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JUN 01 2017

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RE: JURISDICTIONAL CHALLENGE
California Pacific Medical Center - St. Luke's Campus
FYE: 12/31/2008
PRRB Case No.: 13-3209

Dear Mr. Jaeger and Ms. Alcantara,

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

Background

The Provider filed this individual appeal with the Provider Reimbursement Review Board ("Board") on August 30, 2013. The Provider is appealing an original Notice of Program Reimbursement ("NPR") dated March 5, 2013, which was issued for the cost reporting period ending December 31, 2008. The Provider stated twelve issues in their request for appeal. The Medicare Contractor, Noridian Healthcare Solutions, has challenged the Board's jurisdiction over Issue Nos. 1, 2, 3, 4, 5, 6, and 7 in the appeal. The Provider references the same five adjustments for all challenged issues: adjustment nos. 21, 22, 23, 38 and 39.

Issue No. 1

Issue No. 1 is described by the Provider as "Medicare DSH – SSI Ratio, Realignment...".[1]

DSH refers to the Disproportionate Share Hospital payment adjustment, and the SSI Ratio is the Supplemental Security Income proxy of the DSH payment calculation. The Provider further describes this issue as "the SSI percentage as generated by the Social Security Administration (SSA) and put forth by CMS is understated."[2] The Provider also claims it may choose to use its cost reporting period instead

[1] Provider's Request for Appeal (Aug. 29, 2013), Tab 3 at 2.
[2] *Id.*

of the federal fiscal year pursuant to 42 C.F.R. § 412.106(b), and "this part of the Medicare DSH SSI issue may be easily resolvable with the Intermediary's agreement to realign the SSI percentage from the federal fiscal year, to using the Provider's fiscal period."[3]

The Provider filed a request to transfer Issue No. 1, Medicare DSH – SSI Ratio, Realignment issue, to Case No. 15-0420GC (Sutter Health 2008 DSH – SSI Ratio Realignment CIRP Group) on April 15, 2015.

Issue No. 2

The Provider describes Issue No. 2 as "Medicare DSH – SSI Ratio, Accurate Data," and similar to Issue No. 1, the Provider argues that the SSI percentage (or Medicare percentage) of the DSH calculation is understated because "CMS did not use the best data available at the time of settlement to calculate the SSI fraction because of various reasons..."[4]

The Provider filed a request to transfer Issue No. 2, Medicare DSH - SSI Ratio, Accurate Data issue, to Case No. 15-0327GC (Sutter Health 2008 DSH – SSI Ratio Inaccurate Data CIRP Group) on April 15, 2015.

Issue No. 3

The Provider describes Issue No. 3 as "Medicare DSH – Inclusion of Medicare Part C Managed Care Days in the SSI Ratio Issued March 2012..."[5] The Provider claims that all Medicare Dual Eligible Part C Days should be included in the Medicaid patient day ratio of the Medicare DSH and low income patient (LIP) (for Inpatient Rehabilitation Facilities) payment calculations. The Provider claims its position is supported by the federal district court decision in *Allina Health Services v. Sebelius, 756 F. Supp. 2d 61 (D.C. 2010).*

The Provider filed a requests to transfer regarding Issues No. 3, Medicare DSH – Inclusion of Medicare Part C Managed Care Days in the SSI Ratio Issued March 2012 issue, to Case No. 15-0576GC (Sutter Health 2008 DSH – SSI Part C Days CIRP Group) on April 15, 2015.

Issue No. 4

The Provider describes Issue 4 as "Medicare DSH- Inclusion of Medicare Dual Eligible Part A Days in the SSI Ratio Issued March 16, 2012..."[6] The Provider states it "disputes the SSI percentage...in their updated calculation of the Medicare DSH payment and low income patient (LIP) payment for Inpatient Rehabilitation Facilities...".[7] The Provider maintains that all Medicare Part A non-covered days (such as exhausted benefit days and Medicare secondary payor days) should be included in the Medicaid patient

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[3] *Id.*
[4] Provider's Request for Appeal (Aug. 29, 2013), Tab 3 at 3.
[5] Provider's Request for Appeal (Aug. 29, 2013), Tab 3 at 4-5.
[6] Provider's Request for Appeal (Aug. 29, 2013), Tab 3 at 5-6.
[7] *Id.*

day ratio of the DSH and Low Income Patient ("LIP") payment calculations. The Provider claims its position is supported by the federal district court decision in *Allina Health Services v. Sebelius, 756 F. Supp. 2d 61 (D.C. 2010).*

The Provider filed a request to transfer for Issue No. 4, the Medicare DSH- Inclusion of Medicare Dual Eligible Part A Days in the SSI Ratio Issued March 16, 2012 issue, to Case No. 15-0578GC (Sutter Health 2008 DSH – SSI Part A Days CIRP Group) on April 15, 2015.

Issue No. 5

The Provider refers to Issue No. 5 as the "Medicare DSH – SSI MMA Section 951 Applicable to SSI Ratio..." issue.[8] The Provider describes this issue as "CMS has failed to release the supporting data to hospitals upon request" and that "the data that CMS will expectantly release is non-compliant with section 951 of the MMA because CMS has not arranged to furnish Social Security Administration's (SSA) data applicable to all Medicare beneficiaries entitled to SSA benefits..."[9]

The Provider filed a request to transfer of Issue No. 5, Medicare DSH – SSI MMA Section 951 Applicable to SSI Ratio, to Case No. 15-0417GC (Sutter Health 2008 DSH – SSI MMA Section 951 CIRP Group) on April 15, 2015.

Issue No. 6

Issue No. 6 is entitled "Medicare DSH – Medicaid FFP with EDS – Emergency Restricted Aid Code (RAC) 2 and 3...".[10] The Provider states the DSH payment adjustment was not calculated properly, and that "Medicaid eligible days were self disallowed, and that valid eligible emergency restricted aid code (RAC) days were improperly excluded from the DSH calculation."[11]

Issue No. 7

Issue No. 7 is entitled "Medicare DSH – Medicaid Days without State Code 2 & 3 – Emergency Restricted Aid Code (RAC) 2 and 3..."[12] The Provider contends the DSH payment adjustment was not calculated properly, and that "Medicaid eligible days were self disallowed and that valid eligible emergency restricted aid code (RAC) days were improperly excluded from the DSH calculation."[13]

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[8] Provider's Request for Appeal (Aug. 29, 2013), Tab 3 at 6-7.
[9] Provider's Request for Appeal (Aug. 29, 2013) at 6.
[10] Provider's Request for Appeal (Aug. 29, 2013) at 7.
[11] *Id.*
[12] Provider's Request for Appeal (Aug. 29, 2013) at 7-8.
[13] *Id.*

Medicare Contractor's Position

The Medicare Contractor is challenging the Board's jurisdiction over Issue No. 1 or the "Medicare DSH – SSI Ratio, Realignment..." issue.[14] The Medicare Contractor contends that the decision to realign a hospital's SSI ratio with its fiscal year end is a hospital election, not a Medicare contractor determination. The Medicare Contractor cites to 42 C.F.R. § 405.1801 and 401.1835, stating that a Provider's right to a hearing before the Board derives from a Medicare contractor or Secretary determination, and it has not made any determination with regards to this election. The Medicare Contractor also argues that the Provider's appeal is premature and the Provider has not exhausted all available remedies prior to requesting a hearing.

The Medicare Contractor has challenged the Board's jurisdiction to hear Issue Nos. 2, 3, and 4, stating that it has not made a final determination regarding these DSH issues. The Medicare Contractor contends that it utilized the DSH SSI ratio determined and published by CMS. While the Medicare Contractor acknowledges that it updated the SSI ratio with adjustments 21 and 22, it explains the adjustment was simply to implement the SSI ratio which was determined by CMS. The Medicare Contractor claims that adjustments 21, 22, 23, 38, and 39 did not adjust or alter the CMS determined DSH SSI ratio.

Additionally, the Medicare Contractor points to the fact that this cost report covers fiscal year end December 31, 2008, noting that the Provider failed to preserve its right to claim dissatisfaction with the amount of Medicare payment for these three issues because it failed to self-disallow the specific cost items by following the applicable procedures for filing a cost report under protest (as required by 42 C.F.R. §405.1835(a)).

Similar to its arguments regarding Issue Nos. 2, 3, and 4, the Medicare Contractor's position regarding Issue No. 5 is that it has not made a final determination regarding this issue. The Medicare Contractor claims that adjustments 21, 22, 23, 38, and 39 did not adjust or alter the CMS determined DSH SSI ratio. Additionally, the Medicare Contractor states the Provider has not preserved its right to claim dissatisfaction with the amount of Medicare payment for Issue No. 5 as a self-disallowed item by protesting the cost report. The Medicare Contractor concludes that the Board lacks jurisdiction over this issue.

The Medicare Contractor states that the Provider seeks to include 37 additional Code 2 and 3 days <u>with</u> restricted aid codes in the numerator of the DSH Medicaid ratio with Issue No. 6. The Medicare Contractor also states that the Provider seeks to include 256 Code 2 and 3 days <u>without</u> restricted aid codes in the numerator of the DSH Medicaid ratio with Issue No. 7.[15] The Medicare Contractor contends that a final determination was not made regarding these additional days in dispute in both Issue Nos. 6 (37 days)

[14] Provider's Request for Appeal (Aug. 29, 2013), Tab 3 at 2.
[15] Medicare Contractor's Jurisdictional Challenge (Aug. 19, 2014) at 7, 11.

and 7 (256 days), and that the Provider must identify the aspects of the Medicare contractor determination with which it is dissatisfied pursuant to 42. C.F.R. § 405.1841.[16]

The Medicare Contractor claims that adjustment nos. 21, 22, 38 and 39 did not impact the DSH Medicaid ratio, and explains these adjustments as follows:

1) Adjustment no. 21 updated the DSH SSI ratio by increasing the percentage of SSI Recipient Patient Days to Medicare Part A Patient Days from 33.75 to 34.32. It is a flow-through adjustment incorporating adjustments 7 and 8, as well as the updated Medicaid ratio, into the Disproportionate Share Percentage (DPP);

2) Adjustment no. 22 updated the DSH SSI ratio, determined and published by CMS, by decreasing the percentage of SSI Recipient Patient Days to Medicare Part A Patient Days from 34.32 to 3.51;

3) Adjustment no. 23 decreased the DSH Disproportionate Share Percentage ("DPP") by incorporating adjustment no. 9 as well as the updated Medicaid ratio from adjustment no. 22;

4) Adjustment no. 38 has two components – it updated Capital DRG and Other Than Outlier Payments based on the Provider Statistical Summary Report (PS&R), and it also updated the SSI ratio for capital PPS by increasing the percentage of SSI Recipient Patient Days to Medicare Part A Patient Days from 33.75 to 34.32; and

5) Adjustment no. 39 updated the SSI ratio by decreasing the Percentage of SSI Recipient Patient Days to Medicare Part A Patient Days from 34.32 to 30.51.[17]

<u>Provider's Position</u>

The Provider filed an opposition to the Medicare Contractor's jurisdictional challenge on September 16, 2014. The Provider cites to *Bethesda Hospital Association v. Bowen*[18] and the Board's *Norwalk*[19] decision, and states "the Board has jurisdiction over the eligible days issue because at the time of its cost report submission, final Medicaid <u>eligible data was not available to the Provider through no fault of its own</u>."[20] The Provider explains that "the State of California does not allow providers to access the final re-verification eligibility process until 14 months after the fiscal year end,"[21] and as a result "the Provider

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[16] *Id.* at 10, 13.
[17] Medicare Contractor's Jurisdictional Challenge (Aug. 21, 2014) at 8-9.
[18] *Bethesda,* 485 U.S. 399 (1988).
[19] *Norwalk Hosp. v. Blue Cross & Blue Shield Ass'n,* PRRB Hearing Dec. No. 2012-D14, (Mar. 19, 2012), *vacated,* CMS Adm'r Dec. (May 21, 2012).
[20] Provider's Opposition to Jurisdictional Challenge (Sept. 15, 2014) at 5.
[21] *Id.*

has established futility and has established that there is a practical impediment to obtaining California's verified final DSH Medi-Cal eligible days...".[22]

Board Decision

APPLICABLE STATUTES, REGULATIONS AND BOARD RULES

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2013), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific items at issue, by either –

> (i) Including a claim for the specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or
>
> (ii) Effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item(s) by following the applicable procedures for filing a cost report under protest, where the provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy...[23]

The applicable procedures for filing a cost report under protest in CMS Publication 15-2, Section 115.1 state:

> When you file a cost report under protest, the disputed item and amount for each issue must be specifically identified in footnotes to the settlement worksheet and the fact that the cost report is filed under protest must be disclosed.

Board Rule 4.5 states that a Provider may not appeal an issue from a final determination in more than one appeal.

ANALYSIS AND JURISDICTIONAL DETERMINATION

Issue Nos. 1 and 2

In Issue No. 1, the Provider states it is appealing the SSI percentage of the DSH payment calculation as understated, and also that the Provider may request to use its cost reporting period instead of the Federal fiscal year in the computation of its DSH payment.. After review of the referenced adjustment nos. 21,

[22] Id. at 16.
[23] 42 C.F.R. 405.1835(a)(1)(2013).

22, 23, 38 and 39,[24] the Board finds that it has jurisdiction over Issue Nos. 1 and 2 as the DSH SSI percentage was adjusted. However, the Board also finds that Issue No. 1 is duplicative of Issue No. 2, as the basis of both Issues it that the DSH SSI percentage is understated and must be supplied by CMS. Therefore, Issue No. 1 is dismissed as the Provider is prohibited from appealing the same issue from the same cost report in more than one appeal pursuant to Board Rule 4.5.

With regards to the claim that the Provider "may choose to use its cost reporting period instead of the Federal fiscal year" in Issue No. 1, there is no evidence in the record that the Medicare Contractor has made a final determination regarding the use of the Provider's cost reporting period instead of the Federal fiscal year, and therefore this sub-issue does not meet the Board's jurisdictional requirements and is dismissed.

In conclusion, Issue No. 1 is dismissed from this appeal as it is duplicative of Issue No. 2. The Board grants the transfer of Issue No. 2 to PRRB Case No. 15-0327GC and the DSH SSI percentage issue now resides in that case.

Issue Nos. 3 and 4

The Board finds that it has jurisdiction over Issue Nos. 3 (Medicare Part C Days in the DSH SSI Ratio issued March 16, 2012) and Issue No. 4 (Medicare Dual Eligible Part A Days in the DSH SSI Ratio issued March 16, 2012). The Board notes that on June 22, 2012, CMS notified providers that it had "posted the SSI ratios for [fiscal years] 2006, 2007, 2008 and 2009 to the CMS website."[25] CMS goes on to state that "[t]hese SSI ratios include Medicare Advantage (MA) [Part C] patient days and are calculated in the manner prescribed by CMS-1498-R,"[26] which revised Medicare Part A non-covered days. Within this June 22, 2012 notice, CMS states that it "will be working to final settle the backlog of cost reports that have been held, awaiting revised SSI ratios."[27]

The final determination (NPR) from which the Provider has appealed is dated March 5, 2013. Based on CMS' June 22, 2012 notice and adjustment no. 39 which updated the "CMS published SSI% on March 2012 for Operating DSH and Capital DSH...",[28] the Board finds that the Medicare Contractor utilized the Provider's revised SSI ratio[29] to settle its cost report. As such, the Board concludes that Medicare Part C days and Medicare Part A non-covered days were revised within the DSH SSI ratio in the March 5, 2013 NPR, and that the Board has jurisdiction to hear the appeal of these issues.

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[24] Provider's Individual Appeal Request (Aug. 29, 2013), Tab 1.
[25] Department of Health and Human Services, CMS, MLN Matters Number: SE1225 at 1, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1225.pdf.
[26] On April 28, 2010, CMS issued CMS-1498-R that addresses three Medicare DSH issues, including CMS' processes for both matching Medicare and SSI eligibility data and calculating providers' SSI fractions.
[27] Department of Health and Human Services, CMS, MLN Matters Number: SE1225 at 3, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network- MLN/MLNMattersArticles/Downloads/SE1225.pdf.
[28] Provider's Request for Appeal (Aug. 29, 2013), Tab 1.
[29] The terms "SSI fraction," "SSI ratio," "Medicare ratio" and "Medicare fraction" are synonymous in this appeal and used interchangeably.

The Board grants the transfer of these issues. Issue No. 3 now resides in Case No. 15-0576GC, and Issue No 4 resides in 15-0578GC.

Issue No. 5

Section 951 of the Medicare Modernization Act ("MMA") provides:

> Beginning not later than 1 year after the date of the enactment of this Act, the Secretary shall arrange to furnish to subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act, 42 U.S.C. 1395ww(d)(1)(B)) the data necessary for such hospitals to compute the number of patient days used in computing the disproportionate patient percentage under such section for that hospital for the current cost reporting year. Such data shall also be furnished to other hospitals which would qualify for additional payments under Part A of title XVII of the Social Security Act on the basis of such data.

CMS has provided instruction to DSH hospitals on how they can request the data used to calculate their DSH SSI ratios for fiscal year ends 2006 through 2009.[30] Here the Provider argues that CMS has failed to comply with Section 951 of the MMA because it has not furnished all of the data necessary, including "supporting" data.[31]

The Board dismisses Issue No. 5, the "Medicare DSH – SSI MMA Section 951 Applicable to SSI Ratio Issued March 2012" issue because it is duplicative of Issue No. 2, the "Medicare DSH – SSI Ratio, Accurate Data" issue, which is violation of PRRB Rule 4.5. This rule Provides, "A Provider may not appeal an issue from a final determination in more than one appeal."

Issue Nos. 2 and 5 both challenge the DSH SSI ratio utilized to calculate the Provider's DSH payment adjustment, alleging the Provider cannot get the data used to calculate the DSH SSI ratio. Both Issues also claim an identical reimbursement impact of $91,657. Additionally, the Board cannot grant the Provider the relief it seeks with Issue No. 5 – CMS' compliance with Section 951 of the MMA. The Board's jurisdiction does not include matters that are injunctive in nature, as injunctive relief is based in equity, and the Board does not have general equitable authority.[32] The scope of the Board's legal authority is as follows:

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

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[30] Department of Health and Human Services, CMS, MLN Matters Number: SE1225 at 1, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1225.pdf.
[31] Provider's Request for Appeal (Aug. 29, 2013), Tab 3.
[32] *Hospital Corporation of America*, PRRB Dec. No. 2005-D16, *rev'd*, 2005 WL 3447734 (CMS Mar. 3, 2005) (final admin. review).

general statements of policy, and rules of agency organization, procedure, or practice established by CMS.[33]

The Board dismisses Issue No. 5 because the Provider has already appealed the DSH SSI ratio, including the underlying data used to calculate the ratio, in Issue No. 2.

Issue Nos. 6 and 7

The Provider is appealing from a 12/31/2008 cost report, which means that it either had to claim the cost at issue or it is subject to the protest requirement in order for the Board to have jurisdiction. The Board finds that it does not have jurisdiction over Issue Nos. 6 and 7 which seek additional Medicaid eligible Code 2 and 3 Days in this appeal. The Provider did not protest the Medicaid eligible days in Issue Nos. 6 and 7 on its cost report notwithstanding the fact that it knew California would have additional days at a later point in time. Nor did the Provider included a claim for those specific days on its cost report, as required by 42 C.F.R. § 405.1835(a).

The Board acknowledges that the Provider filed Medicaid days on various lines on its as-filed cost report, to which the Medicare Contractor made an adjustment.[34] However, the Provider has presented no evidence that the additional Code 2 and 3 days with restricted aid codes (Issue No. 6) and without restricted aid codes (Issue No. 7) at issue were part of the days adjusted off. Therefore, the Board concludes that the Provider has not met the dissatisfaction requirement of including a specific claim on the cost report, or protesting the specific Medicaid eligible days at issue. Because the Board does not have jurisdiction over Issue Nos. 6 and 7, these issues are dismissed from this appeal.

This appeal is now closed as all issues have been adjudicated through the Partial Administrative Resolution (April 21, 2017), dismissed by the Board, or transferred to other appeals.

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[33] 42 C.F.R. § 405.1867.

[34] There was an adjustment to reported Title XIX and Total Days on Worksheet S-3, Part I. Provider's Request for Appeal (Aug. 29, 2013), Tab 1, Adjustment Nos. 7, 8, and 9.

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

Board Members Participating
L. Sue Andersen, Esq.
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA
Gregory Ziegler

FOR THE BOARD

L. Sue Andersen, Esq.
Chairperson

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

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

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RE: Expedited Judicial Review Request
Sharp Health Care 2008-2009 Observation Days CIRP Group
PRRB Case No. 16-1944GC

Dear Mr. Peabody and Mr. Bauers,

The Provider Reimbursement Review Board ("Board") has reviewed the record and the comments received regarding the suitability of the issue under appeal for Expedited Judicial Review ("EJR"). The Board has determined that it lacks the authority to decide the legal question and therefore grants EJR of the group issue pursuant to 42 C.F.R. § 405.1842(f).

Issue under Appeal

Whether the applicable regulation, 42 C.F.R. § 412.106(a)(1)(B), requiring the inclusion of observation days of outpatients who are ultimately admitted to the hospital as inpatients in the DSH calculation is arbitrary, capricious, or contrary to law.

Factual Background and Providers' Request for EJR

The Centers for Medicare and Medicaid Services ("CMS") has a long history of excluding observation bed days from the DSH calculation. Observation services are those services furnished by a hospital on the hospital's premises that include use of a bed and periodic monitoring by a hospital's nursing or other staff in order to evaluate an outpatient's condition or to determine the need for a possible admission to the hospital as an inpatient.[1] Observation services are specifically defined as, "a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patient will require further treatment."[2] During this time that a patient is under observation but has not been formally admitted, the patient is treated as an outpatient. Therefore, the observation bed days are not recognized under the IPPS as part of the inpatient operating costs of a hospital. This policy of excluding observation bed days from the DSH calculation was confirmed in a memorandum dated February 27, 1997 that was sent to all CMS Regional offices.

In a Proposed Rule published on May 19, 2003, CMS proposed amending the observation bed

[1] 68 Fed. Reg. 27154, 27205 (May 19, 2003).
[2] Medicare Benefit Policy manual Publication No. 100-02, Chapter 6, section 20.6A.

days policy with respect to those patients who are ultimately admitted to the hospital. The proposed rule provided:

> Specifically, we are proposing that, if a patient is admitted as an acute inpatient subsequent to receiving outpatient observation services, because the charges of the observation ancillary services the patient receives are currently treated as inpatient charges on the cost report, in order to be consistent with our policy to treat the costs and patient days consistently, we will begin to include the patient bed days associated with the observation services in the inpatient bed day count.[3]

This proposed change to how observation days for patients that are ultimately admitted was adopted in the final rule for cost reporting periods beginning on or after October 1, 2004.[4]

Subsequently, in 2009, CMS proposed to amend its policy once again and proposed that observation bed days should be excluded from the calculation of DSH, even if the patient is ultimately admitted.[5] CMS offered explanation that observation services are services furnished to outpatients of the hospital, therefore the days should not be included in the IPPS DSH calculation. This rule was finalized in August of 2009 effective for cost reporting periods beginning on or after October 1, 2009.[6]

The Providers argue that the regulation that was effective for cost reporting periods 10/1/2004 – 9/30/2009 is arbitrary, capricious, and contrary to law and statute. According to the Providers, the contested regulation violates the Medicare statute. When Congress enacted the IPPS, the reimbursement scheme was clearly meant to apply to inpatient services. The Providers argue that observation services are outpatient services, therefore their inclusion in the DSH calculation "is inconsistent with the entire statutory scheme for IPPS."[7]

The Providers also argue that the regulation violates the "spell of illness" and other provisions of the Medicare statute. They give the example that pursuant to 42 U.S.C. § 1395€ for a patient day to be considered part of a beneficiary's spell of illness, the patient must have had "inpatient hospital services furnished to him during such a spell." The Provider goes on to give several other examples of provisions that the 2004 regulation violates.[8]

The next argument put forth by the Providers is that CMS failed to provide a sufficient reason for abandoning its longstanding policy of excluding observation days from the DSH calculation. Further, the Provider argues that the agency policy with respect to counting and paying for "days" has been inconsistent. According to the Providers, in returning to its pre-2004 position in 2009, CMS effectively admitted that its 2004 method of determining reimbursements was inconsistent with applicable law because observation bed days are outpatient days.[9]

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[3] 68 Fed. Reg. 27154, 27206 (May 19, 2003).
[4] 69 Fed. Reg. 48916, 49097 (Aug. 11, 2004).
[5] 74 Fed. Reg. 24080, 24190 (May 22, 2009).
[6] 74 Fed. Reg. 43754, 43908 (Aug. 27, 2009).
[7] Provider Final Position Paper at 15.
[8] *Id.* at 17-18.
[9] *Id.* at 28.

Analysis and Decision

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

Jurisdiction

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 that it has jurisdiction over the 4 Providers pending in this group appeal. Each Provider timely appealed from a Notice of Program Reimbursement ("NPR") and the amount in controversy is satisfied for the group. Participants 1-3 have appealed from FYEs 9/30/2008 and from cost reports in which the Medicare Contractor made an adjustment to include observation days. Participant 4 is appealing from a FYE 9/30/2009 cost report and properly protested the observation bed days issue pursuant to 42 C.F.R. § 405.1835(a)(1)(ii).

Board Finding Regarding Authority

Pursuant to 42 C.F.R. § 405.1867, the Board must comply with Title XVIII of the Act and its supporting regulations. The Providers allege that the version of 42 C.F.R. § 412.106(a)(1)(ii)(B) in effect for cost reporting periods 10/1/2004 – 9/30/2009 is contrary to law and arbitrary and capricious. The Board finds that it lacks the authority to examine this legal question.

Conclusion

With regards to the Providers' request for EJR for the observation bed days issue, the Board finds that:

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

2) based upon the Providers' assertions, there are no findings of fact for resolution by the Board;

3) it is bound by 42 C.F.R. § 412.106(a)(1)(ii)(B); and

4) it is without the authority to invalidate the regulation.

Accordingly, the Board finds that the challenge to the observation bed days regulation in effect for

cost reporting periods 10/1/2004 – 9/30/2009 properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants expedited judicial review for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. PRRB Case No. 16-1944GC is hereby closed and removed from the Board's docket.

Board Members
L. Sue Andersen, Esq.
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA, CHFP
Gregory H. Ziegler

FOR THE BOARD

L. Sue Andersen, Esq.
Chairperson

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

cc: Evaline Alcantara, Appeals Coordinator – Jurisdiction E
Noridian Healthcare Solutions
P.O. Box 6782
Fargo, ND 58108-6782

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

CERTIFIED MAIL

JUN 0 6 2017

Toyon Associates, Inc.
Christine Ponce
Director – Client Services
1800 Sutter Street, Suite 600
Concord, CA 94520-2546

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

RE: St. Luke's Rehabilitation Center
Provider No.: 50-3025
FYEs: 12/31/10
PRRB Case No.: 14-3549

Dear Ms. Ponce and Mr. Ward,

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

Background

The Provider submitted a request for hearing on May 30, 2014, based on a Notice of Program Reimbursement ("NPR") dated January 6, 2014. The hearing request included four issues as follows:

1) Issue No. 1 - Medicare Low Income Patient (LIP) Payments – Additional Medicaid Eligible Days;
2) Issue No. 2 – Medicare Low Income Patient (LIP) Payments – Inclusion of Medicare Dual Eligible Part A Days in the SSI Ratio Issued August 23, 2012;
3) Issue No. 3 - Medicare Low Income Patient (LIP) Payments – Inclusion of Medicare Dual Eligible Part C Days in the SSI Ratio Issued August 23, 2012; and
4) Issue No. 4 – Medicare Low Income Patient (LIP) Payments – Accuracy of CMS Developed SSI Ratio Issued August 23, 2012.

With respect Issue No. 1, the Provider contends that there are 231 additional Medicaid paid out-of-state days and these days are includable in the LIP entitlement calculation.[1]

The Medicare Contractor submitted a jurisdictional challenge on all of the issues on January 19, 2016. The Provider submitted a responsive brief on February 8, 2016. Subsequently, the Provider submitted requests dated May 15, 2017 and May 26, 2017 to transfer all of the issues to group appeals.

[1] *See* Provider's Request for Hearing at p. 2.

Medicare Contractor's Position

The Medicare Contractor contends that the language of 42 U.S.C. § 1395ww(j)(8)(B)[2] prohibits and precludes administrative and judicial review of the IRF-PPS rates established under 42 U.S.C. § 1395ww(j)(3)(A). The Medicare Contractor maintains that, because the IRF-PPS rate is comprised of both the general federal rate based on historical costs and adjustments to that federal rate (including but not limited to the LIP adjustment at issue), the statute prohibits administrative and judicial review of the LIP adjustment. Accordingly, the Medicare Contractor argues that the Board is divested of jurisdiction to hear the Provider's appeal because it must comply with all of the provisions of the Medicare Act and the regulations issued thereunder.[3]

Provider's Position

The Provider contends that the NPR issued on January 6, 2014 constitutes a final determination by the Medicare Contractor with respect to the provider's cost report. In 42 C.F.R. § 405.1801(a)(2), it defines a final determination as follows: "An intermediary determination is defined as a "determination of the total amount of payment due to the hospital, pursuant to § 405.1803 following the close of the hospital's cost reporting period..."[4]

The Provider contends that the Medicare Contractor made an adjustment that revised the IRF LIP SSI Ratio from .0307 to .0380 per audit adjustment 13. In addition, the Medicare Contractor made an adjustment to remove the as-filed IRF protested amount totaling $145,116 per audit adjustment number 12, which includes protested amounts for the following LIP payment issues: (a) Understated LIP payments due to an understatement of the SSI ratio as published by CMS; (b) Understated LIP payments due to CMS excluding Medicare/Medicaid dual eligible days; (c) Understated LIP payments pending receipt of California Medicaid eligibility verification. The Provider argues that the Medicare Contractor did indeed post audit adjustments that resulted in a change to the Provider's reported LIP entitlement in the Medicare cost report which thereby allows the Provider an avenue to pursue a correction to their LIP entitlement via the PRRB appeal process.[5]

The Provider contends that the LIP adjustment is not a component of the IRF-PPS rate described in § 1395ww(j)(3)(A) (*i.e.*, the unadjusted federal rates) because LIP is calculated as a current cost reporting period add-on payment to the IRF-PPS federal payment and it is reported on a separate line within the Medicare cost report.[6] The Provider argues that it is only disputing the accuracy of the provider-specific data elements used by the Medicare Contractor, not the establishment or methodology for development of the federal IRF prospective payments.[7] The Provider contends that § 1395ww(j)(8) does not prohibit its challenge as to whether CMS and its agents utilized the proper data elements in executing that formula. The Provider maintains that, while § 1395ww(j)(8) prohibits administrative or

[2] Formerly designated at paragraph (7). Section 3004(b) of the Affordable Care Act addressed the IRF PPS program and reassigned the previously-designated section 1886(j)(7) of the Act [42 U.S.C. § 1395ww(j)(7)] to section 1886(j)(8) [42 U.S.C. § 1395ww(j)(8)] and inserted a new section 1886(j)(7), which contains new requirements for the Secretary to establish a quality reporting program for IRFs.
[3] 42 C.F.R. § 405.1867.
[4] Provider's jurisdictional response at 2 (Emphasis included).
[5] Provider's jurisdictional response at 4.
[6] Provider's jurisdictional response at 4-5.
[7] Provider's jurisdictional response at 5.

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

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 concludes that it does not have jurisdiction over the LIP issues in this appeal as the NPR was issued January 6, 2014, after the October 1, 2013 effective date of the regulatory revision to 42 C.F.R. § 412.630 that precludes Board review of the LIP adjustment.

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

> There shall be no administrative or judicial review . . . of the *establishment* of—
>
> (A) case mix groups, of the methodology for the classification of patients within such groups, and the appropriate weighting factors thereof under paragraph (2),
>
> (B) the prospective payment rates under paragraph (3),
>
> (C) outlier and special payments under paragraph (4), and
>
> (D) area wage adjustments under paragraph (6).[9]

The Secretary adopted a regulation limiting administrative and judicial review which mirrors the statutory limitations, specifically limiting review only to the "unadjusted" Federal payment rate. For the years prior to this appeal, 42 C.F.R. § 412.630 stated:

> Administrative or judicial review under 1869 or 1878 of the Act, or otherwise, is prohibited with regard to the establishment of the methodology to classify a patient into the case-mix groups and the associated weighting factor, the *unadjusted* Federal per discharge payments rates, additional payments for outliers and special payments, and the area wage index.[10]

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[8] Provider's jurisdictional response at 5.
[9] (Emphasis added).
[10] (emphasis added)

Significantly, the term "the unadjusted Federal rate" is defined in 42 C.F.R. § 412.624(c) and it does not include any of the adjustments discussed in § 412.624(e), including the LIP adjustment.

The Board finds that in the August 2013 Inpatient Rehabilitation Facility Prospective Payment System ("IRF PPS") Final Rule, the Secretary expanded the list of adjustments in § 412.630 to include the LIP adjustment. CMS stated in the Final Rule:

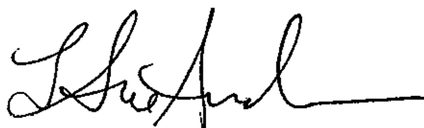
> Our intent was to honor the full breadth of the preclusion of administrative or judicial review provided by section 1886(j)(8) of the Act. However, the regulatory text reflecting the preclusion of review has been at times improperly interpreted to allow review of adjustments authorized under section 1886(j)(3)(v) of the Act. Because we interpret the preclusion of review at § 1886(j)(8) of the Act to apply to all payments authorized under section 1886(j)(3) of the Act, we do not believe that there should be administrative or judicial review of any part of the prospective rate. Accordingly, we are clarifying our regulation at § 412.630 by deleting the word "unadjusted" so that the regulation will clearly preclude review of the "Federal per discharge payment rates."[11]

During the period at issue, the Board finds that the revised regulation precluded review of the LIP adjustment. In this regard, the Board concludes that the regulatory changes made in the August 2013 Final Rule are applicable to this case because they were effective on October 1, 2013. As such, the Board concludes that it does not have jurisdiction over the LIP issues in this appeal. The Provider's requests to transfer the issues to group appeals are denied and the Board dismisses the issues from the appeal.

As no issues remain, the Board closes the case, and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:
L. Sue Andersen, Esq.
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA, CHFP
Gregory H. Ziegler

FOR THE BOARD



L. Sue Andersen, Esq.
Chairperson

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

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

[11] 78 Fed. Reg. at 47900.

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Refer to: 13-3296G
Certified Mail

JUN 08 2017

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

RE: Patton Boggs 2008 Medicare Outliers Optional Group II
Provider Nos. Various
FY 2008
PRRB Case No. 13-3296G

Dear Mr. Nash:

Enclosed is the Provider Reimbursement Review Board's (Board's) Notice of Reopening and Board Order issued incident to the Administrator of the Centers for Medicare & Medicaid Services remand. The Board's order contains a new expedited judicial review determination for the outlier issue.

Sincerely,

L. Sue Andersen, Esq.
Chairperson

Enclosure: Notice of Reopening/Board Order

cc: Bill Tisdale, Novitas (Certified Mail w/Notice of Reopening)
Wilson Leong, FSS (w/Notice of Reopening)

United States Department of Health and Human Services
Provider Reimbursement Review Board

Patton Boggs 2008 Medicare Outliers Optional Group II	*	PRRB Case No. 13-3296GC
v.	*	
	*	FY 2008
Wisconsin Physicians Service	*	

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Notice of Reopening Pursuant to the Administrator's Order of Remand

and

Provider Reimbursement Review Board Order

I
Reopening

By ORDER dated April 6, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) remanded to the Provider Reimbursement Review Board (Board) case number 13-3296G.

On January 13, 2015, the Board denied in part and granted in part the Providers' request for expedited judicial review (EJR) in the above-referenced appeal. The issue under appeal in the case was stated as:

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

The Board found that it lacked jurisdiction over the majority of the Providers in the case because

[1] Board's January 13, 2015 EJR determination at 1, n. 1. (42 C.F.R. §§ 412.80 and 412.86)
[2] *Id.* at n.2.
[3] *Id.* at n 3.

the Providers had received Notices of Program Reimbursement, but had failed to protest the fixed-loss threshold issue as required by 42 C.F.R. § 405.1835(a)(1)(ii). The Board granted in part EJR for portions of appeals for four Providers which had appealed fiscal years ending before December 31, 2008, the effective date of 42 C.F.R. § 405.1835(a)(1)(ii).

The Providers appealed the Board's decision denying jurisdiction to the United States District Court for the District of Columbia. The Court issued a decision in *Banner Heart Hospital v. Burwell ("Banner"),*[4] concluding that:

> [U]nder *Bethesda*[5]—and at *Chevron*[6] Step One—the Secretary's self-disallowance regulation, as applied to Plaintiffs' specific regulatory challenge, conflicts with the plain text of [42 U.S.C. §] 1395oo. The Board therefore erred in ruling that it lacked jurisdiction to hear Plaintiffs' challenge to the outlier regulations. *See [Bethesda Hospital Association v. Bowen 485 U.S. 399,* 408], 108 S.Ct. 1255 [1988] (concluding that the "Board had jurisdiction to entertain this action").[7]

As a result of this finding, the Court remanded the case[8] to the Secretary on November 4, 2016, for proceedings consistent with this order.

On April 4, 2017, the Administrator ORDERED:

- That the [Board] decision in Squire Patton Boggs Medicare Outliers Optional Group II, PRRB Case No. 13-3296G is hereby vacated; and

- That pursuant to the Court's order, the [Board] will reconsider the above cited case[] for further proceedings consistent with the August 19, 2016 Memorandum Opinion in *Banner Heart Hospital v. Burwell,[citation omitted]; and*

- That the decision of the Board is subject to the provisions of 42 C.F.R. § 405.1875.

The Board hereby reopens case number 13-3296G.

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[4] 201 F. Supp.3d 131 (D.D.C. 2016).
[5] 485 U.S. 399 (1988).
[6] *Chevron U.S.A. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837 (1984).
[7] 201 F. Supp. at 142.
[8] *Id.* at 143.

II
Board Order

Consistent with the Administrator's Order, the Board has reviewed the Providers' submissions pertaining to the requests for hearing and expedited judicial review. Based on the Court's legal conclusion in *Banner,* the regulation, 42 C.F.R. § 405.1835(a)(1)(ii), conflicts with 42 U.S.C. § 1395oo and the Board's previous denial of jurisdiction over the Providers for failure to protest the FLT was in error. As a result of the *Banner* decision, the Board has reviewed the Providers' submission under the tenants set forth in *Bethesda* which held that submission of a cost report in full compliance with unambiguous dictates of the Secretary's rules and regulations does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations.[9] The Board concludes that the FLT issue, which is published in the Federal Register,[10] is the type of issue to which the decision in *Bethesda* applies and that it has jurisdiction over the Providers in this appeal.[11] The Board is confined to the application of statutes, regulations and Federal Register notices and is without power to grant the relief the Providers are seeking.[12]

Accordingly, the Board concludes that EJR is appropriate for the disputed issue for the Providers listed on the attached Schedule of Providers for the reasons set forth below. Pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 expedited judicial review is permitted where the Board determines that it does not have the authority to decide a question of law, regulation or CMS ruling. In these cases, the Providers are challenging the validity of the outlier regulations, 42 C.F.R. §§ 412.80 through 412.86. The Medicare Contractors did not oppose the request for EJR. The documentation shows that in the group case the estimated amount in controversy exceeds $50,000 and the Providers' appeals were timely filed.

The Board finds that:

---

[9] *Bethesda* at 1258-1259.

[10] *See e.g.* 73 Fed. Reg. 48,434, 48,763-66 (Aug. 19, 2008)

[11] The Board recognizes that Court discussed but declined to rule on another potential rationale for denying jurisdiction, namely that the Board's jurisdiction is not mandatory but rather discretionary. However, the Board finds that this potential alternative rationale is not applicable to this case. Specifically, the Board finds that its jurisdiction over the Provider(s) is mandatory under 42 U.S.C. § 1395oo(a) because: (1) 42 C.F.R. § 405.1835(a)(1)(ii) does not apply to the Provider(s) based on Court-order application of the *Banner* decision; and (2) prior to the adoption of 42 C.F.R. § 405.1835(a)(1)(ii) in 2008, the Board consistently found jurisdiction to be mandatory under 42 U.S.C. § 1395oo(a) pursuant to *Bethesda* whenever a provider specifically appeals the validity of a regulation or rule that a Medicare contractor is otherwise bound to follow and apply regardless of whether the provider protested (or otherwise claimed on its cost report) the cost associated with the challenged regulation/rule.

[12] *See* 42 C.F.R. § 405.1867 (the Board must comply with all of the provisions of Title XVII of the Act and the regulations issued thereunder, as well as CMS Ruling issued under the authority of the Administrator. The outlier payments made under the regulation: are updated annually through the Secretary's Federal Register notices (*see* 42 C.F.R. § 401.106 (materials required to be published under the provisions of 5 U.S.C. § 552(a)(1) and (2) are published in the Federal Register)).

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

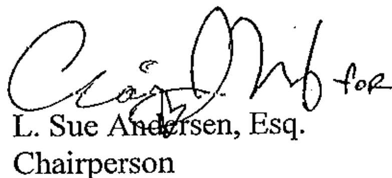
2) based upon the Providers' assertions regarding the outlier regulations, 42 C.F.R. §§ 412.80-412.86, there are no findings of fact for resolution by the Board;

3) it is bound by the regulations; and

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

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

SO ORDERED by the
Provider Reimbursement Review Board



L. Sue Andersen, Esq.
Chairperson

Date: JUN 08 2017

Attachment: Schedule of Providers

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

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

Refer to: 13-0649GC

Certified Mail

JUN 08 2017

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

RE: Patton Boggs/Banner 2008 Medicare Outlier Group
Provider Nos. Various
FY 2012
PRRB Case No. 13-0649GC

Dear Mr. Nash:

Enclosed is the Provider Reimbursement Review Board's (Board's) Notice of Reopening and Board Order issued incident to the Administrator of the Centers for Medicare & Medicaid Services remand. The Board's order contains a new expedited judicial review determination for the outlier issue.

Sincerely,

L. Sue Andersen, Esq.
Chairperson

Enclosure: Notice of Reopening/Board Order

cc: Byron Lamprecht, WPS (Certified Mail w/Notice of Reopening)
Wilson Leong, FSS (w/Notice of Reopening)

United States Department of Health and Human Services
Provider Reimbursement Review Board

Squire Patton Boggs/Banner 2008 Medicare Outlier Group.	*	PRRB Case No. 13-0649GC
v.	*	
	*	FY 2008
Wisconsin Physicians Service	*	

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and

Provider Reimbursement Review Board Order

I
Reopening

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On May 14, 2014, the Board granted denied in part and granted in part the Providers' request for expedited judicial review (EJR) in the above-referenced appeal. The issue under appeal in the case was stated as:

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

The Board found that it lacked jurisdiction over the majority of the Providers in the case because

[1] Providers' March 21, 2014 Request for EJR at 2, n. 1. (42 C.F.R. §§ 412.80 and 412.86)
[2] *Id.* at n.2.
[3] *Id.* at n 3. (42 U.S.C. § 1395ww(d)(5)(A)(i)).

the Providers had received Notices of Program Reimbursement, but had failed to protest the fixed-loss threshold issue as required by 42 C.F.R. § 405.1835(a)(1)(ii). The Board granted in part EJR for portions of appeals for two Providers which had appealed fiscal years ending before December 31, 2008, the effective date of 42 C.F.R. § 405.1835(a)(1)(ii).

The Providers appealed the Board's decision denying jurisdiction to the United States District Court for the District of Columbia. The Court issued a decision in *Banner Heart Hospital v. Burwell ("Banner")*,[4] concluding that:

> [U]nder *Bethesda*[5]—and at *Chevron*[6] Step One—the Secretary's self-disallowance regulation, as applied to Plaintiffs' specific regulatory challenge, conflicts with the plain text of [42 U.S.C. §] 1395oo. The Board therefore erred in ruling that it lacked jurisdiction to hear Plaintiffs' challenge to the outlier regulations. *See* [*Bethesda Hospital Association v. Bowen 485 U.S. 399,* 408], 108 S.Ct. 1255 [1988] (concluding that the "Board had jurisdiction to entertain this action").[7]

As a result of this finding, the Court remanded the case[8] to the Secretary on November 4, 2016, for proceedings consistent with this order.

On April 4, 2017, the Administrator ORDERED:

- That the [Board] decision in Squire Patton Boggs/Banner 2008 Medicare Outlier Group, PRRB Case No. 13-0649GC is hereby vacated; and

- That pursuant to the Court's order, the [Board] will reconsider the above cited case[] for further proceedings consistent with the August 19, 2016 Memorandum Opinion in *Banner Heart Hospital v. Burwell,[citation omitted]; and*

- That the decision of the Board is subject to the provisions of 42 C.F.R. § 405.1875.

The Board hereby reopens case number 13-0649GC.

[4] 201 F. Supp.3d 131 (D.D.C. 2016).
[5] 485 U.S. 399 (1988).
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Accordingly, the Board concludes that EJR is appropriate for the disputed issue for the Providers listed on the attached Schedule of Providers for the reasons set forth below. Pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 expedited judicial review is permitted where the Board determines that it does not have the authority to decide a question of law, regulation or CMS ruling. In these cases, the Providers are challenging the validity of the outlier regulations, 42 C.F.R. §§ 412.80 through 412.86. The Medicare Contractors did not oppose the request for EJR. The documentation shows that in the group case the estimated amount in controversy exceeds $50,000 and the Providers' appeals were timely filed.

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[11] The Board recognizes that the Court discussed but declined to rule on another potential rationale for denying jurisdiction, namely that the Board's jurisdiction is not mandatory but rather discretionary. However, the Board finds that this potential alternative rationale is not applicable to this case. Specifically, the Board finds that its jurisdiction over the Provider(s) is mandatory under 42 U.S.C. § 1395oo(a) because: (1) 42 C.F.R. § 405.1835(a)(1)(ii) does not apply to the Provider(s) based on Court-order application of the *Banner* decision; and (2) prior to the adoption of 42 C.F.R. § 405.1835(a)(1)(ii) in 2008, the Board consistently found jurisdiction to be mandatory under 42 U.S.C. § 1395oo(a) pursuant to *Bethesda* whenever a provider specifically appeals the validity of a regulation or rule that a Medicare contractor is otherwise bound to follow and apply regardless of whether the provider protested (or otherwise claimed on its cost report) the cost associated with the challenged regulation/rule.

[12] *See* 42 C.F.R. § 405.1867 (the Board must comply with all of the provisions of Title XVII of the Act and the regulations issued thereunder, as well as CMS Ruling issued under the authority of the Administrator. The outlier payments made under the regulations are updated annually through the Secretary's Federal Register notices (*see* 42 C.F.R. § 401.106 (materials required to be published under the provisions of 5 U.S.C. § 552(a)(1) and (2) are published in the Federal Register)).

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

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

3) it is bound by the regulations; and

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

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

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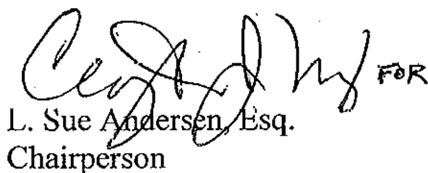
Provider Reimbursement Review Board



L. Sue Andersen, Esq.
Chairperson

Date: JUN 08 2017

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Refer to: 13-3610G
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JUN 08 2017

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

RE: Patton Boggs 2009 Medicare Outliers-NPR Optional Group
Provider Nos. Various
FY 2009
PRRB Case No. 13-3610G

Dear Mr. Nash:

Enclosed is the Provider Reimbursement Review Board's (Board's) Notice of Reopening and Board Order issued incident to the Administrator of the Centers for Medicare & Medicaid Services remand. The Board's order contains a new expedited judicial review determination for the outlier issue.

Sincerely,

L. Sue Andersen, Esq.
Chairperson

Enclosure: Notice of Reopening/Board Order

cc: James Ward, Noridian Healthcare Solutions (Certified Mail w/Notice of Reopening)
Wilson Leong, FSS (w/Notice of Reopening)

United States Department of Health and Human Services
Provider Reimbursement Review Board

Squire Patton Boggs 2009 Medicare Outliers-NPR Optional Grp.	*	PRRB Case No. 13-3610G
v.	*	
	*	FY 2009
Noridian Healthcare Solutions, Inc.	*	

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Notice of Reopening Pursuant to the Administrator's Order of Remand

and

Provider Reimbursement Review Board Order

I
Reopening

By ORDER dated April 6, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) remanded to the Provider Reimbursement Review Board (Board) case number 13-3610G.

On January 13, 2015, the Board granted denied the Providers' request for expedited judicial review (EJR) in the above-referenced appeal. The issue under appeal in the case was stated as:

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

The Board found that it lacked jurisdiction over all of the Providers in the case because the Providers had received Notices of Program Reimbursement, but had failed to protest the fixed-

[1] Providers' December 12, 2014 Request for EJR at 2, n. 1. (42 C.F.R. §§ 412.80 and 412.86)
[2] *Id.* at n.2.
[3] *Id.* at n 3. (42 U.S.C. § 1395ww(d)(5)(A)(i)).

loss threshold issue as required by 42 C.F.R. § 405.1835(a)(1)(ii).

The Providers appealed the Board's decision denying jurisdiction to the United States District Court for the District of Columbia. The Court issued a decision in *Banner Heart Hospital v. Burwell ("Banner")*,[4] concluding that:

> [U]nder *Bethesda*[5]—and at *Chevron*[6] Step One—the Secretary's self-disallowance regulation, as applied to Plaintiffs' specific regulatory challenge, conflicts with the plain text of [42 U.S.C. §] 1395oo. The Board therefore erred in ruling that it lacked jurisdiction to hear Plaintiffs' challenge to the outlier regulations. *See [Bethesda Hospital Association v. Bowen 485 U.S. 399,* 408], 108 S.Ct. 1255 [1988] (concluding that the "Board had jurisdiction to entertain this action").[7]

As a result of this finding, the Court remanded the case[8] to the Secretary on November 4, 2016, for proceedings consistent with this order.

On April 4, 2017, the Administrator ORDERED:

- That the [Board] decision in Squire Patton Boggs 2009 Medicare Outliers-NPR Optional Group, PRRB Case No. 13-3610G is hereby vacated; and

- That pursuant to the Court's order, the [Board] will reconsider the above cited case[] for further proceedings consistent with the August 19, 2016 Memorandum Opinion in *Banner Heart Hospital v. Burwell,[citation omitted]; and*

- That the decision of the Board is subject to the provisions of 42 C.F.R. § 405.1875.

The Board hereby reopens case number 13-3610G.

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[4] 201 F. Supp.3d 131 (D.D.C. 2016).
[5] 485 U.S. 399 (1988).
[6] *Chevron U.S.A. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837 (1984).
[7] 201 F. Supp. at 142.
[8] *Id.* at 143.

II
Board Order

Consistent with the Administrator's Order, the Board has reviewed the Providers' submissions pertaining to the requests for hearing and expedited judicial review. Based on the Court's legal conclusion in *Banner,* the regulation, 42 C.F.R. § 405.1835(a)(1)(ii), conflicts with 42 U.S.C. § 1395oo and the Board's previous denial of jurisdiction over the Providers for failure to protest the FLT was in error. As a result of the *Banner* decision, the Board has reviewed the Providers' submission under the tenants set forth in *Bethesda* which held that submission of a cost report in full compliance with unambiguous dictates of the Secretary's rules and regulations does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations.[9] The Board concludes that the FLT issue, which is published in the Federal Register,[10] is the type of issue to which the decision in *Bethesda* applies and that it has jurisdiction over the Providers in this appeal.[11] The Board is confined to the application of statutes, regulations and Federal Register notices and is without power to grant the relief the Providers are seeking.[12]

Accordingly, the Board concludes that EJR is appropriate for the disputed issue for the Providers listed on the attached Schedule of Providers for the reasons set forth below. Pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 expedited judicial review is permitted where the Board determines that it does not have the authority to decide a question of law, regulation or CMS ruling. In these cases, the Providers are challenging the validity of the outlier regulations, 42 C.F.R. §§ 412.80 through 412.86. The Medicare Contractors did not oppose the request for EJR. The documentation shows that in the group case the estimated amount in controversy exceeds $50,000 and the Providers' appeals were timely filed.

The Board finds that:

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[9] *Bethesda* at 1258-1259.

[10] *See e.g.* 73 Fed. Reg. 48,434, 48,763-66 (Aug. 19, 2008)

[11] The Board recognizes that the Court discussed but declined to rule on another potential rationale for denying jurisdiction, namely that the Board's jurisdiction is not mandatory but rather discretionary. However, the Board finds that this potential alternative rationale is not applicable to this case. Specifically, the Board finds that its jurisdiction over the Provider(s) is mandatory under 42 U.S.C. § 1395oo(a) because: (1) 42 C.F.R. § 405.1835(a)(1)(ii) does not apply to the Provider(s) based on Court-order application of the *Banner* decision; and (2) prior to the adoption of 42 C.F.R. § 405.1835(a)(1)(ii) in 2008, the Board consistently found jurisdiction to be mandatory under 42 U.S.C. § 1395oo(a) pursuant to *Bethesda* whenever a provider specifically appeals the validity of a regulation or rule that a Medicare contractor is otherwise bound to follow and apply regardless of whether the provider protested (or otherwise claimed on its cost report) the cost associated with the challenged regulation/rule.

[12] *See* 42 C.F.R. § 405.1867 (the Board must comply with all of the provisions of Title XVII of the Act and the regulations issued thereunder, as well as CMS Ruling issued under the authority of the Administrator. The outlier payments made under the regulation: are updated annually through the Secretary's Federal Register notices (*see* 42 C.F.R. § 401.106 (materials required to be published under the provisions of 5 U.S.C. § 552(a)(1) and (2) are published in the Federal Register)).

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

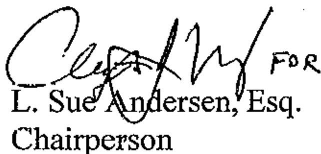
2) based upon the Providers' assertions regarding the outlier regulations, 42 C.F.R. §§ 412.80-412.86, there are no findings of fact for resolution by the Board;

3) it is bound by the regulations; and

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

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

SO ORDERED by the
Provider Reimbursement Review Board



L. Sue Andersen, Esq.
Chairperson

Date: JUN 08 2017

Attachment: Schedule of Providers

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

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

Refer to: 14-0312G
Certified Mail

JUN 08 2017

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

RE: Patton Boggs 2010 Medicare Outliers-NPR Optional Group
Provider Nos. Various
FY 2010
PRRB Case No. 14-0312G

Dear Mr. Nash:

Enclosed is the Provider Reimbursement Review Board's (Board's) Notice of Reopening and Board Order issued incident to the Administrator of the Centers for Medicare & Medicaid Services remand. The Board's order contains a new expedited judicial review determination for the outlier issue.

Sincerely,

L. Sue Andersen
L. Sue Andersen, Esq.
Chairperson

Enclosure: Notice of Reopening/Board Order

cc: James Ward, Noridian Healthcare Solutions (Certified Mail w/Notice of Reopening)
Wilson Leong, FSS (w/Notice of Reopening)

United States Department of Health and Human Services
Provider Reimbursement Review Board

Patton Boggs 2010 Medicare Outliers-NPR Optional Grp.	*	PRRB Case No. 14-0312G
v.	*	
	*	FY 2010
Noridian Healthcare Solutions, LLC	*	

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Notice of Reopening Pursuant to the Administrator's Order of Remand

and

Provider Reimbursement Review Board Order

I
Reopening

By ORDER dated April 6, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) remanded to the Provider Reimbursement Review Board (Board) case number 14-0312G.

On January 13, 2015, the Board denied the Providers' request for expedited judicial review (EJR) in the above-referenced appeal. The issue under appeal in the case was stated as:

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

The Board found that it lacked jurisdiction the Providers because the Providers had received Notices of Program Reimbursement, but had failed to protest the fixed-loss threshold issue as

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[1] Providers' December 12, 2014 Request for EJR at 2, n. 1. (42 C.F.R. §§ 412.80 and 412.86)
[2] *Id.* at n.2.
[3] *Id.* at n 3. (42 U.S.C. § 1395ww(d)(5)(A)(i)).

required by 42 C.F.R. § 405.1835(a)(1)(ii).

The Providers appealed the Board's decision denying jurisdiction to the United States District Court for the District of Columbia. The Court issued a decision in *Banner Heart Hospital v. Burwell ("Banner")*,[4] concluding that:

> [U]nder *Bethesda*[5]—and at *Chevron*[6] Step One—the Secretary's self-disallowance regulation, as applied to Plaintiffs' specific regulatory challenge, conflicts with the plain text of [42 U.S.C. §] 1395oo. The Board therefore erred in ruling that it lacked jurisdiction to hear Plaintiffs' challenge to the outlier regulations. *See* [*Bethesda Hospital Association v. Bowen 485 U.S. 399,* 408], 108 S.Ct. 1255 [1988] (concluding that the "Board had jurisdiction to entertain this action").[7]

As a result of this finding, the Court remanded the case[8] to the Secretary on November 4, 2016, for proceedings consistent with this order.

On April 4, 2017, the Administrator ORDERED:

- That the [Board] decision in Squire Patton Boggs 2010 Medicare Outliers-NPR Optional Group, PRRB Case No. 14-0312G is hereby vacated; and

- That pursuant to the Court's order, the [Board] will reconsider the above cited case[] for further proceedings consistent with the August 19, 2016 Memorandum Opinion in *Banner Heart Hospital v. Burwell,[citation omitted]; and*

- That the decision of the Board is subject to the provisions of 42 C.F.R. § 405.1875.

The Board hereby reopens case number 14-0312G.

[4] 201 F. Supp.3d 131 (D.D.C. 2016).
[5] 485 U.S. 399 (1988).
[6] *Chevron U.S.A. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837 (1984).
[7] 201 F. Supp. at 142.
[8] *Id.* at 143.

II
Board Order

Consistent with the Administrator's Order, the Board has reviewed the Providers' submissions pertaining to the requests for hearing and expedited judicial review. Based on the Court's legal conclusion in *Banner,* the regulation, 42 C.F.R. § 405.1835(a)(1)(ii), conflicts with 42 U.S.C. § 1395oo and the Board's previous denial of jurisdiction over the Providers for failure to protest the FLT was in error. As a result of the *Banner* decision, the Board has reviewed the Providers' submission under the tenants set forth in *Bethesda* which held that submission of a cost report in full compliance with unambiguous dictates of the Secretary's rules and regulations does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations.[9] The Board concludes that the FLT issue, which is published in the Federal Register,[10] is the type of issue to which the decision in *Bethesda* applies and that it has jurisdiction over the Providers in this appeal.[11] The Board is confined to the application of statutes, regulations and Federal Register notices and is without power to grant the relief the Providers are seeking.[12]

Accordingly, the Board concludes that EJR is appropriate for the disputed issue for the Providers listed on the attached Schedule of Providers for the reasons set forth below. Pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 expedited judicial review is permitted where the Board determines that it does not have the authority to decide a question of law, regulation or CMS ruling. In these cases, the Providers are challenging the validity of the outlier regulations, 42 C.F.R. §§ 412.80 through 412.86. The Medicare Contractors did not oppose the request for EJR. The documentation shows that in the group case the estimated amount in controversy exceeds $50,000 and the Providers' appeals were timely filed.

The Board finds that:

---

[9] *Bethesda* at 1258-1259.

[10] *See e.g.* 73 Fed. Reg. 48,434, 48,763-66 (Aug. 19, 2008)

[11] The Board recognizes that the Court discussed but declined to rule on another potential rationale for denying jurisdiction, namely that the Board's jurisdiction is not mandatory but rather discretionary. However, the Board finds that this potential alternative rationale is not applicable to this case. Specifically, the Board finds that its jurisdiction over the Provider(s) is mandatory under 42 U.S.C. § 1395oo(a) because: (1) 42 C.F.R. § 405.1835(a)(1)(ii) does not apply to the Provider(s) based on Court-order application of the *Banner* decision; and (2) prior to the adoption of 42 C.F.R. § 405.1835(a)(1)(ii) in 2008, the Board consistently found jurisdiction to be mandatory under 42 U.S.C. § 1395oo(a) pursuant to *Bethesda* whenever a provider specifically appeals the validity of a regulation or rule that a Medicare contractor is otherwise bound to follow and apply regardless of whether the provider protested (or otherwise claimed on its cost report) the cost associated with the challenged regulation/rule.

[12] *See* 42 C.F.R. § 405.1867 (the Board must comply with all of the provisions of Title XVII of the Act and the regulations issued thereunder, as well as CMS Ruling issued under the authority of the Administrator. The outlier payments made under the regulations are updated annually through the Secretary's Federal Register notices (*see* 42 C.F.R. § 401.106 (materials required to be published under the provisions of 5 U.S.C. § 552(a)(1) and (2) are published in the Federal Register)).

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

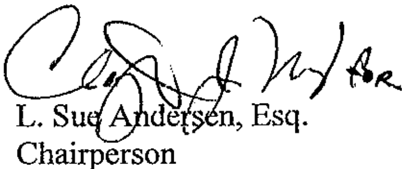
2) based upon the Providers' assertions regarding the outlier regulations, 42 C.F.R. §§ 412.80-412.86, there are no findings of fact for resolution by the Board;

3) it is bound by the regulations; and

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

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

SO ORDERED by the
Provider Reimbursement Review Board



L. Sue Andersen, Esq.
Chairperson

Date: JUN 08 2017

Attachment: Schedule of Providers

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

Internet: www.cms.gov/PRRBReview

Phone: 410-786-2671
FAX: 410-786-5298

Refer to: 15-0355GC
Certified Mail

JUN 08 2017

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

RE: Squire Patton Boggs 2012 Medicare Outliers-Banner Health
Provider Nos. Various
FY 2012
PRRB Case No. 15-0355GC

Dear Mr. Nash:

Enclosed is the Provider Reimbursement Review Board's (Board's) Notice of Reopening and Board Order issued incident to the Administrator of the Centers for Medicare & Medicaid Services remand. The Board's order contains a new expedited judicial review determination for the outlier issue.

Sincerely,

L. Sue Andersen, Esq.
Chairperson

Enclosure: Notice of Reopening/Board Order

cc: Bill Tisdale, Novitas Solutions (Certified Mail w/Notice of Reopening)
Wilson Leong, FSS (w/Notice of Reopening)

United States Department of Health and Human Services
Provider Reimbursement Review Board

Squire Patton Boggs 2012 Medicare Outliers-Banner Health	*	PRRB Case No. 15-0355GC
v.	*	
	*	FY 2012
Novitas Solutions, Inc.	*	

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Notice of Reopening Pursuant to the Administrator's Order of Remand

and

Provider Reimbursement Review Board Order

I
Reopening

By ORDER dated April 6, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) remanded to the Provider Reimbursement Review Board (Board) case number 15-0355GC.

On November 25, 2016, the Board granted in part and denied in part the Providers' request for expedited judicial review (EJR) in the above-referenced appeal. The issue under appeal in the case was stated as:

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

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[1] Providers' October 15, 2015 Request for EJR at 2, n. 1. (42 C.F.R. §§ 412.80 and 412.86)
[2] *Id.* at n.3.
[3] *Id.* at n 1. (42 U.S.C. § 1395ww(d)(5)(A)(i)).

procedurally invalid?[4]

The request for EJR was granted for 12 providers which filed their requests for hearing based on the provision of 42 C.F.R. § 405.1835(a)(3)(ii), which permits providers to file appeals with the Board, if the Medicare Contractor (Contractor) has not issued its determination (through no fault of the provider within 12 months of the date of receipt by the Contractor of the provider's perfected cost report.) A providers' appeal must be filed no later than 180 days after the expiration of the 12-month period for issuing a final determination. The Board found that it lacked jurisdiction over Banner Casa Grande Community Hospital, because the Provider, which had received a Notice of Program Reimbursement, but had failed to protest the fixed-loss threshold issue as required by 42 C.F.R.
§ 405.1835(a)(1)(ii).

The Providers appealed the Board's decision denying jurisdiction over Banner Casa Community Hospital to the United States District Court for the District of Columbia. The Court issued a decision in *Banner Heart Hospital v. Burwell,*[5] concluding that

> under *Bethesda*[6]—and at *Chevron*[7] Step One—the Secretary's self-disallowance regulation, as applied to Plaintiffs' specific regulatory challenge, conflicts with the plain text of [42 U.S.C. §] 1395oo. The Board therefore erred in ruling that it lacked jurisdiction to hear Plaintiffs' challenge to the outlier regulations. *See* [*Bethesda Hospital Association v. Bowen 485 U.S. 399,* 408], 108 S.Ct. 1255 [1988] (concluding that the "Board had jurisdiction to entertain this action").[8]

As a result of this finding, the Court remanded the case[9] to the Secretary on November 4, 2016, for proceedings consistent with this order.

On April 4, 2017, the Administrator ORDERED:

- That the [Board] decision in Squire Patton Boggs 2012 Medicare Outliers-Banner Health, PRRB Case No. 15-0355GC is hereby vacated; and

[4] *Id.* at 2.
[5] 201 F. Supp.3d 131 (D.D.C. 2016).
[6] 485 U.S. 399 (1988).
[7] *Chevron U.S.A. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837 (1984).
[8] 201 F. Supp. at 142.
[9] *Id.* at 143.

- That pursuant to the Court's order, the [Board] will reconsider the above cited case[] for further proceedings consistent with the August 19, 2016 Memorandum Opinion in *Banner Heart Hospital v. Burwell,[citation omitted]; and*

- That the decision of the Board is subject to the provisions of 42 C.F.R. § 405.1875.

The Board hereby reopens case number 15-0355GC.

II
Board Order

Consistent with the Administrator's Order, the Board has reviewed the Providers' submissions pertaining to the requests for hearing and expedited judicial review. Based on the Court's legal conclusion in *Banner,* the regulation, 42 C.F.R. § 405.1835(a)(1)(ii), conflicts with 42 U.S.C. § 1395oo and the Board's previous denial of jurisdiction over the Providers for failure to protest the FLT was in error. As a result of the *Banner* decision, the Board has reviewed the Providers' submission under the tenants set forth in *Bethesda* which held that submission of a cost report in full compliance with unambiguous dictates of the Secretary's rules and regulations does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations.[10] The Board concludes that the FLT issue, which is published in the Federal Register,[11] is the type of issue to which the decision in *Bethesda* applies and that it has jurisdiction over the Providers in this appeal.[12] The Board is confined to the application of statutes, regulations and Federal Register notices and is without power to grant the relief the Providers are seeking.[13]

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[10] *Bethesda* at 1258-1259.

[11] *See e.g.* 73 Fed. Reg. 48,434, 48,763-66 (Aug. 19, 2008)

[12] The Board recognizes that the Court discussed but declined to rule on another potential rationale for denying jurisdiction, namely that the Board's jurisdiction is not mandatory but rather discretionary. However, the Board finds that this potential alternative rationale is not applicable to this case. Specifically, the Board finds that its jurisdiction over the Provider(s) is mandatory under 42 U.S.C. § 1395oo(a) because: (1) 42 C.F.R. § 405.1835(a)(1)(ii) does not apply to the Provider(s) based on Court-order application of the *Banner* decision; and (2) prior to the adoption of 42 C.F.R. § 405.1835(a)(1)(ii) in 2008, the Board consistently found jurisdiction to be mandatory under 42 U.S.C. § 1395oo(a) pursuant to *Bethesda* whenever a provider specifically appeals the validity of a regulation or rule that a Medicare contractor is otherwise bound to follow and apply regardless of whether the provider protested (or otherwise claimed on its cost report) the cost associated with the challenged regulation/rule.

[13] *See* 42 C.F.R. § 405.1867 (the Board must comply with all of the provisions of Title XVII of the Act and the regulations issued thereunder, as well as CMS Ruling issued under the authority of the Administrator. The outlier payments made under the regulations are updated annually through the Secretary's Federal Register notices (*see* 42 C.F.R. § 401.106 (materials required to be published under the provisions of 5 U.S.C. § 552(a)(1) and (2) are

Accordingly, the Board concludes that EJR is appropriate for the disputed issue for the Providers listed on the attached Schedule of Providers for the reasons set forth below. Pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 expedited judicial review is permitted where the Board determines that it does not have the authority to decide a question of law, regulation or CMS ruling. In these cases, the Providers are challenging the validity of the outlier regulations, 42 C.F.R. §§ 412.80 through 412.86. The Medicare Contractors did not oppose the request for EJR. The documentation shows that in the group case the estimated amount in controversy exceeds $50,000 and the Providers' appeals were timely filed.

The Board finds that:

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

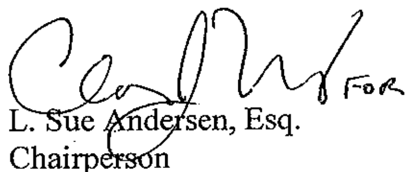
2) based upon the Providers' assertions regarding the outlier regulations, 42 C.F.R. §§ 412.80-412.86, there are no findings of fact for resolution by the Board;

3) it is bound by the regulations; and

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

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

SO ORDERED by the
Provider Reimbursement Review Board



L. Sue Andersen, Esq.
Chairperson

JUN 08 2017

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published in the Federal Register)).

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

Internet: www.cms.gov/PRRBReview

Phone: 410-786-2671
FAX: 410-786-5298

CERTIFIED MAIL

JUN 09 2017

Stephanie A. Webster
Akin Gump Strauss Hauer & Feld, LLP
1333 New Hampshire Avenue, NW
Washington, D.C. 20036-1564

Bruce Snyder
Novitas Solutions, Inc.
JL Provider Audit Manager
Union Trust Building
501 Grant Street, Suite 600
Pittsburgh, PA 15219

RE: Conemaugh Health System 2010 DSH SSI Group
Provider No.: Various
FYE: 06/30/2010
PRRB Case No.: 12-0374GC

Dear Ms. Webster and Mr. Snyder,

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

Background

On December 15, 2011, the Medicare Contractor, Novitas Solutions, Inc. issued the Provider, Miners Medical Center, a Notice of Program Reimbursement ("NPR"). The Board received the group appeal request on June 8, 2012 for the Disproportionate Share Hospital ("DSH") Supplemental Security Income ("SSI") Fraction issue (i.e., Baystate Errors issue). On July 10, 2012, the Board received a letter from the Medicare Contractor which stated that the Provider's appeal met all jurisdictional requirements with the exception of the amount in controversy requirement.

Board's Decision

The Board finds that it does not have jurisdiction over the only provider in the group appeal.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835–405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or at least $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. Effective with cost reporting periods that end on or after December 31, 2008, the Centers for Medicare and Medicaid Services ("CMS") amended the regulations governing cost report appeals to incorporate the Provider Reimbursement Manual ("PRM") 15-2 § 115 *et seq.* by specifying that:

(a) Criteria. A provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination, only if—
  (1) The provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue, by either—
    (i) Including a claim for specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or
    (ii) Effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item(s) by following the applicable procedures for filing a cost report under protest, where the provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy.[1]

Furthermore, a provider must claim reimbursement for item(s) and services in order for a Medicare Contractor to make a final determination from the cost report. To satisfy the dissatisfaction requirement, a provider must state some reimbursement impact for a protested issue (even though there is no reimbursement impact threshold for individual providers in a group appeal).[2] To protest an issue on a provider's cost report for self-disallowance purposes, the provider must include an explanation of the protest.[3] In fact, if the provider is unable to determine whether the payment is correct, the provider must still include an explanation discussing the reason(s).[4]

In this case, the Provider, Miners Medical Center, timely filed its appeal and met the amount in controversy requirement,[5] but the Provider failed to meet the dissatisfaction requirement. The Provider did not meet the dissatisfaction requirement because the Provider listed $0 as the reimbursement impact for the protested Baystate Errors issue.[6] Even though there is no reimbursement impact threshold for a provider's protested issue in a group appeal, the Provider was required to list some reimbursement impact for the Baystate Errors protested issue. By failing to do so, the Provider has not met the dissatisfaction requirement, and the Board does not have jurisdiction over the Provider. As the Board finds that it does not have jurisdiction over the only participant in the group appeal, case number 12-0374GC is hereby closed and removed from the Board's docket.

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

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[1] 42 C.F.R. § 405.1835(a)(1)(ii) (2009).
[2] *See* 42 C.F.R. § 405.1835(b)(2)(iii) (2009) (explaining that if a provider self-disallows a specific item, the provider must include "a description of the nature and amount of each self-disallowed item and the reimbursement or payment sought for the item").
[3] *See id.*
[4] *Id.* § 405.1835(b)(2)(i).
[5] The Provider filed the Group Appeal Request 176 days from the date of receiving the NPR, and the Provider's amount in controversy for the Baystate Errors issue was $195,745.
[6] Conemaugh Health System 2010 DSH SSI Group Appeal at Tab 1, Protest Calculation Workpaper – SSI Issue.

Board Members Participating:
L. Sue Andersen, Esq.
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Jack Ahern, M.B.A.

FOR THE BOARD

L. Sue Andersen, Esq.

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

cc: Federal Specialized Services
Wilson C. Leong, Esq., CPA
PRRB Appeals
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
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Refer to:

JUN 0 9 2017

CERTIFIED MAIL

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

MultiCare Health System
Tiffany Taylor, Reimbursement Mgr.
737 South Fawcett
P.O. Box 5299
Tacoma, WA 98415-0299

RE: QRS MultiCare Health 2014 Two Midnight Census IPPS Payment Reduction CIRP
PRRB Case No. 16-2201GC

Specifically: MultiCare Auburn Medical Center (50-0015), FYE 12/31/2014

Dear Mr. Ravindran and Ms. Taylor:

The Provider Reimbursement Review Board (the Board) is in receipt of a Model Form E - Request To Join An Existing Group Appeal: Direct Appeal From Final Determination (Model Form E) for Multicare Auburn Medical Center. The pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

The QRS MultiCare Health 2014 Two Midnight Census IPPS Payment Reduction CIRP Group was filed on August 16, 2016 by Quality Reimbursement Services, Inc. (QRS). The group was based on the Medicare Contractor's failure to timely issue final determinations and was fully formed at the time of filing.

The Board acknowledged the group and assigned it case number 16-2201GC in an email dated August 16, 2016.

On August 19, 2016, QRS requested expedited judicial review (EJR) of the group. The EJR request did not include all required information so a request for documentation was issued on September 2, 2016. QRS complied with the request for documentation on September 12, 2016.

The Board granted EJR of the issue and closed the group, by letter dated October 4, 2016.

On May 25, 2017, MultiCare Auburn Medical Center filed a Model Form E to join the QRS MultiCare Health 2014 Two Midnight Census IPPS Payment Reduction CIRP. The Model Form E was filed from a Notice of Program Reimbursement (NPR).

Board Determination:

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

The Board hereby denies your request to add MultiCare Auburn Medical Center to the group appeal as it is no longer pending and therefore providers cannot be added to the appeal. As previously stated, the appeal was closed due to the Provider indicating the CIRP group was complete, requesting EJR, and the Board granting EJR. The Board notes, that MultiCare Auburn Medical Center, 50-0015, for 12/31/2014 was one of the three providers that the Board granted EJR on previously. As the issue; the two midnight rule payment reduction issue, has already been raised for this Provider and for this FYE, and the Board has previously issued a decision granting EJR over the payment issue, the Provider cannot raise the issue again in a separate appeal.[1]

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

Board Members:
L. Sue Andersen, Esq.
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA, CHFP
Gregory H. Ziegler

For the Board:

L. Sue Andersen, Esq.
Board Member

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

cc: James Ward, Noridian Healthcare Solutions (J-F)
Wilson C. Leong, Esq., CPA, Federal Specialized Services

[1] *Baptist Memorial Hospital – Golden Triangle, Et Al v. Sebelius*, 566 F.3d 226 (D.C. Cir. 2009).