurisdiction over this appeal because the Provider did not timely file from its original NPR and the Provider's revised NPR did not specifically adjust Part C days.

Pursuant to 42 C.F.R. § 405.1835(a)(3) and PRRB rules, unless the Provider qualifies for a good cause extension, the PRRB must receive a Provider's hearing request no later than 180 days after the date of receipt of the Final Determination. Pursuant to 42 C.F.R. § 405.1801 and PRRB Rule 21, for appeal requests filed after August 21, 2008, the date of filing is the date of receipt by the PRRB, or the date of delivery by a nationally-recognized next-day courier.

The Medicare Contractor issued the Provider's **original** NPR on March 13, 2013. For the Provider to have timely filed an appeal request (including the five-day mailing presumption), the Board should have received the Provider's appeal no later than September 16, 2014. The Board received the Provider's individual appeal request on June 5, 2015, which was well past the allowed filing date. Accordingly, the Provider did not timely file its individual appeal request from its original NPR.

Although the Provider timely filed its appeal from its revised NPR, the Board nonetheless finds that it does not have jurisdiction over the only issue in the appeal, Part C days, because the issue was not adjusted in the Provider's 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.
> >
> > (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.

These regulations make clear that a Provider can only appeal items that are specifically adjusted from a revised NPR. The Notice of Intent to Reopen explains that the cost report was to be reopened for review of various bad debt issues, which is reflect on the audit adjustment report. The revised NPR did not specifically adjust Part C days, which is the only issue under appeal, therefore the Board finds that it does not have jurisdiction over the only issue under appeal.

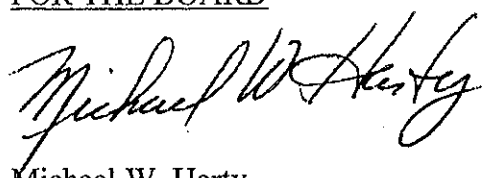
Conclusion

The Board finds that it does not have jurisdiction over PRRB Case No. 15-2728 because the Provider did not timely file the appeal from its original NPR and the Provider's revised NPR did not specifically adjust Part C days (the only issue in the appeal). Therefore, PRRB Case No. 15-2728 is hereby dismissed and removed 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
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

cc: Wilson Leong, Esq., CPA, Federal Specialized Services

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Refer to:

JAN 18 2017

Certified Mail

Russell Jenkins
Hospital Reimbursement Group
5123 Virginia Way, Suite A-12
Brentwood, TN 37027

RE: Hillcrest Medical Center, Provider No. 37-0001, FYE 6/30/2008, PRRB Case No. 16-0789
OSU Medical Center, Provider No. 37-0078, FYE 11/30/2007, PRRB Case No. 16-0791
Bolivar Medical Center, Provider No. 25-0093, FYE 9/30/2008, PRRB Case No. 16-1585
OSU FFY 2016 Understated IPPS Standardized Amount Group, PRRB Case No.16-0932GC
CHS FFY 2016 Understated IPPS Standardized Amount Group, PRRB Case No. 16-0956GC
Ardent Health FFY 2016 Understated IPPS Standardized Amount Group, PRRB Case No. 16-1046GC
Lifepoint FFY 2016 Understated IPPS Standardized Amount Group, PRRB Case No. 16-1048GC
Ardent Health FFY 2008 Understated IPPS Standardized Amount Group, PRRB Case No. 16-2309GC

Dear Mr. Jenkins:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' hearing requests and the issue presented in the above referenced cases. The jurisdictional decision of the Board is set forth below.

Issue under Dispute

The substantive issue under dispute in these cases is:

> Whether the hospitals have been underpaid for the [Federal fiscal year under identified in each hearing request] because the inpatient hospital prospective payment (PPS) standardized amounts are understated for the . . . [F]ederal [fiscal year under appeal] due to the Secretary's failure to properly distinguish between patient

transfers and discharges in establishing the PPS 1983 base year amounts.[1]

The Providers explained in their position papers which were filed in related cases[2] that the prospective payment system (PPS) payment consists of the product of two figures for each provider: the applicable standardized amount multiplied by the DRG weights. The original standardized amount that was established in 1983 (described more fully below) is understated because it did not distinguish between discharges and transfers in the original calculation. The alleged error in the original standardized amount calculation has been perpetuated because the standardized amount has been updated annually for inflation and not recalculated each year. All of these updates are compounded into the current standardized amount for each facility. The Providers are seeking a one-time adjustment to the Standardized Amount in fiscal year (FY) 1983 that would allow for correction of the Secretary's alleged error.[3]

Standardized Amount and DRG Background

Standardized Amount

The standardized amount is the average price per case for all Medicare cases during the year.

Base Year Calculation (1981)

When PPS rates were established, 42 U.S.C. § 1395ww(d)(2)(A) required that, in determining allowable costs for the base period, the most recent cost reporting period for which data was available was to be used. Therefore, cost reports ending in 1981 were used.[4]

In calculating the standardized amounts, the Secretary gathered cost reports from nearly all hospitals participating in Medicare. The data extracted from the cost reports included all allowable costs for treating Medicare patients except for excluded units, capital costs, graduate medical education (GME) and nursing differential costs. The total of these costs was divided by the numbers of Medicare discharges during the year to equal the total allowable Medicare inpatient operating costs per discharge. The number of discharges was a monthly tabulation on the cost report. This was the base year cost data.[5] Pursuant to 42 U.S.C. § 1395ww(d)(2)(B), base year cost data is to be updated annually for inflation.

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[1] *See e.g.* Provider Hearing Request in Bolivar Medical Center, Provider No. 25-0093, FYE 9/30/2008, PRRB Case No. 16-1585, Tab 2.
[2] *See* PRRB Jurisdictional Decision issued August 5, 2015, letter to Russell Jenkins on the internet at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/List-of-PRRB-Jurisdiction-Decisions-Items/2015-08.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=descending.
[3] *See* 48 Fed. Reg. 39,740, 39,763 (Sept. 1, 1983) (the standardized amount for 1983 was developed from 1981 cost report data).
[4] *Id.*
[5] *Id.* at 39,764.

Diagnostic Related Groups (DRGs)

DRGs are created using claims that contain a patient diagnosis and co-morbidity factors which are assigned to one of 499 DRGs based on the diagnosis and complexity of treatment. The DRGs bundle services (labor and non-labor) that are needed to treat a patient with a specific disease. CMS creates a rate of payment for each DRG based on the "average" cost to deliver care to a patient for each specific diagnosis. The average charge allowed for each DRG is calculated by taking the patient charges and removing the effect of regional wage differences, indirect medical education (IME), the disproportionate share (DSH) adjustment, etc. Then all of the charges are summed for all cases involving the DRG and divided by the total number of cases in the DRG. The higher the cost of treatment the higher the weight assigned to the DRG.[6] The DRG is multiplied by the standardized amount, described above, to determine the amount of PPS payments (sometimes called DRG payments).

Discharges and Transfers

Prior to the implementation of PPS, acute care hospitals were paid on the basis of reasonable cost (all the direct and indirect costs that were necessary and proper for the efficient delivery of needed healthcare services) and reasonable charges (physicians' services and other medical and health services that are not furnished directly by a provider of services).[7] Consequently, prior to the implementation of PPS there was no need to distinguish between a discharge (the patient receives no further treatment) and a transfer (the patient continues care at another facility). When PPS was implemented, each spell of illness was paid for under one "umbrella" (DRG or PPS rate) that was to be split between the providers of service.

Discharges and transfers were originally codified at 42 C.F.R. § 405.470(c).[8] These actions were created for purposes of payment under PPS, a system that was designed to provide full payment (less co-insurance and deductibles) associated with a particular diagnosis. Generally, Medicare pays a single rate to one hospital for a service. Originally, the Health Care Financing Administration (HFCA)[9] paid the discharging hospital the full prospective rate on the theory that the discharging facility provided the greatest portion of patient care. The transferring hospital was paid based on a per diem rate (the prospective rate divided by the average length of stay for a DRG) and the patients' length of stay at the transferring hospital. Payment could not exceed the full prospective payment.[10]

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[6] Medicare Hospital Prospective Payment System: How DRG Rates are Calculated and Updated at 5-6, oig.hhs.gov/oei/reports/oei-99-00-00200.pdf.
[7] 48 Fed. Reg. at 39,754.
[8] Recodified at 42 C.F.R. § 412.4.
[9] HCFA is the previous name of the Centers for Medicare & Medicaid Services.
[10] 48 Fed. Reg. at 39,759.

***Kaiser Foundation Hospital,*[11] Predicate Facts and the Changes to 42 C.F.R. § 405.1885**

In the December 10, 2013 Federal Register,[12] the Secretary clarified her position regarding reopening predicate facts in final determinations of reimbursement. Predicate facts were defined as occurring where:

> the factual underpinnings of a specific determination of the amount of reimbursement due a provider may first arise in, or be determined for, a different fiscal period than the cost reporting period under review.
>
> *****
>
> Predicate facts are determined once, either in the first fiscal period in which they arise or are first determined, or in the first fiscal period that they are used as part of a formula for reimbursement, and then applied as part of that reimbursement formula for several fiscal periods thereafter. These facts are not reevaluated annually to determine whether they support a determination that a particular cost is reasonable because the formula is a proxy for reasonable costs. Instead, the formula itself will provide for changes in costs through an updating factor or otherwise. [13]

The Secretary explained that where an issue is appealed or reopened and the issue is a predicate fact that arose in, or was determined for, an earlier fiscal period and was updated for a later fiscal period, the predicate fact could be redetermined by:

> A timely appeal or reopening of:
>
> (1) [t]he NPR [Notice of Program Reimbursement] for the cost reporting period in which the predicate fact first arose; or
> (2) the NPR for the period for which such predicate fact was first used or applied by the intermediary to determine reimbursement.[14]

Through the following example, the Secretary explained that if base period costs for a target amount were calculated for a 12-month cost reporting period ending in 2001, and then the provider challenges the determination of its target amount in 2008, its appeal rights were limited. The provider could not challenge the determination of the base period predicate facts unless it had

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[11] *Kaiser Found. Hosp. v. Sebelius*, 708 F.3d 226 (D.C. Cir. 2013).
[12] 78 Fed. Reg. 74,826, 75,162-69 (Dec. 10, 2013).
[13] *Id.* at 75,163.
[14] *Id.* at 75,164.

appealed the 2001 base period costs within 180 days of the issuance of the 2001 NPR or it had appealed its 2002 NPR when the costs were used to determine reimbursement. In the alternative, the provider could have requested reopening of, or the intermediary could have reopened, the 2001 cost report within three years of the base period determination or application and the base year costs were redetermined.[15]

The Secretary asserts that once the three year reopening period has expired, neither the provider nor intermediary is allowed to revisit the predicate facts that have not been changed through appeal or reopening of the period in which the facts first arose. The base period calculation cannot be redone outside this process (at a later time), resulting in different facts (a calculation or base year rate) being applied to a later cost reporting period. There cannot be two different findings for the same base period.[16] The creation of two base year findings is what occurred in the *Kaiser* case.

In *Kaiser*, the D.C. Circuit found that the providers could appeal predicate facts used to determine reimbursement in later fiscal periods where the predicate facts were not timely appealed or reopened in the year in which they were first used to determine reimbursement. The providers had not appealed their GME base year full-time equivalent (FTE) counts nor had the base year counts been reopened. The Court permitted the updated GME FTE caps of later FYEs, where the base years had not been appealed or reopened to recalculate the base year FTE cap and then apply the update to the FYEs under appeal.

As a result of this decision, the Secretary revised 42 C.F.R. § 405.1885(a)(1)(2013) to preclude appeals of predicate facts for an earlier cost reporting period where there was no appeal or reopening which altered the predicate (base year) facts.[17] Without a change to the predicate facts through these mechanisms, the base year calculations could not be altered.

Decision of the Board

The Board concludes that it lacks jurisdiction over the appeals and hereby dismisses the cases. This action closes the appeals. The Providers are seeking a correction of the standardized amount in 1981 to create discharges and transfers which did not exist in that FYE, and then apply the changes to the cost reporting periods under appeal in these cases. Discharges and transfers were codified in 1983 at 42 C.F.R. § 405.470(c), subsequent to the filing of the 1981 cost reports. The relief sought by the Providers is similar to the remedy created by the intermediary in *Kaiser*. In that case, a new FTE cap for the GME base year was created after both the appeal and reopening periods had expired for appealing the per resident amount determination and the first year in which the cap was applied. This new cap was then applied to later cost reporting periods. However, the Secretary addressed *Kaiser* and revised 42 C.F.R. § 405.1885(a)(1)(2013) to specifically bar this type of prospective corrective action.

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[15] *Id.*
[16] *Id.*
[17] *Id.* at 75,165.

In these cases, the Providers want to create discharges and transfers for FYE 1981 to be used in the calculation of a new standardized amount and then roll the new calculation forward to the years under dispute. Both the appeal periods and reopening periods for the original PPS rate notices and the first cost reporting periods to which they applied (approximately 1984) expired many years ago. In the preamble changing the reopening regulations, the Secretary asserted that once the three year reopening period has expired, neither the provider nor intermediary is allowed to revisit the predicate facts that have not been changed through appeal or reopening of the cost period in which the facts first arose. The base period calculation cannot be revised outside this process (at a later time), resulting in different facts (a calculation) being applied to a later cost reporting period. There cannot be two different findings for the same base period.[18] The revision of the 1981 base year (the predicate facts) in this case is clearly the type of revision the Secretary wanted to preclude through the December 10, 2013 Federal Register notice.

Review of this determination is available under the provisions of 42 U.S.C. 1895oo(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 Benson, CPA
Jack Ahern, MBA

FOR THE BOARD:

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. 1895oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Byron Lamprecht, WPS
Bill Tisdale, Novitas
Barb Hinkle, Cahaba GBA c/o NGS
Wilson Leong, FSS

[18] *Id.* at 75,164.

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JAN 18 2017

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1700 Pennsylvania Avenue, NW
Washington, D.C. 20006-4706

RE: King and Spalding FFY 2016 0.2 Percent IPPS Reduction
Group Appeals
Provider Nos.: Various
FFY 2016
PRRB Case Nos.: See Attached List

Dear Mr. Polston:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' December 22, 2016 request for expedited judicial review (EJR) (received December 23, 2016) for the group appeals on the attached list. The decision of the Board with respect to this request is set forth below.

Issue

Whether the Secretary's[1] 0.2 percent downward adjustment to the Medicare hospital inpatient prospective payment system (IPPS) standardized amount to account for the adoption of the "two-midnight" rule, as implemented in the [F]ederal fiscal year (FFY) 2014 IPPS rulemaking, and as compounded in the FFY 2015 and 2016 rulemakings, was lawful, and if so whether the adjustment was in the correct amount.[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 impact on Medicare beneficiaries who may incur greater financial liability than they would if they were admitted to the hospital as inpatients.[4]

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[1] of the Department of Health and Human Services.
[2] Providers' December 22, 2016 EJR Request at 3 (received December 23, 2016).
[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).
[4] 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 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 Medicare 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]

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").

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[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.
[9] *See generally* 78 Fed. Reg. 27,486 (May 10, 2013).

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 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]

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

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 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

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

from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[19]

Providers' Request for EJR

The Providers in these appeals are seeking EJR because they believe that the Board lacks the authority to overturn the Secretary's compounding of the downward 0.2 percent adjustment to the FFY 2015[20] and FFY 2016[21] IPPS payment rates. The Providers explain that the Secretary compounded this downward adjustment in the 2016 final IPPS rule by failing to reverse the downward payment adjustment originally made in FFY 2014. The FFY 2016 rates are also 0.2 percent lower than they would have been without this adjustment.

The Providers assert that the Secretary's 2015 adjustment was unlawful and should be reversed because:

- the adjustment exceeds the Secretary's statutory authority to adjust IPPS standardized amounts;
- the amount of the adjustment is unsupported by data, is arbitrary and capricious; and
- the Secretary violated the Administrative Procedure Act notice and comment rulemaking requirements because of insufficient discussion of data, assumptions purporting to support the amount of the adjustment, and failing to address or take into account public comments to the proposed rule.[22]

The Providers are requesting that the Secretary's 0.2 percent negative adjustment be overturned and that the Secretary be further instructed to re-propose an adjustment to the FFY 2016 IPPS rates that is consistent with the data cited by the Secretary. Even though the Secretary attempted to reverse her rate reduction in the FFY 2017 IPPS Final Rule,[23] she still has not explained why the data she relied upon in 2014 did not support an increase in IPPS payments to account for a reduction in overall inpatient admission as a result of the two-midnight policy. The Provider contend that her subsequent action does not change the fundamental error with the rate year at issue here. In the alternative, the Providers seek a declaration that the Secretary lacks the statutory authority to reduce IPPS payment rates in this situation.[24]

The Providers assert that the Secretary's decision to apply a downward 0.2 percent adjustment to the IPPS payments for FFY 2014—compounded in FFY 2016, the period under appeal

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[19] *Id.* at 50,990.
[20] 79 Fed. Reg. 49855, 50146-48 (Aug. 22, 2014).
[21] 80 Fed. Reg. 49,326 (Aug. 17, 2015).
[22] Providers' EJR Request at r
[23] 81 Fed. Reg. 56,761,56772 (Aug. 22, 2016)
[24] Providers' December 22, 2016 EJR request at 4-5.

here—was arbitrary, capricious, and a violation of her rulemaking obligations under the Administrative Procedure Act. The Providers contend that the Secretary's calculations, described above, supporting the downward adjustment are not supported by the data in the Federal Register and provider comments identifying errors in reasoning were disregarded.[25]

The Providers believe that the Secretary's payment disallowance is unlawful for a number of reasons. First, the Secretary adopted a proposed rule that runs counter to the data upon which it is based, and therefore its implementation is arbitrary and capricious in violation of 5 U.S.C. § 706(2)A). The Providers allege that the Medicare claims data relied upon to calculate the impact analysis shows that more that more than 1.5 million one-day inpatient stays 2011. The Secretary did not adequately support her assertion in rulemaking that only 360,000 one-day inpatient stays would move to outpatient status under the two midnight rule, The Secretary did not adequately explain how this 1.5 million figure could be reduced down to 360,000 as she asserted in rule making. Similarly, the data do no support her assertion that 400,000 outpatient encounters would move to inpatient status. Thus, the Providers contend, the Secretary's assertion that a net of 40,000 patients would shift from outpatient to inpatient status—the very basis for her decision to apply a 0.2 percent reduction to IPPS payment rates runs counter to the evidence before the agency.[26]

Second, the Secretary relied upon at least one critical assumption for which the public was not afforded an opportunity to meaningfully comments. The notice and comment rulemaking procedures require agencies to identify and make available technical studies and data that they employ in reaching the decisions to proposed rules. In the FFY 2014 rulemaking, the Providers allege that the Secretary failed to disclose—until the comment period had ended—her critical actuarial assumption that medical MS-DRG case would not be affected by the two-midnight rule.[27] As a result, commenters were not put on notice that the Secretary's estimates did not consider the migration of medical MS-DRG cases from inpatient to outpatient status, and were therefor deprived of an opportunity to meaningfully comment on the Secretary's methodology.[28]

Finally, the Providers aver that even if the Secretary did not act arbitrarily or capriciously in reducing the IPPS rates and not increasing the IPPS rates, the Secretary does 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 section 1395ww(d).[29]

Decision of the Board

The Board has reviewed the Providers' 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 conduct a hearing under the provisions of 42 C.F.R. §§ 405.1840(a) and 405.1837(a) .

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[25] *Id.* at 6.
[26] *Id.* at 11.
[27] 78 Fed. Reg. at 5093.
[28] Providers' December 22, 2018 EJR Request at 14.
[29] *Id.* at 15.

The Board concludes that the Providers timely filed their requests for hearing from the issuance of the August 27, 2015 Federal Register[30] and the amount in controversy exceeds the $50,000 threshold necessary for a group appeal.[31] Consequently, the Board has determined that it has jurisdiction over Providers' appeals.[32] This issue involves a challenge to the application of the 0.2 percent reduction, 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 these cases.

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, the hospital-specific rate for some SCH and MDH hospitals, and the Federal rate of capital cost issues, 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 some SCH and MDH hospitals, and the Federal rate of capital cost 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 the Providers' request for expedited judicial review for the issue and the subject year. The Providers have 60 days from the

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[30] *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).

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

[32] The Board notes that one or more of the participants in this consolidated group appeal have cost report periods beginning on or after January 1, 2016, which would subject their appeals to the newly-added 42 C.F.R. § 405.1873 and the related revisions to 42 C.F.R. § 413.24(j) regarding submission of cost reports. *See* 80 Fed. Reg. 70298, 70555-70604 (Nov. 13, 2015). However, the Board notes that § 405.1873(b) has not been triggered because neither party has questioned whether any provider's cost report included an appropriate claim for the specific item under appeal. *See* 80 Fed. Reg. at 70556.

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 on the attached list.

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
List of PPS Rate Reduction Group Cases and Schedules of Providers

cc: Danene Hartley, Nat'l Gov't Servs. (Certified Mail w/Case Listing and Schedules)
Bill Tisdale, Novitas Solutions (Certified Mail w/Case Listing and Schedules)
Bruce Snyder, Novitas Solutions (Certified Mail w/Case Listing and Schedules)
Byron Lamprecht, Wis. Physicians Serv. (Certified Mail w/Case Listing and Schedules)
James Ward, Noridian Healthcare (Certified Mail w/Case Listing and Schedules)
Geoff Pike, First Coast Service Options (Certified Mail w/Case Listing and Schedules)
Pam VanArsdale, Nat'l Gov't Servs. (Certified Mail w/Case Listing and Schedules)
Laurie Polson, Palmetto GBA d/b/a Nat'l Gov't Servs. (Certified Mail w/Case Listing and Schedules)
Barb Hinkle, Cahaba GBA c/o Nat'l Gov't Servs. (Certified Mail w/Case Listing and Schedules)
Judith Cummings CGS Administrators (Certified Mail w/Case Listing and Schedules)
Wilson Leong, FSS (w/Case Listing and Schedules)

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CERTIFIED MAIL

JAN 19 2017

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Noridian Healthcare Solutions
Evaline Alcantara
Appeals Coordinator – Jurisdiction E
P.O. Box 6782
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RE: Request for Bifurcation of the Dual Eligible and Part C/HMO Days Issues
Fremont-Rideout 1994-1995 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 10-0095GC

Dear Mr. Knight and Ms. Alcantara:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the Fremont-Rideout 1994-1995 [Disproportionate Share Hospital ("DSH")] Dual Eligible Days CIRP Group April 20, 2016 request to bifurcate the providers' dual eligible Part A non-covered and HMO/Part C[1] days issues.

Background

This group appeal was established on November 9, 2009, when common issue related party ("CIRP") providers were broken out from two group appeals: 04-1725G (Toyon 1994 DSH Dual Eligible Days Optional Group) and 06-1558G (Toyon Fremont-Rideout 1994-1995 Medicaid Eligible Days CIRP Group). Participants 2-4 were previously in case numbers 98-2852G and 06-1558G.

Board's Decision

Jurisdiction

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

The Board finds that it does not have jurisdiction over Participants 2-4 in this group appeal because

[1] Any individual who was enrolled on December 31, 1998, with an eligible organization under section 1876 of the Social Security Act was considered to be enrolled under Part C as of January 1, 1999. 42 U.S.C. § 1395w-21. As Charity has used the terms HMO days and Part C Days interchangeably for both time periods, the Board will simplify things by referring to the days collectively as "Part C days."

the Providers appealed and transferred the Medicaid eligible days issue, not the dual eligible days issue.

In the group appeal request for the instant appeal, Toyon explains:

> Finally, we are currently working with Cahaba Safeguard Administrators, LLC to administratively resolve Case No. 06-1558G, which is a dispute concerning the inclusion of Medicaid Eligible Days in each group participant's Medicare DSH calculation. Both parties (Cahaba and Toyon) acknowledge the fact that Dual Eligible Days is a component of all Medicaid Eligible Days that Cahaba is not authorized by CMS to administratively resolve at this point in time. However, if the Board grants this request to establish the Fremont-Rideout 1994-1995 DSH Dual Eligible Days CIRP Group noted above, it is likely the parties will be able to conclude their administrative resolution of Case No. 06-1558G in the near future and close this case.[2]

The Board reviewed the position papers in case number 06-1558G and 98-2852G, the groups Participants 2-4 were previously in, and finds that the dual eligible days issue was not briefed. These Providers did not raise the issue until they attempted to transfer to this group when it was formed on November 6, 2009.

The Providers argue that the dual eligible days issue can be read as a sub-issue of the Medicaid eligible days issue, however these are in fact two distinct issues. It would be too broad to read the Medicaid eligible days issue as including the dual eligible Part A non-covered and HMO days issues as sub-issues.[3]

Effective August 21, 2008, new regulations and Board rules were implemented that require more specificity in issue statements and that also limit the time that a Provider can add an issue to its individual appeal. Under these rules and regulations, the Providers had until October 21, 2008 to add issues to their individual appeals. The Providers did not raise the issue until their 2009 transfer requests to this group and the issue was not included in the position papers for the groups in which the Providers previously participated. Therefore, the Board finds that it does not have jurisdiction over Participants 2-4[4] and hereby dismisses the Providers from this appeal.

Bifurcation

The Board grants bifurcation of the dual eligible and HMO issue for the only remaining Provider in the appeal: Participant 1, Fremont Medical Center (provider number 05-0207, FYE 6/30/1994).

Participant 1 filed a request to add the dual eligible days issue to its individual appeal on May 12,

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[2] Group Appeal Request dated Nov. 6, 2009 at 2.
[3] *See Stormont-Vail Regional Medical Center v. Sebelius*, 708 F. Supp. 2d 1178, 1186 (D. Kan. 2010), *aff'd* 435 F. App'x.738 (10th Cir. 2011) (finding that, "It is inconsistent with these instructions to construe the 'Medicaid eligible' days issue raised in the original appeal so broadly as to include the 'general assistance' days issue plaintiff sought to add to the appeal.")
[4] Rideout Memorial Hospital (provider number 05-0133, FYE 6/30/1994); Fremont Medical Center (provider number 05-0207, FYE 6/30/1995); and Rideout Memorial Hospital (provider number 05-0133, FYE 6/30/1995).

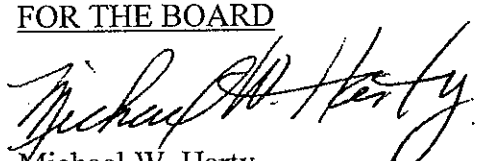
2004, and requested to transfer the dual eligible days issue to case number 04-1725G on June 4, 2004. Both of these requests identified both the dual eligible and HMO days issues.

Accordingly, the Board finds that there are two issues pending in this group for the remaining participant in violation of 42 C.F.R. § 405.1837(a)(2) and PRRB Rule 13. The Board is, therefore, bifurcating the dual eligible Part A non-covered and HMO days issues into separate group appeals. The Board transfer the HMO days issue to case number 16-0270GC, Fremont-Rideout 1997 DSH HMO Days Group. The Provider's dual eligible Part A non-covered days issue remains in the instant appeal and is subject to remand under the Centers for Medicare and Medicaid Services' Ruling 1498-R. The Board will address the remand under separate cover.

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

Board Members
Michael W. Harty
Clayton J. Nix, Esq. (Dissenting)
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

cc: Wilson Leong, Federal Specialized Services

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JAN 2 6 2017

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Cost Report Appeals
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RE: Harrison County Hospital
Provider No.: 15-0079
FYE: 09/30/2004
PRRB Case No.: 06-1899

Dear Ms. Elias and Mr. Lamprecht,

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 filed its initial appeal on June 20, 2006, for its cost reporting period ending September 30, 2004, from a notice of program reimbursement ("NPR") dated December 22, 2005. The Provider initially sought to appeal the (1) refusal to consider costs reported on an amended cost report...; sub-issues: (2) Bad debts and (3) DSH SSI% days.[1]

On January 10, 2014, the Medicare Contractor submitted a Jurisdictional Challenge for the bad debt issue. The Provider submitted its responsive brief on February 4, 2014.[2] On March 17, 2014, the Medicare Contractor submitted an additional Jurisdictional Challenge for the amended cost report issue.

MEDICARE CONTRACTOR'S JURISDICTIONAL CHALLENGE:

Amended Cost Report issue:

The Medicare Contractor contends that the Board does not have jurisdiction over the Provider's appeal of the Medicare Contractor's "refusal to consider costs reported on an amended cost report filed prior to the completion of the Provider's cost report audit." The Medicare Contractor asserts that the Provider did not include the disputed bad debts or additional Medicaid eligible days on its as-filed cost report.

Consistent with the CMS Administrator's decision in PRRB Decision Number 2004-D12, Saginaw General Hospital, the Medicare Contractor believes that the Board does not have jurisdiction.

[1] The Provider refers to "DSH SSI days" but these days are actually Medicaid eligible days.
[2] Provider's argument addresses the amended cost report issue as main issue under challenge. *See* Provider Response to MAC Jurisdictional Challenge dated February 4, 2014 at 1.

Refusing to accept the amended cost report does not constitute a determination as defined in 42 C.F.R. § 1801(a)(1).

Bad debts issue:

The Medicare Contractor contends that issues do not arise simply because at some point a provider wishes it had presented a claim for costs on the cost report. In hindsight, the Provider realized that it failed to maximize reimbursement by not making a claim for additional bad debts. The Provider filed an appeal request stating, "...the Hospital was still compiling bad debts related cost data at the time its initial cost report was filed...For this reason, there are no specific audit adjustment to enumerate...the Provider is dissatisfied with the final determination of the Medicare Contractor as reflected in the December 22, 2005 NPR..."

The Medicare Contractor argues that it did not make an adjustment on the Provider's cost report for the additional bad debts and therefore, the Provider is unable to demonstrate that it satisfies 42 C.F.R. § 405.1835.[3]

PROVIDER'S POSITION:

Response to the challenge to bad debts/amended cost report issues:

The Provider contends that the Medicare Contractor arbitrarily and capriciously refused to consider an amendment to its cost report. The amendment had the effect of becoming the new version of the Provider's "as filed cost report." The Provider asserts that the Medicare Contractor "rushed" a desk audit, without notice to the Provider, and then retroactively applied a new guideline that amended cost reports would not be considered after initiation of the desk audit.

At issue is information furnished related to additional Medicaid eligible days and bad debts data submitted on the amended cost report. The Provider contends that the Medicare Contractor's notice dated November 18, 2005 was retroactively implementing administrative rule changes. On November 21, 2005, the Provider notified the Medicare Contractor via a letter that "the Provider was attempting identify additional DSH and bad debt data and was planning to submit an amended cost report to correct data related to these issues..."[4]

The Provider stresses that the "bottom line on Board jurisdiction is that this is a case where the Provider declared the costs at issue in its amended cost report." The Provider states that it "had given the MAC repeated advance notice that the amendment was forthcoming..."

BOARD'S DECISION:

The Board majority concludes that the Provider does not have a right to a hearing on the amended cost report issue under 42 U.S.C. § 1395oo(a) and that it is unable to exercise its discretionary

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[3] 42 CFR § 405.1835 states: "The Provider...has the right to a hearing before the Board about any matter designated in 42 CFR § 405.1801(a)(1), if...[a] Intermediary determination has been made with respect to the provider."
[4] *See* Provider Response to MAC Jurisdictional Challenge dated February 4, 2014 at 2.

authority to hear the underlying Medicaid eligible days and bad debt issues under 42 U.S.C. § 1395oo(d).

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-1841 (2004), a provider has a right to 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 date of the NPR. Pursuant to 42 U.S.C. § 1395oo(d), once the Board has jurisdiction over a disputed cost report under § 1395oo(a), the Board may affirm, modify, or reverse a final decision of the Medicare Contractor with respect to that cost report, and make any other revisions on "matters covered by such cost report" (that is, a cost or expense that was incurred within the period for which the cost report was filed) even if such matters were not considered by the Medicare Contractor in making a final determination.

The Medicare statute mandates that the Provider file a cost report with its Medicare Contractor.[5] For the applicable cost reporting period, 42 C.F.R. § 413.24(f) states in relevant part:

> For cost reporting purposes, the Medicare program requires each provider of services to submit periodic reports of its operations that generally cover a consecutive 12-month period of the provider's operations. Amended cost reports to revise cost report information that has been previously submitted by a provider may be permitted or required as determined by CMS. (Emphasis added.)

In addition, the regulation at 42 C.F.R. § 413.24(f)(2) (2004) explains that cost reports are "due on or before the last day of the fifth month following the close of the period covered by the cost report."

The Provider Reimbursement Manual § 2931.2.A *Filing Amended Cost Reports* provides additional guidance regarding when cost reports may be permitted or required to be amended.

> Under limited circumstances, the program will accept an amended cost report. An amended cost report is one which is intended to revise information submitted on a cost report which has been previously filed by the provider.
>
> A provider may file or an Intermediary may require an amended cost report to:
>
> 1. Correct material error detected subsequent to the filing of the original cost report,
> 2. Comply with the health insurance policies or regulations, or
> 3. Reflect the settlement of a contested liability

[5] Section 1878(a) of the Act.

***

> Once a cost report is filed, the provider is bound by its elections. Except in 2 above, a provider may not file an amended cost report to avail itself of an option it did not originally elect. (Emphasis added).

Upon receipt of a provider's cost report, (or amended cost report where permitted), the Medicare Contractor must, within a reasonable time, furnish the provider with an NPR reflecting the Medicare Contractor's determination of the total amount of reimbursement due the provider.

In this subject appeal, the Provider filed its cost report for FYE 09/30/2004 without including all claims for bad debts or Medicaid eligible days. The Provider submitted an amended cost report on November 30, 2005 that included additional bad debts and Medicaid eligible days. The Medicare Contractor issued the Provider's NPR on December 22, 2005 without considering these additional bad debts or Medicaid eligible days.

The Board majority concludes that it does not have jurisdiction over the Provider's appeal because it has not satisfied the requirements of 42 U.S.C. § 1395oo(a). The Board majority finds that the Medicare Contractor's non-action with respect to the amended cost report is not a "final determination" within the meaning of § 1878 of the Social Security Act and 42 U.S.C. § 1395oo(a). The Board majority also finds that there is nothing in the statute that requires a Medicare Contractor to accept an amended cost report. There is nothing in the statute which provides for corrections to the cost report submissions after the filing deadline established by regulations.

Further, the Provider's NPR did not make adjustments to the additional bad debts or Medicaid eligible days currently under appeal, therefore the Provider has not established that it is dissatisfied with the NPR final determination. The Board majority therefore determines that it lacks jurisdiction under 42 U.S.C. § 1395oo(a) for the amended cost report issue in the subject appeal. The Provider also did not establish that it was dissatisfied with an adjustment to its NPR final determination for the two issues under appeal.

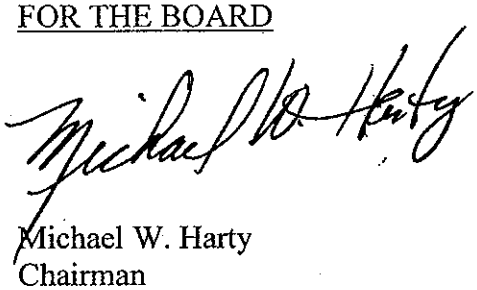
The Board majority finds that it does not have jurisdiction over the amended cost report issue because the Provider did not appeal from a final determination. The Board majority also finds that it does not have jurisdiction over the underlying bad debts and Medicaid eligible days issues as the Provider did not establish dissatisfaction pursuant to 42 U.S.C. § 1395oo(a) and the Board cannot exercise its discretionary authority under 42 U.S.C. § 1395oo(d).

As no issues remain in the appeal, Case No. 06-1899 is hereby closed and removed 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:
Michael W. Harty
Clayton J. Nix, Esq. (dissenting)
L. Sue Anderson, Esq.
Charlotte F. Benson, CPA
Jack Ahern, M.B.A.

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
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Clayton J. Nix, *dissenting.*

I respectfully disagree with the majority's decision to deny jurisdiction over the two issues claimed in the amended cost report. As explained below I would find jurisdiction over these two issues.
CMS provides guidance on the requirements for filing a cost report in the Provider Reimbursement Manual, CMS Pub. Nos. 15-1 and 15-2 ("PRM 15-1" and "PRM 15-2"). PRM 15-2 § 104(A)(4) specifies that the filing date for a cost report is determined by its postmark date (*i.e.*, the date of mailing).

With respect to amended cost report, PRM 15-1 § 2931.2(A) states:

> *Under limited circumstances*, the program *will accept* an amended cost report. An amended cost report is one which is intended to revise information submitted on a cost report which as previously been filed by the provider.
>
> A provider *may file* . . . an amended cost report to:
>
> 1. correct material errors detected subsequent to the filing of the original cost report.
> 2. comply with the health insurance policies or regulations, or
> 3. reflect the settlement of a contested liability . . . .
>
> Once a cost report is filed, the provider is bound by its elections. Except in 2 above, a provider may not file an amended cost report to avail itself of an option it did not originally elect. For example, a provider which has filed a cost report using a more sophisticated method of cost finding cannot file an amended report using the step-down method of cost finding for that period.[1]

Thus, it is clear that one of the limited circumstances in which the Medicare program "will accept" an amended cost report is to "correct material errors detected subsequent to the filing of the original cost report." Here is it clear that the provider filed the amended cost report to "correct material errors detected subsequent to the filing of the original cost report" and that this filing was done prior to the issuance of the NPR on the original cost report. Thus, it was improper for the Medicare Contractor to refuse to accept the amended cost report.

Moreover, the Board regulations at 42 C.F.R. § 405.1835(a) (2007) specify that "[t]he provider . . . has a right to a hearing before the Board about any matter designated in § 405.1801(a), if . . . [a]n intermediary determination has been made with respect to the provider . . . ." Section 405.1801(a)(1) states the following regarding the term "intermediary determination: "With respect to a provider of services *that has filed a cost report* . . ., the term means a determination of the amount of total reimbursement due the provider, pursuant to § 405.1803 following the close of the provider's cost reporting period, for items and services furnished to beneficiaries for which reimbursement may be made on a reasonable cost basis under Medicare for the period covered by the cost report." The key

[1] (Emphasis added.)

requisite here is the *filing* of the cost report. Further, as previously discussed, it is clear from PRM § 2931.2(A) that one of the limited circumstance in which a provider can file an amended cost report is to "correct material errors" and that the provider did timely[2] file the amended cost report on that basis. Accordingly, I conclude that: (1) notwithstanding the Medicare Contractor's improper refusal to process the amended cost report, the provider did properly tender its claim for the costs at issue on the amended cost report which was filed prior to the issuance of the NPR; and (2) the Medicare contractor's issuance of the NPR without the inclusion of the costs at issue otherwise constitutes a reviewable reimbursement determination on the costs at issue.

Clayton J. Nix, Esq.
Board Member

[2] The filing was timely as it was prior to the expiration of three years and, more importantly, was prior to the issuance of the NPR. Indeed, the letter from the Medicare Contractor notifying the provider of its internal change in procedure from prior years was not issued with sufficient notice to the Provider. Indeed the Provider filed (*i.e.*, mailed) its amended cost report just 8 days after it received that notice from the Medicare Contractor on November 22, 2005.

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RE: King & Spalding 2008 Low Income Pool Sec. 1115 DSH Waiver Days Group
Jurisdictional Review
PRRB Case Number: 14-0645G

Dear Mr. Polston and Mr. Pike,

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

BACKGROUND FACTS –

The Board established a group appeal on November 7, 2013 for King & Spalding 2008 Low-Income Pool Sec. 1115 DSH Waiver Days Group. The group issue statement reads, in part, as follows:

> "The Providers are appealing the Intermediary's exclusion of days associated with a Section 1115 Medicare waiver program known as the Florida Low-Income Pool ("LIP") from the numerator of the Medicaid fraction of the Medicare DSH payment … The Board further has jurisdiction over any adjustment to the Providers' Medicare DSH payment, including those aspects of the DSH calculation that were not specifically considered by the Intermediary in the NPR …"[1]

All of the years in this appeal are 9/30/2008, prior to the requirement to file an "unclaimed cost" under protest. None of the providers included the Florida LIP 1115 Waiver days on their as-filed cost reports, or included them as a protested item. The Board must decide if the LIP Sec. 1115 waiver days issue falls under Bethesda, ie. the

[1] Provider's appeal request at Tab 2 (November 7, 2013).

Provider was barred from claiming the days by regulation or statute, or if the Provider simply failed to claim all the costs it was entitled to, and the Board would lack jurisdiction under 42 U.S.C. § 1395oo(a).

Board's Decision:

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.

The Board finds each of the Providers included in Case No. 14-0645G do not have a right under 42 U.S.C. § 1395oo(a) to a hearing on the LIP Sec. 1115 DSH waiver day issue. The adjustments cited by the Providers were for DSH in general and not specific to the LIP Sec. 1115 DSH Waiver days. Also, review of the reimbursement calculation, under tab D of the Schedule of Providers, clearly shows that the LIP Sec. 1115 DSH Waiver days are additional days and were never included on the Providers' cost report. Additionally, the Board cannot exercise its discretionary powers of review pursuant to 42 U.S.C. § 1395oo(d) since the Providers did not establish a jurisdictionally valid appeal.

The crux of this dispute centers around the gateway to Board jurisdiction under 42 U.S.C. § 1395oo(a), which 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 . . .

After jurisdiction is established under 42 U.S.C. § 1395oo(a), the Board has the discretionary power to make a determination over all matters covered by the cost report under 42 U.S.C. § 1395oo(d) which states in relevant part:

> The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

The Providers did not report LIP Sec. 1115 DSH waiver days correctly on their as-filed cost reports and the Medicare Contractor did not make a determination regarding these LIP Sec. 1115 DSH Waiver days. Therefore, the Providers cannot claim dissatisfaction. It was only after the fact that the Providers determined that they should have made a claimed for these days (as other providers did), on their cost reports to increase their DSH payments, but failed to do so.

The operation of the jurisdictional gateway established by 42 U.S.C § 1395oo(a) was addressed by the Supreme Court in the seminal Medicare case of *Bethesda Hospital Association v. Bowen.*[2] The narrow facts of the *Bethesda* controversy dealt with the self-disallowed apportionment of malpractice insurance costs.[3] The provider failed to claim the cost because a regulation dictated it would have been disallowed. In that situation, the Supreme Court found § 1395oo(a) permitted jurisdiction over the "self-disallowed" claim. The Court wrote:

> [U]nder subsection (a)(1)(A)(i), a provider's dissatisfaction with the amount of its total reimbursement is a condition to the Board's jurisdiction. It is clear, however, that the *submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations.*[4]

The Court recognized that a situation where a regulation pre-determines a disallowance is distinct from those in which a provider simply neglects to include an item on the cost report for which it would be due reimbursement:

> Thus, petitioners stand on different ground than do providers who bypass a clearly prescribed exhaustion requirement or *who fail to request from the intermediary reimbursement for all costs to which they are entitled under applicable rules.* While such defaults might well establish that a provider was satisfied with the amounts requested in its cost report and awarded by the fiscal intermediary, those circumstances are not presented here.[5]

While the Supreme Court has not had an opportunity to squarely address whether the Board must take jurisdiction of an appeal of a cost that was unclaimed through inadvertence rather than futility, other appellate courts have. However, there is a split among the circuit courts that have addressed the issue of unclaimed or self-disallowed costs since the *Bethesda* decision was issued.[6]

The Seventh Circuit has adopted an interpretation of *Bethesda* that precludes Board jurisdiction where the provider's request would not have been clearly futile. Specifically, in 1994 in *Little*

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[2] *Bethesda,* 485 U.S. 399 (1988).
[3] *Id.* at 401-402.
[4] *Bethesda.* at 1258, 1259. (Emphasis added).
[5] *Id.* at 1259. (Emphasis added).
[6] *See Loma Linda Univ. Med. Ctr. v. Leavitt,* 492 F.3d at 1065; *MaineGeneral Med. Ctr. v. Shalala,* 205 F.3d 493 (1st Cir. 2000); *UMDNH-Univ. Hosp. v. Leavitt,* 539 F. Supp. 2d 70 (D.D.C. 2008), *appeal dismissed sub nom, UMDNJ-Univ. Hosp. v. Johnson,* 2009 WL 412888 (Feb. 5, 2009). *But see Little Company of Mary Hosp. v. Shalala,* 24 F.3d 984 (7th Cir. 1994).

Co. of Mary Hosp. v. Shalala ("*Little Co. I*"),[7] the Seventh Circuit relied on the *Bethesda* dicta, noting that a provider's failure to claim all the reimbursement to which it is entitled under program policies is tantamount to a "failure to exhaust" administrative remedies before the fiscal intermediary, which establishes that the provider is not "dissatisfied" with the intermediary's final reimbursement determination.[8]

Subsequently, in 1999, the Seventh Circuit addressed the same issue in a case involving the same provider ("*Little Co. II*").[9] In *Little Co. II*, the Seventh Circuit held that the Board lacked jurisdiction over an appeal of an issue that the Intermediary had not considered, and distinguished *Bethesda* on the grounds that the cost issue on appeal in *Little Co. II* did not involve an "issue of policy" like the *Bethesda* plaintiffs' challenge to the malpractice regulations.[10] The Seventh Circuit noted:

> But while the statute is curiously worded, the intent is plain that the provider must give the intermediary a first shot at the issue, provided the issue is within the intermediary's competence...[11]

Citing *Little Co. II,* the preamble to the 2008 final rule (while not controlling for this cost reporting year under appeal) states that it has been the agency's "longstanding view that providers that fail to claim on their cost reports costs that are allowable under Medicare law and regulations cannot meet the 'dissatisfaction' requirement" of subsection (a).[12] The Agency policy of presentment aims to prevent an end-run around the Intermediary. The Agency further states that it "interpret[s] section 1878(d) of the Act as permitting the Board to make revisions to cost report items that directly flow from the determination with which the Provider has expressed dissatisfaction and from which the provider has filed a jurisdictionally proper appeal under section 1878(a) of the Act."[13]

In contrast, the First and Ninth Circuits have determined that the language of the Medicare statute provides for Board jurisdiction over claims not included in the initial cost report, whether they have been inadvertently omitted or "self-disallowed."[14] Both circuits rejected the Seventh Circuit's interpretation of the statute, finding it contained neither an exhaustion requirement to obtain a hearing before the fiscal intermediary, nor a limitation on the Board's scope of review once its jurisdiction was invoked. The progeny of decisions in these circuits have generally regarded subsection (a) to be read in conjunction with subsection (d) and supports the discretionary nature of subsection (d).

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[7] 24 F.3d 984 (7th Cir. 1994).
[8] *Little Co. I,* 24 F.3d at 992.
[9] *Little Co. of Mary Hosp. v. Shalala,* 165 F.3d 1162 (7th Cir. 1999).
[10] *Little Co. II,* 165 F.3d at 1165.
[11] *Id.*
[12] 73 Fed. Reg. at 30196.
[13] 73 Fed. Reg. at 30203.
[14] *See Loma Linda Univ. Med. Ctr. v. Leavitt,* 492 F.3d at 1065; *MaineGeneral Med. Ctr. v. Shalala,* 205 F.3d 493 (1st Cir. 2000).

The seminal case in the 9th Circuit is the 2009 decision in *Loma Linda Univ. Med. Ctr. v. Leavitt* ("*Loma Linda*").[15] In *Loma Linda,* the provider had inadvertently zeroed out reimbursable interest expense in the cost report and filed it without any claim for reimbursement. The intermediary issued its NPR without any adjustments for interest expense. The provider then appealed to the Board and identified six aspects of the Intermediary's final determination with which it was dissatisfied (not including the zeroed out interest expense). When it later discovered its interest error, the provider added the interest expense issue to its pending appeal. The Ninth Circuit Court stated:

> We conclude that once the Board acquires jurisdiction pursuant to 42 U.S.C. § 1395oo(a) over a dissatisfied provider's cost report on appeal from the intermediary's final determination of total reimbursement due for a covered year, it has *discretion under § 1395oo(d) to decide whether to order reimbursement of a cost or expense ... even though that particular expense was not expressly claimed or explicitly considered by the intermediary.*[16]

This holding suggests that the "dissatisfaction" requirement to exercise a right to appeal under § 1395oo(a) applies only to the total amount of program reimbursement reflected on the NPR and that "dissatisfaction" does not need to be tied to a specific gateway claim or issue under § 1395oo(a) before the Board can exercise discretion under § 1395oo(d) to hear a claim or issue not raised with the intermediary (*e.g.*, unclaimed costs).[17] Further, the Ninth Circuit stated it was joining the First Circuit's view as expressed in *MaineGeneral Med. Ctr. v. Shalala* ("*MaineGeneral*")[18] and *St. Luke's Hosp. v. Secretary* ("*St. Luke's*")[19] which were decisions issued in 2000 and 1987 respectively.[20]

MaineGeneral involved hospitals that listed zero for reimbursable bad debts on their cost reports. The providers did not discover mistakes in their as-filed cost reports until after the NPRs had been issued. The providers appealed several items adjusted by the NPRs, but also appealed certain previously unclaimed bad debts (*i.e.*, costs not claimed due to inadvertence rather than futility). The Board dismissed the bad debt claims for lack of jurisdiction because the claims had not been disclosed on the as-filed cost reports, despite there being no legal impediment. The First Circuit in *MaineGeneral* relied on its prior pre-*Bethesda* decision in *St. Luke's* in which costs were self-disallowed, not inadvertently omitted. However, that First Circuit found the *St. Luke's* decision nevertheless addressed the question of whether the Board has the power to decide an issue that was not first raised by the intermediary, holding the Board does have the power, but that the power is discretionary. In *St. Luke's*, the First Circuit expressly rejected the provider's assertion that the court should order the Board to hear the case even though it found the hospital had a strong equitable argument favoring review under the particular circumstances.[21] Specifically, the First Circuit wrote: "The statute [*i.e.*, § 1395oo(d)] does not

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[15] 492 F.3d 1065 (9th Cir. 2007).
[16] *Id.* at 1068 (emphasis added).
[17] *See* 73 Fed. Reg. at 30197.
[18] 205 F.3d 493 (1st Cir. 2000).
[19] *St. Luke's Hosp. v. Secretary*, 810 F.2d 325 (1st Cir. 1987).
[20] *See Loma Linda,* 492 F.3d at 1068.
[21] *St. Luke's*, 810 F.2d at 332.

say that the Board *must* consider matters not considered by the intermediary. But, it does say the Board may, it can, it has the 'power' to do so."[22]

The First Circuit in *MaineGeneral* then found that the Board could adopt a policy of hearing such claims or refusing to hear them, or it could opt to decide on a case-by-case basis. The First Circuit further noted that "a rule of consistently refusing to hear inadvertently omitted claims would be rational, given the ability of providers to request the intermediary to reopen an NPR up to three years after it has been issued."[23] Similarly, in *St. Luke's*, the First Circuit opined that, even though the Board has legal power to consider matters not specifically raised before the intermediary, whether to exercise that power is for the Board to decide and, like many similar powers of courts and agencies, should be exercised only sparingly.[24] Although the First Circuit in *MaineGeneral* analyzed appeal rights on a "claim" or issue specific basis, the First Circuit included the following dicta:

> That a cost is listed in a cost report says nothing about whether the provider is "dissatisfied" with the later decision by the intermediary to reimburse or not reimburse costs. . . . [N]othing in St. Luke's suggests that the hospital would not have been "dissatisfied" if it omitted to list the cost on a worksheet in the cost report (whether through inadvertence or in reliance on the agency's earlier determination that the costs were not recoverable). ...Under *St. Lukes's*, the statutory word '"dissatisfied"' is not limited to situations in which reimbursement was sought by the hospital from the intermediary."[25]

This dicta suggests that, similar to the Ninth Circuit in *Loma Linda*, the First Circuit would interpret § 1395oo(a) as not requiring that a specific gateway issue or claim be established under § 1395oo(a) before the Board could exercise discretion under 1395oo(d) to hear an issue or claim not considered by the intermediary (*e.g.*, unclaimed cost). Rather, the First Circuit appears to decouple the listing of costs claimed in the cost report from the ability of the provider to be "dissatisfied" with the later decision by the intermediary to reimburse or not reimburse.

This application of § 1395oo(d) is further supported by the D.C. District Court in the 2008 case of *UMDNJ-University Hospital v. Leavitt*.[26] As in *MaineGeneral* and *Loma Linda*, the provider filed its appeal based on several intermediary adjustments to its cost report claims with which it was dissatisfied, but it also included an appeal of costs for its clinical medical education programs that were omitted entirely from the cost report. That court wrote:

> The Board may adopt a policy of hearing claims not initially presented to the fiscal intermediary or of refusing to hear them, or it may decide on a case by case basis. This conclusion comports with the plain language of subsection (d), ...[27]

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[22] *Id.* at 327-328 (emphasis in original).
[23] *MaineGeneral*, 205 F.3d at 501.
[24] *St. Luke's*, 810 F.2d at 327.
[25] *MaineGeneral*, 205 F.3d at 501.
[26] *UMDNJ Univ. Hosp. v. Leavitt*, 539 F.Supp.2d. 70 (D.D.C. 2008) [hereinafter "*UMDNJ*"].
[27] *Id.* at 79.

Similar to the Ninth Circuit in *Loma Linda*, the D.C. District Court interpreted § 1395oo(a) as requiring only general dissatisfaction with the amount of total reimbursement on the NPR in order to establish Board jurisdiction under § 1395oo(a).[28]

In the aggregate, the case law of the First and Ninth Circuits and the D.C. District Court consistently conforms to the notion that § 1395oo(d) bestows the Board with a limited discretion, which is preconditioned on first establishing jurisdiction under § 1395oo(a). The case law does not stand for the proposition that § 1395oo(d) is a grant of "alternate" jurisdiction, but instead, these decisions make it clear that, once the Board acquires jurisdiction over a cost report itself pursuant to 42 U.S.C. § 1395oo(a), the Board has the discretionary power under § 1395oo(d) to hear any discrete items and services on the cost report. The Board *may* then hear the appeals of claims inadvertently omitted or mistakenly reported on the cost report, but the Board is *not required* to hear those claims.

Historically, the Board's interpretation of §§ 1395oo(a) and (d) has generally been more closely aligned with the interpretation of the First Circuit rather than arguably broader interpretation of the Ninth Circuit or the more narrow interpretation of the Seventh Circuit. Specifically, the Board has generally interpreted § 1395oo(a) as: (1) the gateway to establishing Board jurisdiction to hear an appeal; and (2) contrary to *Loma Linda* and *UMDNJ*, requiring that dissatisfaction be expressed with respect to the total reimbursement for "each claim" (as opposed to a general dissatisfaction to the total reimbursement on the NPR) because the Board has viewed the NPR as being comprised of many individual determinations on various items for which the provider has sought payment in the as-filed cost report.[29]

42 U.S.C. § 1395oo(a) dictates that to obtain jurisdiction, a provider must be "dissatisfied" with a "final determination" of the intermediary. Thus, it follows that a provider must have claimed reimbursement for items and services for the intermediary to make a "final determination" regarding such items and services. The Providers in this case failed to claim the LIP Sec. 1115 DSH Waiver days they now seek. The Board generally has interpreted 42 U.S.C. § 1395oo(a) as the gateway to establishing Board jurisdiction to hear an appeal and requiring a provider to establish a right to appeal on a claim-by-claim or issue-specific basis. In *Saint Vincent Indianapolis Hospital v. Sebelius,* No. 1:13-cv-01769-RDM (D.D.C. filed Sept. 29, 2015), the U.S. District Court for the District of Columbia recently upheld the Board's interpretation of the dissatisfaction requirement, 42 U.S.C. § 1395(a) and 42 U.S.C. § 1395(d).

Accordingly, the Board finds that it does not have jurisdiction under 1395(a) to hear the LIP Sec. 1115 DSH waiver days issue as these days were not claimed or properly reported on the Providers' cost reports, and failure to claim was due to inadvertence rather than futility. The Providers argue that the days meet the plain language of the regulatory requirements of 42 C.F.R. § 412.106(b) which allows providers to include days of care in the Medicaid fraction in three situations: (1) where a patient is eligible for inpatient hospital services under an approved State Medicaid plan; (2) where a patient is eligible for inpatient hospital services under a waiver

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[28] *Id.* at 77.

[29] *See, e.g., Affinity Med. Ctr. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2010-D15 (Mar. 11, 2010), *declined review*, CMS Administrator (May 3, 2010) ("*Affinity*") (analyzing a provider's right to a hearing on an issue-specific basis rather than a general basis). *See also* Board Rule 7; 73 Fed. Reg. at 30197.

authorized under section 1115(a)(2) of the Act; or (3) where the days are attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Act. Therefore the Providers cannot also claim they were barred by regulation or statute from including this days on its cost report, as is required to meet *Bethesda.*

The Board also finds that since the Providers failed to established a jurisdictionally valid appeal under § 1395oo(a), (these providers were all direct adds into this group appeal, they did not file into individual appeals with "other" issues, to which the Board has jurisdiction under § 1395oo(a)) the Board cannot use its discretionary power to make a determination under 42 U.S.C. § 1395oo(d). Therefore, the Board dismisses and closes Case No. 14-0645G.

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

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