DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Baltimore, MD 21207
410-786-2671

**Via Electronic Delivery**

Greg Wilgocki
VP, Corporate Reimbursement
Mountain States Health Alliance
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Beverly Vinecki
Smyth County Community Hospital
North Point 2, 1021 W. Oakland
Suite 201
Johnson City, TN 37604

RE: Smyth County Memorial Hospital (Prov. No. 49-0038) FYE 06/30/2013
Case No. 16-0699
Request for Legacy Add Determination of FY 2020 Quality Reporting Determination and Jurisdiction for DSH Payment/SSI Percentage (Provider Specific) Issue

Dear Mr. Wilgocki and Ms. Vinecki:

The Provider Reimbursement Review Board ("Board" or "PRRB") has begun a review of the above-captioned appeal involving the Provider's fiscal year ending June 30, 2013 ("FY 2013") and the Provider's request for "Legacy Add Determination" to this FY 2013 appeal. The pertinent facts of the case and the Board's determination are set forth below.

**Pertinent Facts**

The Medicare Contractor issued a Notice of Program Reimbursement ("NPR") for the Provider's ***FY 2013*** on July 22, 2015. Mountain States Health Alliance filed an individual appeal on behalf of the subject Provider for the FY 2013 NPR on January 13, 2016, to which the Board assigned Case No. 16-0699.[1] The individual appeal request included eight issues. Six of the issues were subsequently transferred to group appeals. On September 21, 2016, the Provider withdrew the issue involving Medicaid Eligible Days concurrent with its the preliminary position paper filing and acknowledged that only the Disproportionate Share Payment ("DSH")/Supplemental Security Income ("SSI") Percentage (Provider Specific) issue remained in the case.

On May 21, 2018, the Medicare Contractor filed a jurisdictional challenge on the sole remaining issue in the case – DSH SSI Percentage (Provider Specific). Per Board Rule 44.4 (July 2015), the Provider had 30 days to respond to the jurisdictional challenge; however, the Provider did not file a response. Per Board Rule 44.4, "[t]he responding party must file a response within 30 days of

[1] The original appeal was filed prior to the Board's implementation of its new electronic filing system – the Office of Hearings Case and Document Management System ("OH CDMS") in August of 2018. The case is therefore referred to a "Legacy" case.

the Intermediary's [*i.e.*, Medicare Contractor's] jurisdictional challenge. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

On January 3, 2020, Beverly Vinecki of Smyth County Community Hospital filed a "Legacy Add Determination" in the above-captioned case using OH CDMS. Ms. Vinecki uploaded a copy of the "Notice of Quality Reporting Program ("QRP") Noncompliance Decision Upheld" and other support related to the Provider's **FY 2020**.

## Board Determination

### *A. FY 2020 Quality Reporting Program Noncompliance Issue*

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 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.

Further, Board Rule 6.3.1, indicates that "an appeal may be for only one cost reporting period. If multiple final determinations were issued on different dates for the cost reporting period being appealed (e.g., NPR, revised NPRs, exception request denials, etc.), providers must timely request to add the subsequent determination to its pending appeal for that cost reporting period."[2]

In this case the Board finds that the **FY 2020** QRP determination, added on January 3, 2020, by Ms. Vinecki does not relate to the Provider's **FY 2013**, the year under appeal in the subject case. Therefore, the Board denies the Provider's request to add the QRP determination issued on July 19, 2019 to Case No. 16-0699 and, consequently, dismisses the QRP Noncompliance issue from this case.

Having reviewed the Provider's January 3, 2020 submission, however, the Board finds that the Provider attempted to appeal its FY 2020 QRP determination within the 180 day appeal period. In addition, the Board notes that the amount in controversy for the issue in dispute meets the $10,000 jurisdictional threshold as required in 42 C.F.R. § 405.1835. ***Based on these factors, the Board has established a new separate individual case for the Provider's FY 2020 QRP Noncompliance Determination to which we have assigned Case No. 20-1676***. *To this end, the Parties will receive an Acknowledgement and Critical Due Dates letter for the new case by email, under separate cover, although further information for the new individual appeal is still required.*

[2] Board Rules (Aug. 29, 2018) at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/PRRB-Rules-August-29-2018.pdf.

In reviewing the record in Case Nos. 16-0699 and 20-1676, the Board has identified certain deficiencies that need immediate correction by the Provider. Specifically, ***by Wednesday, July 8, 2020***, the Provider must provide the following information:

1. *For Case No. 20-1676, you must submit a representation letter for the FY 2020 appeal under Case No. 20-1676 – see Board Rule 5.4 for specific requirements*.[3]—The Board needs to have a designated representative from the organization to which it will direct all correspondence related to Case No. 20-1676.

2. *For Case No. 20-1676, you must correct and resubmit the issue statement to comply with Board Rule 7.2*.—The document Ms. Vinecki uploaded as the "issue statement" for the QRP noncompliance issue was actually a second copy of the QRP determination. Pursuant to Board Rule 7.2, for each issue the Provider *must* include: "[a]n issue title and a concise statement describing: … the controlling authority, why the adjustment is incorrect, how the payment should be determined differently, the reimbursement effect, and the basis for jurisdiction before the PRRB."[4] The issue statement must include each of the referenced elements.[5] Board Rule 7.2 is consistent with 42 C.F.R. 405.1835(b) addressing the content of appeal requests.

3. *For Case Nos. 16-0699* ***and*** *20-1676, you must redact or remove Protected Health Information ("PHI") or other personally identifiable information ("PII") from any documentation included with the appeal – see Board Rule 1.4 for specific requirements*.—The following documents in both Case Nos. 16-0699 ***and*** 20-1676 include PHI/PII such as patient ID numbers:

    - "Appeal Letter.pdf" submitted as the audit adjustment support;
    - "Letter and Reconsideration Form.pdf" submitted as Other Issue Document 1; and
    - "IQR Validation cases.pdf" submitted as Other Issue Document 2.

    Therefore, pursuant to Board Rule 1.4, these documents will be removed from the record in ***both*** Case Nos. 16-0699 ***and*** 20-1676 and the documents will not be considered by the Board in either case. If you believe this information is necessary for your appeal under Case Nos. 16-0699 and/or 20-1676, please reference Board Rule 1.4 regarding redaction or providing the protected information under seal and then resubmit the appropriate

[3] *Id*.
[4] *Id*.
[5] The first element of an issue statement identified in Board Rule 7.2, an adjustment number, is not applicable to QRP appeals.

redacted version of the documentation as relevant to Case Nos. 16-0699 and 20-1676.[6] As explained in Board Rule 1.4, the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule requires a covered entity and its business associates to make reasonable efforts to limit use, disclosure of, and requests for PHI or other PII to the minimum necessary to accomplish the intended purpose. While the Privacy Rule permits uses and disclosures for litigation, subject to certain conditions, such information is generally not necessary for documentation submitted to the Board. Because the record in Board proceedings may be disclosed to the public, the parties must carefully review their documents to ensure that they do not contain patient names, health insurance or social security numbers, addresses, or other information that identifies individuals.[7] If such documentation is necessary for a Board appeal, then the party must redact any PHI or PII from those documents prior to submitting them to the Board.

***Be advised that the Provider's July 8, 2020 filing deadline is firm*** *as the Board has determined to specifically exempt this filing deadline from Board Alert 19's suspension of Board filing deadlines.*[8] ***Accordingly, unless the Provider requests an extension and the Board approves that extension prior to the deadline, the Board may take remedial action such as dismissal of Case No. 20-1676 if the Provider fails to timely file its response to Request Nos. 1 and 2.***

***B. DSH/SSI Percentage (Provider Specific) Issue in Case No. 16-0699***

As set forth below, the Board is dismissing Issue No. 1 regarding the DSH/SSI Percentage (Provider Specific) issue from Case No. 16-0699. The dismissal of Issue No. 1 from Case No. 16-0699 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of Issue 2, the DSH/SSI Percentage (Systemic Errors) issue, that was transferred to Case No. 16-2037GC on September 28, 2016.

Per the Provider's issue statement for Issue 1 that accompanied the appeal request, the DSH/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare

[6] The redacted document(s) can be uploaded as an "Other" case action in OH CDMS and should be labeled "Redacted Issue Support."
[7] *See* Board Rule 1.4 (Aug. 29, 2018).
[8] The Board notes that the request for information pertains to a deficient request for hearing and that the Board is exercising its discretion under 42 C.F.R. §§ 405.1835(b) and 405.1868 to take the remedial action to request additional information as opposed to the remedial action to dismiss the appeal.

Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital Calculation."[9] The Provider's legal basis for its DSH/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[10] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed…" and it "…specifically disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[11]

The Provider's issue statement for Issue 2 that accompanied the appeal request as well as the issue statement for the group to which it transferred this issue are virtually identical (i.e., Case No. 16-2037GC). They describe the DSH SSI Percentage (Systemic Errors) issue in group similarly allege that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F) and 42 C.F.R. § 412.106. These factors include but are not limited to "availability of MEDPAR and SSA records" and "not in agreement with ***provider's*** records." As such, it is clear Issue 2 include "Provider Specific" SSI issues.

Based on the scant record before it, the Board is unable to differentiate the two issues[12] and finds that Issue 1 is either a subset or entirely the same as Issue 2 that was transferred. Accordingly, the Board finds that that the DSH SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH SSI Percentage (Systemic Errors) issue in Case No. 16-2037GC.[13] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Rule 4.5 (2015), the Board dismisses this aspect of the DSH/SSI Percentage (Provider Specific) issue.

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[9] *Model Form A – Individual Appeal Request* (Jan. 13, 2016) at Tab 3, Issue 1.
[10] *Id.*
[11] *Id.*
[12] The Board notes that the content requirements for appeal request are designed to elicit sufficient information to identify each item in dispute, including how and why the provider is the provider believe reimbursement for each such item is incorrect and, when the item is self-disallowed such as here (it is self disallowed since CMS determines all SSI percentages), include "an explanation of the nature and amount of each self-disallowed item, the reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement.. 42 C.F.R. § 405.1835(b). *See generally* Board Rules 7, 8 (Jul. 1, 2015); Board Rule 7.2 (addressing content requirements of appeal requests for self-disallowed items); 8.1-8.2 (specifying that some issues have multiple components, that each component in dispute must be identified in the appeal request and that DSH is a multi-component issue).
[13] In making this finding, the Board notes that it has been more than two years since the Medicare Contractor filed its jurisdictional challenge. Per Board Rule 44, a response from the Provider was due within 30 days but, the Provider never responded. As a result, the Provider forwent its opportunity to present argument or additional information on how the issues may have been different and, per Board Rule 44.4, the Board had to rely on the scant record before it in making its findings.

The second aspect of the DSH/SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board for lack of jurisdiction. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request…" Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding the Provider's DSH SSI Percentage realignment.

Based on the above, the Board dismisses Issue 1, the DSH SSI Percentage (Provider Specific) issue, in its entirety.

**Conclusion**

The Board denies the Legacy Add transaction and dismisses the FY 2020 QRP Noncompliance issue from Case No. 16-0699 as it does not relate to FY 2013 which is the year under appeal in case No. 16-0699. Notwithstanding, the Board has established a new individual appeal under Case No. 20-1676 for the FY 2020 QRP Noncompliance issue from which the provider may pursue its appeal of this issue. *The Board has also requested certain information from the Provider as set forth fully above* ***that must be filed by June 26, 2020*** *or the Board may take remedial action such as dismissing Case No. 20-1676.*

Finally, the Board dismisses the DSH/SSI Percentage (Provider Specific) issue from the appeal based on lack of jurisdiction. Since this was the sole remaining issue in the case to be adjudicated, the Board hereby closes Case No. 16-0699 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:
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

6/5/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services, Inc.
Laurie Polson, Palmetto GBA c/o National Government Services, Inc. (J-M)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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**RE: Request to Rescind Remand & Bifurcate DSH Part C Days Issue**
St. Rita's Medical Center (Prov. No. 36-0066)
FYE 12/31/02
Case No. 06-0064

Dear Mr. Blumberg and Ms. Cummings,

The Provider Reimbursement Review Board ("Board") has reviewed St. Rita's Medical Center (St. Rita's) June 7, 2016 Request for Rescission of Remand and Bifurcation of Individual Appeal Regarding DSH Part C Days issue. The Board denies St. Rita's Request for Rescission of Remand and Bifurcation of the Individual Appeal Regarding the DSH Part C Days issue.

## Background

On February 10, 2014, St. Rita's *requested* a standard remand of the Dual Eligible Days and Supplemental Security Income ("SSI") percentage issues pursuant to the Centers for Medicare & Medicaid Services ("CMS") Ruling 1498-R.[1]

On February 12, 2014, St. Rita's requested to ***withdraw the appeal*** once the Dual Eligible Days and SSI percentage issues were remanded pursuant to Ruling 1498-R. On April 11, 2014, the Board remanded St. Rita's dual eligible Part A days issue to the Medicare Contractor in Case No. 06-0064 pursuant to CMS Ruling 1498-R. The case remained open for resolution of the remaining issues in the appeal (Medicare Bad Debts, SSI percentage realignment, and Hospice Care Assurance Program fund days ("HCAP")).

On June 13, 2014, the Board determined that: (1) the Medicare Bad Debts issue had been abandoned; (2) the SSI issue had already been transferred to a group case; and (3) St. Rita's had

[1] Ruling 1498-R was issued on April 28, 2010, by the CMS Administrator to address three specific issues regarding the calculation of the Medicare disproportionate share hospital (DSH) payment adjustment: (1) the Medicare SSI fraction data matching process issue and the method for recalculating the hospital's Medicare SSI fraction, (2) the exclusion from the DSH calculation of non-covered patient hospital days for patients entitled to Medicare Part A including days for which the patient's Part A inpatient hospital benefits were exhausted for cost reporting periods before October 1, 2004, and (3) the exclusion from the DSH calculation of the labor/delivery room (LDR) inpatient days.

withdrawn the HCAP fund days issue. As there were no remaining issues, the Board closed Case No. 06-0064.

On June 7, 2016 (more than two years following St. Rita's requests for remand *and* withdrawal), St. Rita's filed a Request for Rescission of Remand and Bifurcation of Individual Appeal Regarding Disproportionate Share Hospital (DSH) Part C Days issue. St. Rita's recognized that the Board remanded its appeal of the DSH dual eligible days issue but argued that its appeal of the dual eligible days issue was intended to refer to persons eligible for both Medicare Parts A and C. St. Rita's contends that, based on numerous decisions of the Board, the dual eligible days issue did not come within the scope of Ruling 1498-R. St. Rita's requested that the Board rescind its remand and reinstate its appeal of the dual eligible days issue.[2] St. Rita's requested that the Board reinstate the appeal for purposes of appealing the DSH Part C days issue.[3]

## Decision of the Board

Board Rule 46.1 (effective July 1, 2015) addresses how the Board handles a Motion for Reinstatement: , provides "[a] Provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case . . . if an issue(s)/case was remanded pursuant to a CMS ruling (*e.g.*, CMS Ruling 1498-R), the Provider must address whether the CMS ruling permits reinstatement of such issue(s)/case."

> **46.1 – Motion for Reinstatement**
> A Provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case or, if no dismissal was issued, within three years of the Board's receipt of the Provider's withdrawal of the issue(s) (see 42 C.F.R. § 405.1885 addressing reopening of Board decisions). The request for reinstatement is a motion and must be in writing setting out the reasons for reinstatement (see Rule 44 governing motions). The Board will *not* reinstate an issue(s)/case *if the Provider was at fault*. If an issue(s)/case was remanded pursuant to a CMS ruling (e.g., CMS Ruling 1498-R), the Provider *must* address whether the CMS ruling permits reinstatement of such issue(s)/case. If the Board reinstates an issue(s) or case, the Provider will have the same rights (no greater and no less) that it had in its initial appeal. These requirements also apply to Rules 46.2 and 46.3 below.[4]

St. Rita's Motion for Reinstatement is deficient in several aspects. First, it has not addressed whether Ruling 1498-R permits reinstatement of the dual eligible days issue and, thus, has failed

[2] Provider's Request for Rescission of Remand and Bifurcation of Individual Appeal Regarding DSH Part C Days Issue at 1.
[3] *Id.* at 4.
[4] (Italics emphasis added.)

to comply with this requirement. Nevertheless, the Board concludes CMS Ruling 1498-R does not permit reinstatement of this issue.

CMS Rulings are published under the authority of the CMS Administrator and serve as precedent final opinions and orders or statements of policy or interpretation. CMS Rulings are binding on all CMS components, on all Department of Health and Human Services components that adjudicate matters under the jurisdiction of CMS, and on the Social Security Administration (SSA) to the extent that components of the SSA adjudicate matters under the jurisdiction of CMS.[5] The Board is a CMS component that adjudicates matters under the jurisdiction of CMS, as such, is bound by CMS Rulings. The Board must comply with all of the provisions of Title XVIII of the Social Security Act (Act) and regulations issued thereunder, as well as CMS Rulings issued under the authority of the Administrator.

On April 28, 2010, the CMS Administrator issued CMS Ruling 1498-R to address three specific Medicare disproportionate share hospital issues. One of these issues involves the exclusion from the DSH calculation of non-covered inpatient hospital days for patients entitled to Medicare Part A, including days for which the patient's Part A inpatient hospital benefits were exhausted (dual eligible days). With respect to this issue, the Ruling requires the Board to remand each qualifying appeal of the dual eligible days issue for cost reports with pre-October 1, 2004 discharges to the appropriate Medicare Contractor.[6] Upon remand, CMS and the Medicare Contractor will recalculate the hospital's SSI fraction and DSH payment adjustment for the period at issue by including the inpatient days of a person entitled to Medicare Part A in the numerator of the hospital's SSI fraction (provided that the person was also entitled to SSI) and in that fraction's denominator, even if the inpatient stay was not covered under Part A or the patient's Part A hospital benefits were exhausted.

The Ruling provides:

> CMS' action eliminates any actual case or controversy regarding the hospital's previously calculated DSH payment adjustment and thereby renders moot each properly pending claims in a DSH appeal, for cost reports with pre-October 1, 2004 discharges, in which the hospital seeks inclusion in the DPP of the non-covered inpatient hospital days (for example, MSP days) or exhausted benefit inpatient hospital days of a person entitled to Part A. . . . *Accordingly, it is hereby held that the PRRB and the other Medicare administrative tribunals lack jurisdiction over each properly pending claim on the non-covered or exhausted benefit inpatient hospital day issue for a cost report with discharges before October 1, 2004.*[7]

[5] CMS Ruling 1498-R at 1.
[6] *Id*. at 17.
[7] *Id.* at 11 (emphasis added).

Here, within CMS Ruling 1498-R, the CMS Administrator has spoken directly on the issue of the Board's jurisdiction over the dual eligible Part A days issue for cost reports with discharges before October 1, 2004, that is subject to the mandatory remand. In the instant appeal, once the Board determined that the dual eligible Part A days issue was within CMS Ruling 1498-R's mandates, the Board no longer had jurisdiction over the issue and was required to remand the issue to the Medicare Contractor.[8] Nothing within CMS Ruling 1498-R indicates that the Board may reassume jurisdiction over this issue once it has been remanded.

In fact, CMS Ruling 1498-R states that upon remand, "CMS' action eliminates any actual case or controversy regarding the hospital's previously calculated DSH payment adjustment and thereby renders moot each properly pending claim in a DSH appeal, for cost reports with pre-October 1, 2004, discharges in which the hospital seeks inclusion in the disproportionate patient percentage (DPP) of the non-covered inpatient hospital days (for example, MSP days) or exhausted benefit inpatient hospital days of a person entitled to Part A."[9] Once St. Rita's dual eligible Part A days claim was remanded to the Medicare Contractor, any actual case or controversy in the appeal was eliminated and the claim was rendered moot. Accordingly, the Board denies St. Rita's request to rescind the dual eligible Part A days remand and reinstate the dual eligible Part A days issue because, in accordance with CMS Ruling 1498-R, the Board lacks jurisdiction over the issue.

In addition, the Board points out that it was St. Rita's that requested the remand of dual eligible Part A days issue pursuant to CMS Ruling 1498-R ***and*** then submitted a request to withdraw its appeal. St. Rita's made this 1498-R remand and withdrawals requests on February 12, 2014 and February 14, 2014, respectively, well after the Part C Days issue had become well known in the industry.[10] Indeed, notwithstanding, it took St. Rita's more than two plus to assert the allegation that its dual eligible Part A days issue included a Part C element that should be bifurcated. The Board takes issue with this excessive delay and, more importantly, notes that the Provider is "at fault" per Board Rule 46.1 as the Provider opted not to request bifurcation when it submitted its request for remand of the issue and withdrawal of the appeal.[11] This is an alternative independent grounds for denying the reinstatement request.

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[8] *Id*. at 13, 17-18.
[9] *Id*. at 11.
[10] *See, e.g., Northeast Hosp. Corp. v. Sebelius*, 699. Supp. 2d 81 (D.D.C. 2010), *aff'd by*, 657 F.3d 1 (D.C. Cir. 2011); *Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75 (D.D.C. 2012), *aff'd by*, 746 F.3d 1102 (D.C. Cir. 2014) (decided April 1, 2014); *King & Spalding Inclusion of Medicare Advantage Days in 2007 SSI Ratios v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D38 (June 29, 2010) (this decision is an EJR determination and the Board only publishes an EJR determination as a "D-" decision when it is a seminal case). *See also* CMS Ruling 1498-R (April 28, 2010); FY 2011 IPPS final rule, 75 Fed. Reg. 50042, 50275-50285 (Aug. 16, 2010).
[11] Had St. Rita's believed that the Part C days issue remained in the appeal post requesting the CMS Ruling 1498-R remand, it could have stated so and proceeded to a hearing on the issue (the Board issued a Notice of Hearing to St. Rita's on September 19, 2013, for a hearing date of February 14, 2014). However, St. Rita's withdrew its appeal without any mention of the Part C days issue it now says it intended to appeal. Now over two years later after the withdrawal, St. Rita' argues that its appeal of the dual eligible days issue was intended to refer to persons eligible for Medicare Parts A and C and that the dual eligible days issue did not come within the scope of CMS Ruling 1498-R and the Board should reinstate its appeal for purposes of appealing the Part C days issue. If St. Rita's believed the Part C days issue was in the appeal, it abandoned the Part C days issue when it withdrew its appeal.

Based on the above, the Board hereby denies St. Rita's Request for Rescission of Remand and Bifurcation of the Individual Appeal Regarding the DSH Part C Days Issue pursuant to CMS Ruling 1498-R, Board Rule 46.1 and the Board's authority under 42 C.F.R. § 405.1868.

Board Members participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA
Robert Evarts, Esq.
Susan Turner, Esq.

FOR THE BOARD

6/10/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

cc: Wilson Leong, Federal Specialized Services

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**RE:** ***Jurisdictional Decision***
Empire Health CY 2006-2007 SSI Part C Days CIRP Group
Case No. 19-1983GC

Dear Mr. Ravindran and Mr. Lamprecht,

The Provider Reimbursement Review Board ("PRRB" or "Board") has conducted an own motion review the above-captioned common issue related party ("CIRP") group appeal. The pertinent facts of the case and the Board's jurisdictional determination are set forth below.

**Pertinent Facts**

The CIRP group, Case No. 19-1983GC, only contains the following two participants:

1. Deaconess Hospital (Provider No. 50-0044) ("Deaconess"); and
2. Valley Hospital Medical Center (Provider No. 50-0119) ("Valley").

Both of Deaconess and Valley requested a recalculation of the Medicare SSI percentage based upon the provider's cost report period in accordance with the regulation 42 C.F.R. § 405.106(b)(3). Through the Providers' respective Notices of Reopening, the Medicare Contractor agreed to reopen the cost reports once a response was received from CMS to update the SSI ratio. The SSI adjustments identified as the subject of the disputes in this case reflect implementation of the SSI ratio realigned by CMS and adjusted by the Medicare Contractor.

The regulation, 42 C.F.R. § 412.106(b)(3), permits a provider to request to have its data reported on its cost reporting period instead of the Federal fiscal year. To do so, "It must furnish to CMS, through its Intermediary, a written request including the hospital's name, provider number, and cost reporting period end date. This exception will be performed once per hospital per cost reporting period, and the resulting percentage becomes the hospital's official Medicare Part A/SSI percentage for that period."

Deaconess and Valley requested that their SSI percentages be recalculated from the federal fiscal year to their respective cost reporting years. CMS does ***not*** utilize a new or different data match process when it issues a realigned SSI percentage – all of the underlying data remains the same,

it is simply that a different time period is used.[1] The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated and used in the original CMS published SSI percentage) and reports it on the provider's cost reporting period instead of the September 30 Federal Fiscal Year.[2]

Deaconess and Valley both received a Revised NPR on December 7, 2018. The disputed revised NPRs each only adjusted the SSI percentage to the realigned ratio (from the Federal Fiscal Year to the Provider's cost report year). Both of the Providers were directly added to the subject appeal filed with the Board from the revised NPRs on May 24, 2019. The issue for the subject appeal, Empire Health CY 2006-2007 SSI Part C Days CIRP Group, states:

> Whether HMO / Medicare Plus Choice / Medicare Managed Care / Medicare Part C / Medicare Advantage ("MA") Days were properly accounted for in the Disproportionate Share Hospital ("DSH") calculation.

**Board Decision**

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

The Board finds that it does not have jurisdiction over the DSH Part C Days issue from the revised NPRs, as the specific issue, was not adjusted as part of the revised NPRs.

The Code of Federal Regulations provides for an opportunity to reopen a determination and issue a revised determination (*e.g.*, a revised NPR). In this regard, 42 C.F.R. § 405.1885 (2018) provides in relevant part:

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

[1] CMS describes the matching process that it uses as part of the FY 2011 IPPS final rule published on August 16, 2010. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010). Similarly, CMS' policy on Part C days was set in the FFY 2005 Final Rule and is incorporated into and reflected in this data matching process. *See* 75 Fed. Reg. at 50276, 50285-6.

[2] As noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data on a month-by-month basis.

> (5) If a matter is reopened and a revised determination or decision is made, a revised determination or decision is appealable to the extent provided in § 405.1889 of this subpart.

42 C.F.R. § 405.1889 (2018) explains the extent to which a provider may appeal a revised determination such as a revised NPR:

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

These regulations make clear that a provider can only appeal items that are "specifically revised" from a revised NPR.

The Providers in this appeal are not challenging that the Medicare Contractor or CMS calculated the realigned SSI ratio incorrectly (*e.g*, did not use the right patients for those dates), but instead they are challenging whether Medicare Part C days should or should not be included in the SSI fraction of the DSH calculation. Additionally, CMS does not utilize a new or different data match process when it issues a realigned SSI percentage – all of the underlying data remains the same, it is simply that a different time period is used.[3] Rather, the realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated and used in the original CMS published SSI percentage) and reports it on the provider's cost reporting period instead of the September 30 FFY.[4] Therefore, the Board finds that, pursuant to 42 C.F.R. 405.1889(b), it does not have jurisdiction over the Medicare Part C days issue for these Providers, as these days were not adjusted in revised NPR and hereby dismisses Deaconess and Valley from this appeal.

[3] *See supra* note 1.
[4] *See supra* note 2.

As no Providers remaining pending in the appeal, Case No. 19-1983GC is hereby closed and removed from the Board's docket.

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

Board Members Participating:

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Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

6/10/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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**RE:** ***Jurisdictional Decision***
Sharon Regional Health System (39-0211)
FYE: 06/30/2013
Case No.: 16-1673

Dear Messrs. Summar and Snyder,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal in response to the Medicare Contractor's jurisdictional challenge. The pertinent facts of the case, the Parties' positions and the Board's jurisdictional determination are set forth below.

**Background:**

On May 20, 2016, the Provider submitted a request for hearing which included two issues based on a Notice of Program Reimbursement ("NPR") dated November 23, 2015 for fiscal year end ("FYE") 6/30/2013:[1]

1. Whether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income (SSI) percentage in the Disproportionate Share Hospital (DSH) calculation (Provider Specific).

   The Provider contends that its' SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.

   The Provider contends that the SSI percentage issued by CMS is flawed.

[1] Provider's Appeal Request at Tab 3 (received May 23, 2016).

> …The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based on the Provider's cost reporting period.

2. Whether the MAC properly excluded Medicaid eligible days from the DSH calculation.

On December 17, 2018, the Medicare Contractor submitted its jurisdictional challenge over the DSH SSI Provider Specific issue.

**Medicare Contractor's Position:**

The Medicare Contractor argues that the SSI data accuracy component of Issue 1, the SSI Provider Specific Issue, should be dismissed because it is duplicative of the issue that the Provider is also pursuing in Group Case 15-3254G, Southwest Consulting 2013 DSH Post 1498R Medicare Part A/SSI % Group.[2]

The Medicare Contractor asserts that the Provider is arguing the same issue in both cases, i.e. that the SSI percentage is understated. Therefore, the SSI data accuracy portion on issue 1 is duplicative of the issue in Case No. 15-3254G. Per PRRB rule 4.6 a provider may not appeal an issue in more than one appeal. The Medicare Contractor requests that the Board dismiss this issue from Case No. 16-1673.

The Medicare Contractor contends that the decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. The Provider has not requested to use its fiscal year end to recalculate the SSI percentage.

The Medicare Contractor also argues that the Provider's appeal of the SSI Realignment issue is premature as it did not make a determination with respect to the SSI Realignment issue. To date, the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). The Medicare Contractor requests that the Board dismiss this issue consistent with recent jurisdictional decisions.[3]

**Board Analysis and 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

[2] Medicare Contractor's Jurisdictional Challenge at 1 (Dec. 17, 2018). This Provider was directly added to Case No. 15-3254G on March 25, 2016.
[3] Medicare Contractor's Jurisdictional Challenge at 2-3 (Dec. 17, 2018)

dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination. The jurisdictional issue presented here is whether or not this hospital has preserved its right to claim dissatisfaction with the amount of Medicare payment. "A provider. . . has a right to a Board hearing . . . only if – (1) the provider has preserved its right to claim dissatisfaction . . . by . . . [i]ncluding a claim for specific item(s) on its cost report . . . or . . . self-disallowing the specific item(s) by . . . filing a cost report under protest."

The Provider's appeal of the SSI Provider Specific issue is based on the contention that the SSI percentage published by CMS was incorrectly computed because CMS failed to include all patients entitled to SSI benefits in the Provider's DSH calculation. The Board finds that this issue is duplicative of the SSI Percentage Systemic errors issue in group appeal, Case No. 15-3254G, Southwest Consulting 2013 DSH Post 1498R Medicare Part A/SSI % Group that the Provider was directly added to on March 25, 2016. The Providers in that CIRP Group challenge their SSI percentages because of disagreement over how the SSI percentage is calculated and contend that CMS has not properly computed the SSI percentage because it failed to correct flaws in the data and match process used by CMS in determining the SSI fractions. Pursuant to Board Rule 4.6.1, "A provider may not appeal an issue from a single determination in more than one appeal." Therefore, the Board finds that the SSI Provider specific issue is duplicative of the issue the Provider is appealing in the group appeal and dismisses this aspect of the SSI Provider specific issue.

In its SSI Provider Specific issue statement, the Provider also asserts that it "preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period." Under 42 C.F.R. § 412.106(b)(3), "if a hospital prefers that CMS use its cost reporting data instead of the Federal Fiscal Year, it must furnish to CMS, through its intermediary, a written request…" Without a written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for purposes of appeal. Additionally, even if the Provider has requested (and received) a realignment of its SSI percentage, that is not a final determination from which the Provider can appeal, or with which the Provider can be dissatisfied, as required by 42 C.F.R. § 405.1835(a). Therefore, the Board finds that it does not have jurisdiction over the realignment portion of the Provider's SSI Provider Specific issue.

**Conclusion:**

In conclusion, the Board lacks jurisdiction over the SSI Provider Specific issue in the subject appeal. Case No. 16-1673 remains open for the sole pending issue – the DSH Medicaid Eligible Days issue.

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

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

6/11/2020

X Gregory H. Ziegler

Gregory H. Ziegler, CPA
Board Member
Signed by: Gregory H. Ziegler -S

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

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RE: ***Jurisdictional Decision***
Holy Redeemer Hospital and Medical Center (Prov. No. 39-0097)
FYE 06/30/2008
Case No. 13-3279

Dear Mr. Newell and Mr. Snyder,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the record in the above-captioned appeal and determined the Total Patient Days issue is dismissed from this appeal. The Board's decision regarding this issue is set forth below.

**Pertinent Facts:**

On September 4, 2013, Holy Redeemer Hospital and Medical Center ("Provider") filed an individual appeal request which appealed a Notice of Program Reimbursement ("NPR") dated March 8, 2013. The Provider's Request for Appeal contained two issues:

(1) DSH Medicaid Eligible Days, and
(2) Total Patient Days.

On April 17, 2014, the Provider submitted a Preliminary Position Paper which briefed both issues.

On August 19, 2019, the Board issued a Notice of Hearing and Critical Due Dates ("Notice of Critical Due Dates") requiring the Provider to file its Final Position Paper for this case by December 5, 2019 and gave the following instruction regarding the content of that filing:

> *For **each** remaining issue*, the position paper ***must*** state the material facts that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), and provide arguments applying the material facts to the controlling authorities. This filing must also include any exhibits the Provider will use to support its position. See

> Board Rule 27 for more specific content requirements. *If the Provider misses its due date, the Board will dismiss the cases.*[1]

On December 2, 2019, the Provider timely filed its Final Position Paper which briefed only Issue 1, the DSH Medicaid Eligible Days issue. Subsequently, on January 10, 2020, the Provider filed a *Corrected* Final Position Paper in an attempt to remedy the omission of the Total Patient Days issue from its Final Position Paper.

On March 5, 2020, the Medicare Contractor has filed a Jurisdictional Challenge which states the Provider abandoned the Total Patient Days issue in its Final Position Paper, and the Corrected Final Position Paper represents an improper adding of an issue. The Provider did not respond to the Jurisdictional Challenge.

**Provider's Position:**

While the Provider did not respond to the Jurisdictional Challenge, the Provider's position appears to be laid out in the cover letter to the Provider's January 10, 2020 filing of its Corrected Final Position Paper. This cover letter explains that the original Position Paper "*mistakenly omitted* the facts and information regarding the correction of total days [i.e., the Total Patient Days issue]."[2] The Provider states it "never meant" to remove the issue, and it now requests the Board replace its Final Position Paper filed on December 2, 2019 with the *Corrected* Final Position Paper that it subsequently filed on January 10, 2020. In the cover letter to its Corrected Final Position Paper, the Provider's Representative represents that Medicare Contractor does not object to the request and that the Provider is working with the Medicare Contractor to resolve both the DSH Medicaid Eligible Days and the Total Patient Days issues.

**Medicare Contractor's Jurisdictional Challenge and Position**

The Medicare Contractor points to Board Rule 27.2 addressing Final Position Papers, and argues that the Paper must address each remaining cost issue including a narrative and exhibits as outlined in Board Rule 25. The Medicare Contractor contends that Board Rule 27.3 prohibits revised or supplemental position papers from containing new arguments. The Medicare Contractor also refers to Board Rule 27.4 which allows the Board to exclude arguments or evidence in revised position papers which expand the scope of a final position paper. Lastly, the Medicare Contractor cites to Board Rule 6.2.1 which states an issue may be added to an individual appeal no later than 60 days after the expiration of the applicable 180 days period for filing the initial hearing request, and all supporting documentation in Board Rule 7 must be included.

The Medicare Contractor takes the position that the Provider abandoned the Total Patient Days issue in its Final Position Paper, and the Corrected Final Position Paper represents an improper adding of an issue.

---

[1] (Emphasis added and footnote omitted.)
[2] (Emphasis added.)

**Board Decision**

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1841, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (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.

For each cost issue appealed, providers are required to give a brief summary of the determination being appealed and the basis for dissatisfaction.[3] With respect to position papers, the regulations at 42 C.F.R. § 405.1853(b)(2) state the following:

> Each position paper *must* set forth the relevant facts and arguments regarding the Board's jurisdiction over ***each*** remaining matter at issue in the appeal, and the merits of the provider's Medicare payment claims for ***each*** remaining issue.[4]

Board Rule 27 addresses Final Position Papers, and indicates they should address each remaining issue in the appeal. In this regard, it states the following, in pertinent part:

> **Rule 27 Final Position Papers**
>
> ****
>
> **27.2 Content**
>
> The final position paper should address each remaining issue. The minimum requirements for the position paper narrative and exhibits are the same as those outlined for preliminary position papers at Rule 25.
>
> **27.3 Revised or Supplemental Final Position Papers**
>
> Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence. However, the Board encourages revised or supplemental final position papers which, for administrative efficiency, further narrow the parties' positions or provide legal development (such as new case law) that has occurred since the final position paper was filed. Prior to filing such papers, the parties should contact each other to discuss the anticipated substance of such papers and anticipated objections. If a revised or supplemental position paper is filed to further refine or narrow the issues, the opposing party may file a rebuttal or reserve such rebuttal for hearing.

[3] Board Rule 7.
[4] (Emphasis added.)

> **27.4 Expanding the Scope of Arguments in Final Position Papers is Prohibited**
>
> If at hearing or through a revised position paper, a party presents an argument or evidence *expanding* the scope of the position papers, the Board may, upon objection or its own motion, exclude such arguments or evidence from consideration.[5]

Significantly, Rule 27 incorporates the content requirements of Rule 25 governing preliminary position papers which states in pertinent part:

> **Rule 25 Preliminary Position Papers**
>
> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must contain the elements addressed in the following subsections.
>
> 25.1.1 **Provider's Position Paper**
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
>
> B. For each issue that has not been fully resolved, state the material facts that support the provider's claim.
>
> C. Identify the controlling authority (e.g., statutes, regulations, policy, or case law) supporting the provider's position.
>
> D. Provide a conclusion applying the material facts to the controlling authorities. . . .
>
> **25.2.1 Position Paper Exhibits**
>
> **25.2.1 General**
> With the position papers, the parties must exchange all available documentation as exhibits to fully support your position. The Medicare contractor must also give the provider all evidence the Medicare contractor considered in making the determination (s*ee* 42 C.F.R. § 405.1853(a)(3)) and identify any documentary evidence that the Medicare contractor believes is necessary for resolution but has not been submitted by the provider. When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4.

[5] (Underline emphasis added.)

> Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.
>
> **25.2.2 Unavailable and Omitted Documents**
> If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.
>
> **25.2.3 List of Exhibits**
> Parties must attach a list of the exhibits exchanged with the position paper.
>
> **25.3 Filing Requirements to Board**
> Parties should file with the Board a **complete** preliminary position paper with a fully developed narrative (Rule 23.1 [*sic* 25.1]), all exhibits (Rule 23.2 [*sic* 25.2]), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.[6]

Finally, the regulations at 42 C.F.R. § 405.1868 state the following:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal.
>
> (b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may-
>
> (1) Dismiss the appeal with prejudice;
>
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
>
> (3) Take any other remedial action it considers appropriate.

[6] (Commentary omitted.) The Board notes that the Commentary at the beginning of Rule 25 states, in part, that "preliminary position papers are expected to present ***fully developed*** positions of the parties and, therefore, require analysis well in advance of the filing deadline." (Emphasis added.)

The Provider in this case included the Total Days Issue in its Individual Appeal Request and in its Preliminary Position Paper. The Provider admits it "mistakenly omitted" this issue from its Final Position Paper and, 5 ½ weeks later, the Provider has filed a Corrected Final Position Paper in an attempt to cure this error.

The regulation at 42 C.F.R. § 405.1853(b)(2), as well as Board Rules 25 and 27 make it clear that Final Position Papers must address each remaining issue in the appeal. The Board has determined that the Provider has violated Board Rule 25 and 27, the Critical Due Dates Notice, and 42 C.F.R. § 405.1853(b)(2) because these authorities required the full briefing of ***each*** issue in the Provider's Final Position Paper and the Provider's Final Position Paper did not set forth the relevant facts and arguments regarding the merits of this Provider's claims for the Total Days Issue.
Further, it is clear from the explanation included in the cover letter to the Corrected Final Position Paper that the Provider is at fault for its failure to brief the Total Days Issue in its Final Position Paper. By not timely briefing the issue, the Provider essentially abandoned the Total Days Issue.

Based on the above, the Board hereby dismisses the Total Patient Days issue from the appeal pursuant to the Board's authority under 42 C.F.R. § 405.1868. This appeal remains open as the DSH Medicaid Eligible Days issue remains. 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 upon final disposition of the appeal.

Board Members

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA
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FOR THE BOARD

6/12/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
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cc: Wilson Leong, Federal Specialized Services

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**RE:** ***Jurisdictional Challenge***
East Georgia Regional Medical Center (11-0075)
FYE: 09/30/2014
PRRB Case No.: 18-0357

Dear Mr. Summar and Mr. Lamprecht,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the documents in the above-referenced appeal. The Board finds that it does not have jurisdiction over the last remaining issue in the appeal: the Disproportionate Share Hospital ("DSH") Supplemental Security Income (SSI) Percentage (Provider Specific) issue.

**Background:**

On December 18, 2017, East Georgia Regional Medical Center (East Georgia) filed an appeal from an original Notice of Program Reimbursement (NPR) dated June 29, 2017 for the fiscal year ending (FYE) September 30, 2014. East Georgia appealed the following nine issues:

1) DSH SSI Percentage (Provider Specific) including SSI realignment,
2) DSH SSI Percentage,
3) DSH SSI Percentage Managed Care Part C Days,
4) DSH SSI Percentage Dual Eligible Days (Exhausted Part A Benefit Days, MSP Days and No-Pay Part A Days),
5) DSH Medicaid Eligible Days,
6) DSH Medicaid Fraction Managed Care Part C Days,
7) DSH Medicaid Fraction Dual Eligible Days (Exhausted Part A Benefit Days, MSP Days and No-Pay Part A Days),
8) UCC Distribution Pool and
9) Two Midnight Census IPPS Payment Reduction.

On April 12, 2018, the Medicare Contractor filed a Jurisdictional Challenge challenging

jurisdiction over issue 1, the DSH SSI Percentage (Provider Specific) including SSI realignment issue, over issue 2, the DSH SSI Percentage issue, over issue 5, the DSH Medicaid Eligible Days issue, and over issue 8, the UCC Distribution Pool issue.

On August 29, 2018, East Georgia requested to transfer issue 2, the DSH SSI Percentage issue, to case number 17-0578GC; requested to transfer issue 3, the DSH SSI Percentage Managed Care Part C Days issue, to case number 17-0576GC; requested to transfer issue 4, the DSH SSI Percentage Dual Eligible Days (Exhausted Part A Benefit Days, MSP Days and No-Pay Part A Days) issue, to case number 17-0575GC; requested to transfer issue 6, the DSH Medicaid Fraction Managed Care Part C Days issue, to case number 17-0574GC; requested to transfer issue 7, the DSH Medicaid Fraction Dual Eligible Days (Exhausted Part A Benefit Days, MSP Days and No-Pay Part A Days) issue, to case number 17-0577GC; requested to transfer issue 8, the UCC Distribution Pool issue, to case number 17-0573GC; and requested to transfer issue 9, the Two Midnight Census IPPS Payment Reduction issue, to case number 17-0572GC. After all transfers, two issues remained in the appeal: issue 1, the DSH SSI Percentage (Provider Specific) including SSI realignment issue and issue 5, the DSH Medicaid Eligible Days issue. On January 2, 2020, East Georgia requested to withdraw issue 5, the DSH Medicaid Eligible Days issue. After the withdrawal, only one issue remained in the appeal: issue 1, the DSH SSI Percentage (Provider Specific) including SSI realignment issue.

## Medicare Contractor's Position

The Medicare Contractor contends that issue 1, the DSH SSI Percentage (Provider Specific) including SSI realignment issue, is not an appealable issue. The Medicare Contractor maintains the decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election, not a Medicare Contractor determination. The Medicare Contractor argues the hospital must make a formal request to CMS in order to receive a realigned SSI percentage. The Medicare Contractor contends it did not and cannot make a determination in terms of the provider's SSI percentage realignment; the only party that can make the election regarding the fiscal year end for the SSI percentage is the provider. The Medicare Contractor maintains since there is no determination for the provider to contest and because the provider is not challenging a final determination but merely wants to change its election of the fiscal year end for the SSI percentage of the DSH computation, the Board does not have jurisdiction over this issue.

The Medicare contractor contends the provider did not pursue its available remedy and therefore it is not appropriate to include this issue in a Board appeal. The Medicare Contractor maintains the provider should not be permitted to raise this issue for the first time before the Board and/or preserve its right to make such request under separate cover to CMS.[1] The Medicare Contractor requests the Board dismiss the SSI realignment issue from the Appeal.[2]

The Medicare Contractor asserts that in describing the issues in its appeal request the Provider disputes whether the Medicare Contractor used the correct SSI percentage in computing its DSH

[1] Medicare Contractor April 12, 2018 Jurisdictional Challenge at 3-4.
[2] *Id.* at 5.

calculation. The Medicare Contractor argues both issue 1, the DSH SSI Percentage (Provider Specific) issue, and issue 2, the DSH SSI percentage (Systemic Errors) issue reference the same audit adjustment numbers and the SSI data is the underlying issue in both issues. The Medicare Contractor contends the provider is ultimately appealing the SSI percentage under separate issues. The Medicare Contractor maintains the Board must conclude that both issues are one and the same with the same potential outcome and effective reimbursement amount. The Medicare Contractor requests that the Board dismiss issue 1, the DSH SSI percentage (Provider Specific) issue, as it is a subset of issue 2, the DSH SSI percentage (Systemic Errors) issue.[3]

**Board Decision:**

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2016), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Board finds that it does not have jurisdiction over Issue 1, the DSH SSI Percentage (Provider Specific) including SSI realignment issue. The jurisdictional analysis for Issue 1 has two relevant aspects to consider: 1) East Georgia disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) East Georgia preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

The first aspect of Issue 1—East Georgia disagreeing with how the Medicare Contractor computed its SSI percentage that would be used to determine its DSH percentage—is duplicative of issue 2, the DSH SSI Percentage issue that was transferred to case no. 17-0578GC, QRS HMA 2014 DSH SSI Percentage CIRP Group, on August 29, 2018. The DSH SSI Percentage (Provider Specific) issue, issue 1, concerns "[w]hether the Medicare Administrative Contractor ("MAC') used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation." The legal basis for East Georgia DSH SSI Percentage (Provider Specific) issue is that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)." Specifically, East Georgia disagrees with "the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations." East Georgia asserts that "its' [sic] SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation."[4]

The DSH SSI Percentage, Issue 2, that was transferred to case no 17-0578GC, also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). East Georgia asserts "the SSI percentages calculated by the Centers for Medicare and Medicaid Services

[3] *Id.* at 11-12.
[4] Provider's December 18, 2017 Individual Appeal Request at Tab 3, Issue 1.

("CMS") and used by the Lead MAC to settle their Cost Report were incorrectly computed." Also, "the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)." The issue concerns "[w]hether the Medicare/SSI fraction used in the Medicare Disproportionate Share Hospital . . . calculations accurately and correctly counted the correct number of patient days to be included in the numerator and denominator of the Medicare/SSI fraction calculation per the Medicare Statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)."[5] The Board finds that the DSH SSI Percentage (Provider Specific) issue, Issue 1, is duplicative of the DSH SSI Percentage issue, issue 2, transferred to case no. 17-0578GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination[6] are prohibited by PRRB Rule 4.5 (July 1, 2015),[7] the Board dismisses this aspect of the DSH SSI Percentage (Provider Specific) issue from Issue 1.

The Board also dismisses the second aspect of the DSH SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—for lack of jurisdiction. In East Georgia's Appeal Request it asserts that it "preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period."[8] Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate that East Georgia has made a formal request to CMS through the Medicare Contractor and that the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Thus, the Board dismisses this aspect of the DSH SSI Percentage (Provider Specific) issue as well.

**Conclusion:**

The Board notes that the Medicare Contractor also challenged jurisdiction over Issue 2, the DSH SSI Percentage issue, Issue 5, the DSH Medicaid Eligible Days issue, and Issue 8, the UCC Distribution Pool issue. As these issues have all been transferred to group appeals, the Board will not address these challenges in this appeal.

The Board concludes that it does not have jurisdiction over issue 1, the DSH SSI Percentage (Provider Specific) including SSI realignment issue. The Board dismisses issue 1 from the appeal. As the DSH SSI percentage (Provider Specific) including SSI realignment issue is the only issue in this appeal, the Board hereby closes case number 18-0357 and removes it from its docket.

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[5] *Id.* at Issue 2.
[6] Issues 1 and 2 were appealed from a June 29, 2017 NPR.
[7] The rule in effect at the time the Provider filed its appeal stated, "PRRB Rule 4.5 – No Duplicate Filings, A provider may not appeal an issue from a single final determination in more than one appeal."
[8] Provider's December 18, 2017 Individual Appeal Request at Tab 3, Issue 1.

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

**Board Members Participating:**

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA
Robert Evarts, Esq.
Susan Turner, Esq.

**FOR THE BOARD**

6/15/2020

X Gregory H. Ziegler

Gregory H. Ziegler, CPA
Board Member
Signed by: Gregory H. Ziegler -S

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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**Via Electronic Delivery**

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RE: ***Jurisdictional Determination***
Forsyth Memorial Hosp. (Prov. Nos. 34-0014, 34-T014)
FYE 12/31/2006
Case No. 13-3101

Dear Mr. Ravindran and Ms. Polson:

This case involves the Provider's appeal of its Medicare reimbursement for the fiscal year ending ("FYE") in 2006. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Provider's documentation on its own motion in response to the 2018 decision of the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") in *Mercy Hosp., Inc. v. Azar* ("*Mercy*").[1] As set forth below, the Board finds that it does not have jurisdiction to hear the Provider's Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") reimbursement issues and dismisses the instant appeal as there are no remaining issues.

**Pertinent Facts**

On August 21, 2013, the Board received the Provider's request for a hearing ("RFH") regarding a Notice of Program Reimbursement ("NPR"), corresponding to FYE ending in 2006.[2] In its RFH, the Provider lists four (4) issues for the appeal and all four issues relating to one subject — the calculation of the Low-Income Patient fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units:

> **Issue 1: The Low Income Proxy**
>
> The Provider has a separately licensed Rehabilitation unit (i.e. Provider Number 34-T014)…. All IRFs are eligible to receive a LIP adjustment. There is not a required threshold for a minimum number of beds or a minimum amount of DSH in order to receive the adjustment. The Provider appeals the following components of LIP:

[1] *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062 (June 8, 2018).
[2] *See* Provider's Request for Hearing (Aug. 21, 2013).

**1A. SSI**

Whether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Provider's IRF LIP adjustment.

**2B. Medicaid Eligible Days**

Whether the Intermediary included all Medicaid-eligible days m the Medicare IRF LIP adjustment as required by 42 C.F.R. § 412.624(e)(2).

**3C. Medicare Managed Care Part C Days**

Whether Medicare Managed Care / Medicare Part C Days were properly accounted for in the IRF LIP adjustment.

**4D. Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)**

Whether patient days associated with Medicare Part A and Title XIX eligible patients should be included in the IRF LIP adjustment.[3]

On June 20, 2014, the Medicare Contractor filed a Jurisdictional challenge arguing that all issues pending in the appeal are related to the LIP adjustment under the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS).[4] They argue that it is not an appealable issue, and that Title 42 U.S.C. § 1886(j)(8)(B) precludes administrative review of the IRF LIP adjustment.[5]

## Board's Analysis and Decision

### Applicable Regulatory Provisions and Board Rules

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2012), a provider has a right to a Board hearing with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date of receipt of the final determination.

[3] *See* Provider's Request for Hearing, Issue Statement, at Ex. 3 (Aug. 21, 2013).
[4] *See* MAC's Jurisdictional Challenge (Jun. 20, 2014).
[5] *Id.*

**Rehab Days in LIP Adjustment Calculations**

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities. Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the D.C. Circuit's decision in *Mercy* answers this question and clarifies what is shielded from review in its analysis of this issue.[6]

In *Mercy*, the D.C. Circuit describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year."[7] One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The D.C. Circuit in *Mercy* affirmed the District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[8] The D.C. Circuit concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[9]

In the instant appeal, the Provider seeks Board review of several of the components utilized by the Medicare Contractor to determine the Provider's LIP adjustment: the SSI percentage, Medicaid eligible days, Medicare Part C Days, and Dual Eligible Days. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the four LIP adjustment issues and dismisses these issues in the instant appeal that challenge this adjustment. In making this finding, the Board notes that the Court of Appeals decision in *Mercy* is controlling precedent because the Providers could bring suit in the D.C. Circuit.[10]

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[6] *Mercy*, 891 F.3d 1062.
[7] *Id.* at 1064.
[8] *Mercy Hosp., Inc. v. Burwell*, 206 F. Supp. 3d 93, 102 (D.D.C. 2016).
[9] *Mercy*, 891 F.3d at 1068.
[10] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

Based on the above, the Board hereby dismisses the 4 LIP issues from this appeal due to a lack of jurisdiction pursuant to 42 U.S.C. § 1395ww(j)(8)(B). As there are no remaining issues in this appeal, the Board hereby closes Case No. 13-3101 and removes it the appeal 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.

Board Members Participating:

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For the Board:

6/17/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

cc: Wilson Leong, Federal Specialized Services

***DEPARTMENT OF HEALTH & HUMAN SERVICES***

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**Via Electronic Delivery**

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RE: ***Request to Form Group Appeal or, Alternatively, Reinstate Case No. 08-0327GC for*** Mercy Hospital (Prov. No. 16-0028, FYE 6/30/2006) *as a participant in* CHI 2006 DSH Labor & Delivery Room Days Group Case No. 08-0327GC

Dear Ms. Webster and Mr. Lattimore:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the Providers' Request for Hearing dated July 11, 2016, and related documentation in Case No. 08-0327GC which originally involved 31 participants. As set forth more fully below, consistent with CMS Ruling 1498-R ("Ruling 1498-R"), the Board is denying the Provider's Request for Hearing and the Provider's alternative request for reinstatement of Case No. 08-0327GC and, accordingly, will neither establish a new appeal nor reinstate Case No. 08-0327GC. Notwithstanding, the Board has determined that the Medicare Contractor failed to follow the Board's original 1498-R "Standard Remand" Order dated August 29, 2013, as it relates to the following participant in Case No. 08-0327GC:

1. Mercy Hospital, Provider No. 16-0028, FYE 6/30/2006 ("Mercy");

Accordingly, ***the Board hereby orders the Medicare Contractor*** *to recalculate the DSH payment adjustment for the following provider as mandated by the August 29, 2013, Board Order* pursuant the Board's authority under both the "standard or default implementation procedure" specified in § 4.a of Ruling 1498-R and 42 C.F.R. § 405.1845(h). *If the Medicare Contractor refuses or fails to implement the Board's August 29, 2013, Order as it relates to Mercy* ***within 90 days of the date of this letter (i.e., by Thursday, September 17, 2020)***, the Provider may petition the Board for a referral of this matter to CMS pursuant to 42 C.F.R. § 405.1868(c).

**Background**

On August 29, 2013, the Board issued a 1498-R "Standard Remand" Order to remand Case No. 08-0327GC to the Medicare Contractor "for recalculation of the Providers' DSH adjustments." At issue in this matter is a request from the group representative to either establish a new individual appeal for Mercy or, in the alternative, reinstate the original group appeal, Case No. 08-0327GC, for a subset of the original participants, namely, Mercy.[1]

[1] *See* Provider's Request to Form Group Appeal (Jul. 11, 2016).

### *A. Overview of the Original Group Appeal under Case No. 08-0327GC and the 1498-R Remand*

On November 30, 2007, the hearing request for Case No. 08-0327GC was submitted to the Board.[2] The Providers contended that CMS and its fiscal intermediaries improperly failed to include labor and delivery room days in the number of the Medicaid patient days used for purposes of calculating DSH, and thereby failed to pay the hospitals' proper DSH entitlements.[3] On January 21, 2010, Mercy Hospital was directly added to the group appeal from its revised Notice of Program Reimbursement.

On April 28, 2010, CMS issued Ruling 1498-R to address, in part, "DSH appeals challenging the exclusion from the DPP of labor/delivery room (LDR) inpatient days"[4] and required the Board "to remand each qualifying appeal to the appropriate Medicare contractor."[5]

On November 5, 2012, the Board informed the parties that it "recently began a review of [Case No. 08-0327GC], as the Labor and Delivery Days issue is subject to CMS Ruling 1498-R." The Board sought Schedule of Providers with jurisdictional documents in order to both review jurisdiction and process a standard remand. Further, on February 1, 2013, the Board requested additional documents for the ten (10) providers that appealed from Revised NPRs, including Mercy. The Board requested original NPRs, DSH work papers, and Reopening documentation, in an effort to further analyze jurisdiction over these specific providers.[6] The Providers' representative submitted documents on April 1, 2013 in response to the Board's request. The Board reviewed these documents, including the workpapers, and determined that there was an adjustment to the labor and delivery room days sufficient to determine that the Providers, *including Mercy*, filed jurisdictionally valid appeals.

The amount in controversy was $1,320,254 for the group, and all of the Providers filed a request with the Board for a hearing (or were directly added to the group) within 180 days of the date of their respective NPRs.

The Board applied the "standard or default implementation procedure" specified in § 4.a of Ruling 1498-R to Case No. 08-0327GC and, on August 28, 2013, issued the 1498-R "Standard Remand" Order for Case No. 08-0327GC.[7] In this Order, the Board found that "this appeal satisfies the applicable jurisdictional and procedural requirements of 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-1840." Accordingly, the Order remanded the remaining participants in Case No. 08-0327GC (including Mercy) "to the Medicare Contractor for recalculation of the Providers' DSH adjustment."[8]

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[2] Providers' Request for Hearing (Nov. 30, 2007).
[3] Providers' Request for Hearing (Nov. 30, 2007).
[4] CMS Ruling 1498-R at 12.
[5] *Id.* at 1.
[6] *See* Board's Request for Additional Documentation (Feb. 1, 2013).
[7] PRRB Letter of Standard Remand under Ruling 1498-R (Aug. 28, 2013).
[8] *Id.*

### *B. The Medicare Contractor's Denial of Remand Following the 1498-R Standard Remand Order*

On January 13, 2016, the Medicare Contractor sent a letter regarding the earlier identified provider, Mercy Hospital, stating their determination that the Provider did not meet the requirements for remand per 1498-R. Specifically, the Medicare Contractor stated:

> Remand requirements per 1498-R were not met. L&D was not added as a specific issue to the individual appeal (08-0201) and the revised NPR did not specifically adjust L&D days, it only added general Medicaid eligible days and removed total days. L&D was added directly to the group after R.O. #2. It appears Medicaid L&D days were self-disallowed on the as-filed cost report.[9]

In response to these letters, the group representative petitioned to the Board to form an appeal, challenging the Medicare Contractor's final determination in this matters or in the alternative, to reinstate the original appeal (Case No. 08-0327GC, closed on August 29, 2013).[10] In their request, the provider representative characterizes the issue as the Medicare Contractor's illegal refusal to perform its nondiscretionary duty to effect payment revisions under a final Board order.[11] The representative notes that the Board, in its remand order, had found that the appeal and the providers satisfied the applicable jurisdictional and procedural requirements. The representative states that it believes that the Medicare Contractor does not have discretion to decide not to comply with the Board's final order.[12] Further, they state that the only situation when the Medicare Contractor is permitted to make jurisdictional findings after a remand by the Board is under the "alternative remand" procedure established under 1498-R, which was not utilized in this remand.[13] Finally, the representative notes that the Board has jurisdiction from these remand denials because they are final determinations, they are dissatisfied, and they are filed timely within 180 days.[14]

## Board Determination

### *A. Denial of the Provider's Request to Form Group Appeal or, Alternatively, Reinstate Case No. 08-0327GC*

At the outset, the Board notes that the January 13, 2016, letters from the Medicare Contractor essentially denied the Board's remand under Ruling 1498-R based on its findings that: (1) Mercy did not met the jurisdictional requirements for a Board hearing based on their appeal of a revised NPR; and (2) as a result, Mercy did not meet the requirements for remand under 1498-R. The first finding is a typical jurisdictional finding that the Board (not a Medicare contractor) makes, pursuant to 42 C.F.R. § 405.1840, in any appeal pending before the Board.

The group representative is asking the Board to either open a new appeal based on the Medicare Contractor's January 13, 2016, determination, or to reinstate the original appeal so that the challenge against the denials may move forward. Under 42 C.F.R. § 401.108(b)-(c) (2011), CMS Rulings are published under the authority of the CMS Administrator and serve as precedent final

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[9] *See* Provider's Request for Hearing, at Ex. 1. (Jul. 11, 2016).
[10] *Id*. at 1.
[11] *Id*. at Ex. 3, Issue Statement.
[12] *Id*.
[13] *Id*.
[14] *Id.* (Further, MAC's notice states Provider's appeal rights with regards to that final determination).

opinions and orders or statements of policy or interpretation. Accordingly, CMS Rulings are binding on all Department of Health and Human Services, Social Security Administration, and CMS components that adjudicate matters under the jurisdiction of CMS,[14] including the Board pursuant to 42 C.F.R. § 405.1867.

Here, within CMS-1498-R, the CMS Administrator has spoken directly on the issue of Board jurisdiction over a provider's Labor and Delivery Days DSH issue and subjected that issue to mandatory remand.[15] In the present case, once the Board initially determined that the groups' L&D days issue for fiscal year 2006 was within CMS-1498-R's mandates, the Board no longer had jurisdiction over the issue and was required to remand the issue to the Medicare Contractor. Nothing within CMS-1498-R suggests that the Board may reassume jurisdiction over this issue once it has been remanded.

In fact, CMS-1498-R states that upon remand, "CMS' action eliminates *any* actual case or controversy regarding the hospital's previously calculated L&D Days, SSI fraction, and DSH payment adjustment *and thereby renders moot* each properly pending claim in a DSH appeal involving the hospital's previously calculated SSI fraction and the process by which CMS matches Medicare and SSI eligibility data, provided that such claim otherwise satisfies the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines."[16] The Ruling further provides "that the [Board] and the other administrative tribunals lack jurisdiction over provider appeals of any of [these] three issues."[17] Accordingly, the Board was divested of its authority to act on this case as soon as the Board determined that the Providers' claims satisfied the applicable jurisdictional and procedural requirements for appeal and remanded the L&D Days issue to the Medicare Contractor. As a consequence of this divestiture, the Board must conclude that the case cannot be reinstated.[18]

Similarly, the Board finds that this matter is not yet ripe for formation of an individual appeal because the January 13, 2016, letter from the Medicare Contractor addressing Mercy was improper and void because the Medicare Contractor lacked authority under Ruling 1498-R to make the findings that: (1) Mercy did not meet the jurisdictional requirements for a Board hearing based on their appeal of a revised NPR; and (2) as a result, Mercy did not meet the requirements for remand under 1498-R. As such, these letters cannot be considered a final determination to which appeal rights to the Board attach. Rather this is a situation where the Medicare Contractor failed to follow a Board Remand Order issued pursuant to § 4.a of 1498-R and 42 C.F.R. § 405.1845(h). Accordingly, the Board hereby denies the Provider's request to form a new individual appeal.

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[15] Ruling 1498-R at 6.
[16] *Id.* at 6.
[17] *Id.* at 1.
[18] For any appeal filed with the Board, the Board must make jurisdictional findings pursuant to 42 C.F.R. § 405.1840. The alternative method bypasses Board review of jurisdiction under § 405.1840 by having the Medicare Contractor make jurisdictional findings in lieu of the Board. Accordingly, the alternative method is only applied *if and only if* the provider requests it. Similarly, apparently in recognition of § 405.1840, Ruling 1498-R specifies that, *under this alternative method*, if the Medicare contractor finds that the "claim does not meet all applicable jurisdictional and procedural requirements," a provider "may resume without prejudice its original appeal of the same claim before the same administrative appeals tribunal that previously remanded such claim to the contractor" and "[u]pon receipt of such a written notice from the provider, the appeals tribunal will then process the provider's original appeal of the same claim in accordance with the tribunal's usual, generally applicable appeal procedure." Ruing 1498-R at 20.

### *B. The Medicare Contractor Lacks Authority to Deny Jurisdiction for Mercy Hospital*

CMS issued Ruling 1498-R in April 2010 for three distinct issues, one of which was the inclusion of L&D days in the Medicaid fraction.[19] The Ruling takes jurisdiction over each properly pending claim of the three issues away from the Board *but only if* such claims otherwise have satisfied the applicable jurisdictional and procedural requirements for the appeal.[20] The Ruling creates two different methods to apply the Ruling – the standard/default method and the alternative method.

The first method is the "standard" or "default" method and is laid out in § 4.a of Ruling 1498-R entitled "The Standard Implementation Procedure." Section 4.a describes the standard/default method to apply the Ruling as follows:

> Under the standard or default implementation procedure, ***the administrative tribunal*** (*i.e*., the PRRB, the Administrator of CMS, the fiscal intermediary hearing officer, or the CMS reviewing official) ***before which the appeal is pending*** will determine whether each claim at issue is for one of the three DSH issues and whether such claim satisfies the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines. ***If*** *the administrative tribunal* [***i.e., the Board in this case***] *finds that the applicable jurisdictional and procedural requirements are satisfied* for a given claim on one of the three DSH issues, *then the appeals tribunal will issue a brief written order, remanding each claim that qualifies for relief under the Ruling to the appropriate Medicare contractor for recalculation of the DSH payment adjustment* (in accordance with the instructions set forth below in Section 5 of this Ruling) for the period at issue.
>
> However, *if the administrative tribunal [**i.e., the Board in this case**] finds that* a given claim is outside the scope of the Ruling (because such claim is not for one of the three DSH issues) or *the claim fails to meet the applicable jurisdictional and procedural requirements for relief under the Ruling, then the appeals tribunal [**i.e., the Board in this case**] will issue a written order, briefly explaining why the tribunal found that such claim is not subject to the Ruling*. The appeals tribunal will then process the provider's original appeal of the same claim in accordance with the tribunal's usual, generally applicable appeal procedures.[21]

Thus, *for this case* under the standard/default method, the Board is the administrative tribunal charged with "determin[ing] whether each claim at issue is for one of the three DSH issues and whether such claim satisfies the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines."[22]

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[19] Ruling 1498-R at 6.
[20] *Id.*
[21] *Id.* at 17-18.
[22] *Id.* at 17.

In recognition of the volume of cases covered by Ruling 1498-R, CMS provided for an alternative method for remand in § 4.b of Ruling 1498-R entitled "The Alternative Implementation Procedure." Significantly, § 4.b of the Ruling 1498-R specifies that ***only*** the provider may initiate the alternative method:

> Under this alternative implementation procedure, ***the hospital*** in a single provider appeal ***may submit a*** *single written* ***request*** to the pertinent administrative tribunal, requesting a remand of each and every specific claim on any of the three DSH issues for qualifying patient discharge dates and cost reporting periods (as described above in Sections 1, 2, and 3 of this Ruling) that was raised in such appeal to the appropriate Medicare contractor for implementation of the Ruling, *without the administrative tribunal* ***first determining*** whether each of the provider's claims is for one of the three DSH issues and whether such claim satisfies the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines. On remand, under this alternative procedure, *the Medicare contractor would* ***then*** *assume the responsibility for determining whether each of the provider's claims is subject to the Ruling*.
>
> The same alternative implementation procedure is available for pending group appeals on one of the three DSH issues, *provided that* ***the group's designated representative*** ***submits a*** *single written* ***request***, on behalf of every provider and for every period at issue in the group appeal, to the administrative tribunal, requesting that the entire group appeal be remanded to the appropriate Medicare contractor for implementation of the Ruling; *here too, the Medicare contractor*, instead of the administrative appeals tribunal, *would* ***then*** *determine whether each claim in the group appeal is for one of the three DSH issues and whether such claim satisfies the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines*. (However, if a provider in the group appeal were to submit a written objection to the group representative's prior request for a remand under this alternative implementation procedure, and the administrative tribunal received such written objection before it had issued a remand order under the alternative implementation procedure, then the tribunal will instead follow the standard implementation procedure (as described in Section 4.a. of this Ruling); as a result, the appeals tribunal would then determine whether each claim in the group appeal is for one of the three DSH issues and whether such claim satisfies all applicable jurisdictional and procedural requirements for relief under the Ruling.)[23]

Thus, ***if and only if*** a relevant provider or group representative specifically has requested in writing the alternative method may the Board deviate from the standard/default method and remand pursuant to the alternate method. Similarly, ***if and only if*** a provider or group representative has

[23] *Id.* at 18-19 (emphasis added.)

made a written request for the alternate method and the Board issues a remand under that method, may the relevant Medicare contractor follow the alternative procedure and "determin[e] whether each of the provider's claims is for one of the three DSH issues and whether such claim satisfies the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines."[24]

In this case, the record confirms that Provider did ***not*** initiate the alternate remand with a written request. Accordingly, the Board properly applied the standard/default remand method to this case. As required by Ruling 1498-R and 42 C.F.R. § 1840, the Board made jurisdictional and procedural findings on each of the remaining 31 participants in Case No. 08-0327GC, *including Mercy*, and found jurisdiction for all of them. Accordingly, the Board memorialized these jurisdictional finding in the 1498-R "Standard Remand" Order and remanded the 31 remaining participants in Case No. 08-0327GC (including Mercy Hospital) "to the [Medicare Contractor" for recalculation of the Providers' DSH adjustment." Significantly, the Administrator did not exercise her discretion under 42 C.F.R. § 405.1875 to review the Board's final jurisdictional determination in Case No. 08-0327GC.[25] Accordingly, the Board's jurisdictional determination became the Agency's final determination.

The Medicare Contractor apparently mistakenly believed that the alternative method was applicable to this case when it issued its January 13, 2016, letters essentially denying jurisdiction over Mercy Hospital by asserting that their appeal to the Board based on a revised NPR was not proper under 42 C.F.R. § 405.1887. However, as noted above, the alternative method clearly does not apply to this case. As such, the Medicare Contractor did not have the authority under Ruling 1498-R to make findings of jurisdiction over Mercy or, more importantly, to either ignore or overrule the Board's finding of jurisdiction in the Board's August 29, 2013, Remand Order.

Since the Board issued its Remand Order under the standard/default remand method, if the Medicare Contractor disagreed with the Board's finding of jurisdiction over Mercy Hospital, then the Medicare Contractor should have filed its jurisdictional challenge with the Board while the appeal was still pending with the Board pursuant to Board Rules 22 and 44.4 (July 2009).[26] The Medicare Contractor had plenty of notice and opportunity in this case to do so. By letter dated December 26, 2012, the Provider submitted jurisdictional documents on all providers. Further, by

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[24] *Id.*

[25] A standard remand order under Ruling 1498-R is analogous to EJR decisions under 42 C.F.R. § 405.1875(a)(2)(3) where only the final jurisdictional decision would be reviewable by the Administrator. As such, a standard remand order would fall under § 405.1875(a)(2)(iv) and would be consistent with the example given in § 405.1875(b)(5); *See also* 42 C.F.R. § 405.1845(h)(3) (recognizing the Administrator's authority to review Board remand orders pursuant to § 405.1875(a)(2)(iv)). The Board recognizes that § 4.e of the Ruling addresses "Request for Review of a Finding That a Claim Is Not Subject to the Ruling" and that this section contains the statement: "Or, *if a Medicare fiscal intermediary* ***hearing officer*** *were to find,* ***under the standard implementation procedure*** (as set forth in § 4.a. of this Ruling), that a particular claim on one of the three DSH issues was not subject to the Ruling because the provider's appeal of such DSH claim did not meet a jurisdictional requirement (such as the requirement of timely filing of the provider's appeal), then the provider might request *the CMS reviewing official* to review the hearing officer's finding that the Ruling was inapplicable." CMS Ruling 1498-R at 26 (emphasis added). However, this statement is not applicable to this case because it involves a situation where the amount in controversy is less than $10,000 and the Medicare contractor *hearing officer* as part of a "contractor hearing" (*see* 42 C.F.R. §§ 405.1809 to 405.1834) is conducting the review under the alternative/default method and such "contractor hearings" are subject to review by a "CMS reviewing official" (*see* 42 C.F.R. § 405.1834).

[26] Board Rule 22 states that, in group appeals, "[t]he lead Intermediary is responsible for reviewing the Schedule of Provider and the associated jurisdictional documentation" and "[t]he lead Intermediary must forward the final Schedule of Providers with the documentation to the Board to become part of the official record along with a cover letter verifying its position that the issue is suitable for appeal and whether jurisdictional impediments exist."

letter dated February 1, 2013, the Board informed the parties that the Board had requested additional documentation regarding 10 providers that had appealed from Revised NPRs (including Mercy) and specifically advised the Medicare Contractor that it needed to submit any comments on jurisdiction within 30 days.[27] However, the Medicare Contractor failed to submit any comments or specifically respond to the jurisdictional documents that the Provider submitted. Further, even after the Board issued the August 29, 2013, Remand Order, the Medicare Contractor did not, to the Board's knowledge, request that the Administrator exercise its discretion to review the Board's finding of jurisdiction in that Remand Order.

Accordingly, ***the Board hereby orders the Medicare Contractor*** *to recalculate the DSH payment adjustment for the following provider as mandated by the August 29, 2013, Board Order* pursuant the Board's authority under both the "standard or default implementation procedure" specified in § 4.a of Ruling 1498-R and 42 C.F.R. § 405.1845(h):

1. Mercy Hospital, Provider No. 16-0028, FYE 6/30/2006;

*If the Medicare Contractor refuses or fails to implement the Board's August 29, 2013, Order as it relates to Mercy Hospital* ***within 90 days of the date of this letter (i.e., by Thursday, September 17, 2020)***, the Providers may petition the Board for a referral of this matter to CMS pursuant to 42 C.F.R. § 405.1868(c).

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

6/19/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

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

[27] *See* Board's Request for Additional Information (Feb. 1, 2013).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
1508 Woodlawn Drive, Suite 100
Baltimore, MD 21207
410-786-2671

**Via Electronic Delivery**

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

RE: ***Jurisdictional Decision***

| | |
|---|---|
| 15-1252GC | HRS Prime Healthcare FFY 2015 UCC Distribution Pool CIRP |
| 15-1253GC | HRS SCHS FFY 2015 UCC Distribution Pool CIRP |
| 15-1254GC | HRS UHHS FFY 2015 UCC Distribution Pool CIRP |
| 15-1255GC | HRS ProMedica FFY 2015 UCC Distribution Pool CIRP |
| 15-1256GC | HRS WKHS FFY 2015 UCC Distribution Pool CIRP |
| 15-1310GC | HRS Lafayette General Health FFY 2015 UCC Distribution Pool CIRP |
| 15-1356GC | HRS FMOLHS FFY 2015 UCC Distribution Pool CIRP |

Dear Ms. Goron,

The Provider Reimbursement Review Board ("Board") has reviewed the documents in the above referenced seven (7) common issue related party ("CIRP") appeals and finds that it does not have jurisdiction over the Uncompensated Care Payment issue. The jurisdictional decision of the Board is set forth below.

**Pertinent Facts:**

All of the above-referenced CIRP group appeals were received between January 28 and February 6, 2015, and are appealing from the Federal Register published August 22, 2014. The issue being appealed is a challenge to the DSH payment for uncompensated care costs ("UCC"), which argues that CMS acted beyond its authority and otherwise arbitrarily and capriciously in its calculation of the size of the pool of the UCC payments available for distribution to DSH eligible hospitals, specifically, in its calculation of Factors 1 and 2.[1] First, the Providers claim that CMS acted beyond its authority by violating the notice and comment rulemaking requirements of the Administrative Procedure Act ("APA") and, as such, the preclusion of review provision found in the Social Security Act § 1886(r)(3) does not apply. In support, the Providers further assert that they had a lack of information during the initial rulemaking for rules regarding UCC payments and, as a result, could not submit meaningful commentary on the proposed rules.[2] Second, the Providers state that CMS acted beyond its authority by failing to adhere to the *Allina*[3] decision. They argue that the base year (2011) statistic used to calculate the 2014 UCC payments was understated due to mistreatment of Part C days, and claim that *Allina* required a recalculation of the 2011 data since that case rendered CMS' policy regarding those days "null and void."[4]

[1] Request for Form Group Appeal, Group Issue Statement at 1.
[2] *Id.* at 1-2.
[3] *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1111 (D.C. Cir. 2014).
[4] Group Issue Statement at 4.

In Case No. 15-1254GC, the Medicare Contractor submitted its Response to Group Acknowledgement Letter on March 4, 2015. In that letter, the Medicare Contractor briefly stated that the Board does not have jurisdiction to decide the issue under appeal because its review is barred by 42 U.S.C. § 1395ww(r)(3).

On April 3, 2015, the Provider's Representative filed a Jurisdictional Response addressing the Medicare Contractor's argument. First, the Provider's Representative claims that the Secretary lacked the authority to "estimate" the uninsured patient percentage with regard to Factor 2 of the UCC payment, claiming that the omission of the term "estimate" from the second prong of Factor 2 in the UCC payment statute was deliberate, and that the Secretary should be required to reconcile her estimate with more accurate data once it is available. The Provider's Representative also claims that the Board has jurisdiction to review the Secretary's estimates because: (1) federal courts have the authority to do so via the issuance of a writ of mandamus, and (2) the regulations and policies relied upon by the Secretary in computing the estimates may be challenged, even if the estimates themselves are precluded from review.

**Board's Decision:**

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH payment issue in these appeals because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). In this regard, 42 C.F.R. § 412.106(g)(2) implements essentially *verbatim* the bar on certain administrative/judicial review that is delineated in 42 U.S.C. § 1395ww(r)(3):

> *Preclusion of administrative and judicial review*. There is no administrative or judicial review under sections 1869 or 1878 of the Act [*i.e*., 42 U.S.C. §§ 1395ff or 1395oo], or otherwise, of the following:
>
> (A) **Any estimate** of the Secretary for purposes of determining the factors described in paragraph (g)(1) of this section;[5] and
>
> (B) Any period selected by the Secretary for such purposes.[6]

Further, in *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Serv.* ("*Tampa General*"),[7] the D.C. Circuit Court upheld a D.C. District Court decision[8] that there is no judicial or administrative review of UCC DSH payments. In *Tampa General*, the provider challenged

[5] Paragraph (g)(1) is a reference to the three factors that make up the uncompensated care payment. Factor 1 represents 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r). 78 Fed. Reg. 50495, 50627-28 (Aug. 19, 2013). Factor 2, for FYs 2014-2017, is one (1) minus the percentage of individuals under age 65 who are uninsured in 2013. *Id.* at 50631. Factor 3 is a hospital-specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with the potential to receive DSH payments relative to the estimated uncompensated care amount for all hospitals estimated to receive DSH payments in the fiscal year for which the uncompensated care payment is to be made. *Id.* at 50634.

[6] (Bold emphasis added and italics emphasis in original.)

[7] 830 F.3d 515 (D.C. Cir. 2016).

[8] 89 F. Supp. 3d 121 (D.D.C. 2015).

the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit affirmed the District Court's finding that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[9] The D.C. Circuit also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[10]

The D.C. Circuit went on to address Tampa General's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[11] Finally, it addressed the argument that the estimate made by the Secretary was *ultra vires*, or beyond the scope of statutory authority, but plainly found that "the Secretary's choice of data is not obviously beyond the terms of the statute."[12]

In 2019, the D.C. Circuit revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. V. Azar* ("*DCH v. Azar*").[13] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment, and that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself."[14] It further stated that, allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." The D.C. Circuit recognized that it had previously held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves. The D. C. Circuit then applied this holding *DCH v. Azar* and found that the same relationship existed with regard to the methodology used to generate the estimates.[15]

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[9] 830 F.3d 515, 517.
[10] *Id.* at 519.
[11] *Id.* at 521-22.
[12] *Id.* at 522.
[13] 925 F.3d 503 (D.C. Cir. 2019).
[14] *Id.* at 506.
[15] *Id.* at 507.

The Board finds that the same findings of the D.C. Circuit are applicable to the Providers' challenge to their UCC payments in these appeals. The Providers here are challenging their uncompensated care DSH Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for FFY 2015. The challenge to CMS' notice and comment procedures focuses on a lack of information and underlying data used by the Secretary to determine the UCC payments, but *Tampa General* held that the underlying data cannot be reviewed or challenged. Likewise, the Providers' arguments centering on the *Allina* decision claim that certain data should recalculated or revised. Again, a challenge to the underlying data used in calculating UCC DSH payments is not subject to administrative or judicial review. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DSCH v. Azar,* finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review. In making these findings, the Board notes that, for purposes of the Board's review, the D.C. Circuit's decisions in both *Tampa General* and *DCH v. Azar* are controlling precedent for the interpretation of the statutory and regulatory provisions at issue because the Provider could bring suit in the D.C. Circuit.[16]

The Board concludes that it does not have jurisdiction over the Uncompensated Care DSH issue in these appeals because judicial and administrative review of the calculation is barred by statute and regulation.

As the Uncompensated Care DSH issue is the only issue in the appeal, the Board hereby closes the referenced appeals and removes them from its docket.

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

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

6/19/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators
Justin Lattimore, Novitas Solutions, Inc.
Judith Cummings, CGS Administrators

[16] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
1508 Woodlawn Drive, Suite 100
Baltimore, MD 21207
410-786-2671

**Via Electronic Delivery**

Corinna Goron
Healthcare Reimb. Servs., Inc.
c/o Appeals Department
17101 Preston Rd., Ste. 220
Dallas, TX 75248-1372

RE: ***Jurisdictional Decision***

| | |
|---|---|
| 16-0848GC | HRS WKHS FFY 2016 UCC Distribution Pool CIRP |
| 16-0850GC | HRS UHHS FFY 2016 UCC Distribution Pool CIRP |
| 16-0946GC | HRS ProMedica Health System FFY 2016 UCC Distribution Pool CIRP Group |
| 16-0958GC | HRS Prime Healthcare FFY 2016 UCC CIRP Group |
| 16-0967GC | HRS FMOLHS FFY 2016 UCC Distribution Pool CIRP Group |
| 16-0968GC | HRS Lafayette General Health FFY 2016 UCC Distribution Pool CIRP Group |
| 16-0984GC | HRS ECHN FFY 2016 UCC Distribution Pool CIRP Group |
| 16-0986GC | HRS SCHS FFY 2016 UCC Distribution Pool CIRP Group |

Dear Ms. Goron,

The Provider Reimbursement Review Board ("Board") has reviewed the documents in the above-referenced eight (8) common issue related party ("CIRP") appeals and finds that it does not have jurisdiction over the Uncompensated Care Payment issue. The jurisdictional decision of the Board is set forth below.

**Pertinent Facts:**

All of the above referenced group appeals were received between January 29 and February 12, 2016, and are appealing from the Federal Register published August 17, 2015. The issue being appealed is a challenge to the DSH payment for uncompensated care costs ("UCC"), which argues that CMS acted beyond its authority and otherwise arbitrarily and capriciously in its calculation of the size of the pool of the UCC payments available for distribution to DSH eligible hospitals, specifically, in its calculation of Factors 1 and 2.[1] First, the Providers claim that CMS acted beyond its authority by violating the notice and comment rulemaking requirements of the Administrative Procedure Act ("APA") and, as such, the preclusion of review provision found in 42 U.S.C. § 1395ww(r)(3) does not apply. They say that providers had a lack of information during the initial rulemaking for rules regarding UCC payments, and as a result could not submit meaningful commentary on the proposed rules.[2] Second, the Providers state that CMS acted beyond its authority by failing to adhere to the *Allina*[3] decision. They argue that the base year (2011) statistic used to calculate the 2014 UCC payments was understated due to mistreatment of Part C days, and claim that *Allina* required a recalculation of the 2011 data since that case rendered CMS' policy regarding those days "null and void." They conclude in stating that "[f]undamentally, the issue presented . . . is not whether the FY 2016 uninsured rate is [incorrect]. Rather, the fundamental

[1] Request for Form Group Appeal, Group Issue Statement at 1.
[2] *Id.* at 1-2.
[3] *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1111 (D.C. Cir. 2014).

issue is that the Secretary must reconcile her estimate of the FY 2016 nationwide uninsured rate to actual data."[4]

In Case No. 16-0984GC, the Medicare Contractor submitted its Lead MAC 30 Day Response on March 15, 2016. In that submission, the Medicare Contractor briefly stated that the Board does not have jurisdiction to decide the issue under appeal because its review is barred by 42 U.S.C. § 1395ww(r)(3).

On April 12, 2016, the Provider's Representative filed a Jurisdictional Response addressing the Medicare Contractor's argument. First, the Provider's Representative claims that the Secretary lacked the authority to "estimate" the uninsured patient percentage with regard to Factor 2 of the UCC payment, claiming that the omission of the term "estimate" from the second prong of Factor 2 in the UCC payment statute was deliberate, and that the Secretary should be required to reconcile her estimate with more accurate data once it is available. The Provider's Representative also claims that the Board has jurisdiction to review the Secretary's estimates because: (1) federal courts have the authority to do so via the issuance of a writ of mandamus, and (2) the regulations and policies relied upon by the Secretary in computing the estimates may be challenged, even if the estimates themselves are precluded from review.

**Board's Decision:**

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). In this regard, 42 C.F.R. § 412.106(g)(2) implements essentially *verbatim* the bar on certain administrative/judicial review that is delineated in 42 U.S.C. § 1395ww(r)(3):

> *Preclusion of administrative and judicial review*. There is no administrative or judicial review under sections 1869 or 1878 of the Act [*i.e.*, 42 U.S.C. §§ 1395ff or 1395oo], or otherwise, of the following:
>
> (A) **Any estimate** of the Secretary for purposes of determining the factors described in paragraph (g)(1) of this section;[5] and
>
> (B) Any period selected by the Secretary for such purposes.[6]

Further, in *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Serv.* ("*Tampa General*"),[7] the D.C. Circuit Court upheld a D.C. District Court decision[8] that there is no

[4] Group Issue Statement at 4.
[5] Paragraph (g)(1) is a reference to the three factors that make up the uncompensated care payment. Factor 1 represents 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r). 78 Fed. Reg. 50495, 50627-28 (Aug. 19, 2013). Factor 2, for FYs 2014-2017, is one (1) minus the percentage of individuals under age 65 who are uninsured in 2013. *Id.* at 50631. Factor 3 is a hospital-specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with the potential to receive DSH payments relative to the estimated uncompensated care amount for all hospitals estimated to receive DSH payments in the fiscal year for which the uncompensated care payment is to be made. *Id.* at 50634.
[6] (Bold emphasis added and italics emphasis in original.)
[7] 830 F.3d 515 (D.C. Cir. 2016).
[8] 89 F. Supp. 3d 121 (D.D.C. 2015).

judicial or administrative review of UCC DSH payments. In *Tampa General*, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit affirmed the District Court's finding that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[9] The D.C. Circuit also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[10]

The D.C. Circuit went on to address Tampa General's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[11] Finally, it addressed the argument that the estimate made by the Secretary was *ultra vires*, or beyond the scope of statutory authority, but plainly found that "the Secretary's choice of data is not obviously beyond the terms of the statute."[12]

In 2019, the D.C. Circuit revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. V. Azar* ("*DCH v. Azar*").[13] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment, and that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself."[14] It further stated that, allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." The D.C. Circuit recognized that it had previously held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves. The D. C. Circuit then applied this holding *DCH v. Azar* and found that the same relationship existed with regard to the methodology used to generate the estimates.[15]

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[9] 830 F.3d 515, 517.
[10] *Id.* at 519.
[11] *Id.* at 521-22.
[12] *Id.* at 522.
[13] 925 F.3d 503 (D.C. Cir. 2019).
[14] *Id.* at 506.
[15] *Id.* at 507.

The Board finds that the same findings are applicable to the Providers' challenge to their UCC payments in this appeal. The Providers here are challenging their uncompensated care DSH Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for FFY 2016. The challenge to CMS' notice and comment procedures focuses on a lack of information and underlying data used by the Secretary to determine the UCC payments, but *Tampa General* held that the underlying data cannot be reviewed or challenged. Likewise, the Provider's arguments centering on the *Allina* decision claim that certain data should recalculated or revised. Again, a challenge to the underlying data used in calculating UCC DSH payments is not subject to administrative or judicial review. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DSCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review. In making these findings, the Board notes that, for purposes of the Board's review, the D.C. Circuit's decisions in both *Tampa General* and *DCH v. Azar* are controlling precedent for the interpretation of the statutory and regulatory provisions at issue because the Provider could bring suit in the D.C. Circuit.[16]

The Board concludes that it does not have jurisdiction over the Uncompensated Care DSH issue in these appeals because judicial and administrative review of the calculation is barred by statute and regulation. As the Uncompensated Care DSH issue is the only issue in these appeals, the Board hereby closes the referenced appeals and removes them from its docket.

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

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

6/19/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators
Justin Lattimore, Novitas Solutions, Inc.
Judith Cummings, CGS Administrators
Pam VanArsdale, National Government Services, Inc.

[16] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
1508 Woodlawn Drive, Suite 100
Baltimore, MD 21207
410-786-2671

**Via Electronic Delivery**

Corinna Goron
Healthcare Reimb. Servs., Inc.
c/o Appeals Department
17101 Preston Rd., Ste. 220
Dallas, TX 75248-1372

RE: ***Jurisdictional Decision***
16-1849GC HRS Prime Healthcare FFY 2014 UCC Distribution Pool CIRP Group

Dear Ms. Goron,

The Provider Reimbursement Review Board ("Board") has reviewed the documents in the above-referenced common issue related party ("CIRP) group appeal and finds that it does not have jurisdiction over the Uncompensated Care Payment issue. The jurisdictional decision of the Board is set forth below.

**Pertinent Facts:**

The issue being appealed in this group appeal is a challenge to the DSH payment for uncompensated care costs ("UCC"), which argues that CMS acted beyond its authority and otherwise arbitrarily and capriciously in its calculation of the size of the pool of the UCC payments available for distribution to DSH eligible hospitals, specifically, in its calculation of Factors 1 and 2.[1] First, the Providers claims that CMS acted beyond its authority by violating the notice and comment rulemaking requirements of the Administrative Procedure Act ("APA") and, as such, the preclusion of review provision found in the Social Security Act § 1886(r)(3) does not apply. They say that providers had a lack of information during the initial rulemaking for rules regarding UCC payments, and as a result could not submit meaningful commentary on the proposed rules.[2] Second, the Providers state that CMS acted beyond its authority by failing to adhere to the *Allina*[3] decision. They argue that the base year statistic used to calculate the 2014 UCC payments (2011) was understated due to mistreatment of Part C days, and claim that *Allina* required a recalculation of the 2011 data since that case rendered CMS' policy regarding those days "null and void."[4]

**Board's Decision:**

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). In this regard, 42 C.F.R. § 412.106(g)(2) implements essentially *verbatim* the bar on certain administrative/judicial review that is delineated in 42 U.S.C. § 1395ww(r)(3):

[1] Request for Form Group Appeal, Group Issue Statement at 1 (June 15, 2016).
[2] *Id.* at 1-2.
[3] *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1111 (D.C. Cir. 2014).
[4] Group Issue Statement at 4.

> *Preclusion of administrative and judicial review*. There is no administrative or judicial review under sections 1869 or 1878 of the Act [*i.e.*, 42 U.S.C. §§ 1395ff or 1395oo], or otherwise, of the following:
>
> (A) **Any estimate** of the Secretary for purposes of determining the factors described in paragraph (g)(1) of this section;[5] and
>
> (B) Any period selected by the Secretary for such purposes.[6]

Further, in *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Serv.* ("*Tampa General*"),[7] the D.C. Circuit Court upheld a D.C. District Court decision[8] that there is no judicial or administrative review of UCC DSH payments. In *Tampa General*, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit affirmed the District Court's finding that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[9] The D.C. Circuit also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[10]

The D.C. Circuit went on to address Tampa General's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[11] Finally, it addressed the argument that the

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[5] Paragraph (g)(1) is a reference to the three factors that make up the uncompensated care payment. Factor 1 represents 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r). 78 Fed. Reg. 50495, 50627-28 (Aug. 19, 2013). Factor 2, for FYs 2014-2017, is one (1) minus the percentage of individuals under age 65 who are uninsured in 2013. *Id.* at 50631. Factor 3 is a hospital-specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with the potential to receive DSH payments relative to the estimated uncompensated care amount for all hospitals estimated to receive DSH payments in the fiscal year for which the uncompensated care payment is to be made. *Id.* at 50634.

[6] (Bold emphasis added and italics emphasis in original.)

[7] 830 F.3d 515 (D.C. Cir. 2016).

[8] 89 F. Supp. 3d 121 (D.D.C. 2015).

[9] 830 F.3d 515, 517.

[10] *Id.* at 519.

[11] *Id.* at 521-22.

estimate made by the Secretary was *ultra vires*, or beyond the scope of statutory authority, but plainly found that "the Secretary's choice of data is not obviously beyond the terms of the statute."[12]

In 2019, the D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. V. Azar* ("*DCH v. Azar*").[13] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment, and that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself." [14] It further stated that, allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." The D.C. Circuit recognized that it had previously held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves. The D. C. Circuit then applied this holding *DCH v. Azar* and found that the same relationship existed with regard to the methodology used to generate the estimates. [15]

The Board finds that the same findings are applicable to the Providers' challenge to their UCC payments in this appeal. The Providers here are challenging their uncompensated care DSH Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for FFY 2014. The challenge to CMS' notice and comment procedures focuses on a lack of information and underlying data used by the Secretary to determine the UCC payments, but *Tampa General* held that the underlying data cannot be reviewed or challenged. Likewise, the Providers' arguments centering on the *Allina* decision claim that certain data should recalculated or revised. Again, a challenge to the underlying data used in calculating UCC DSH payments is not subject to administrative or judicial review. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DSCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review. In making these findings, the Board notes that, for purposes of the Board's review, the D.C. Circuit's decisions in both *Tampa General* and *DCH v. Azar* are controlling precedent for the interpretation of the statutory and regulatory provisions at issue because the Provider could bring suit in the D.C. Circuit.[16]

The Board concludes that it does not have jurisdiction over the Uncompensated Care DSH issue in this appeal because judicial and administrative review of the calculation is barred by statute and regulation.

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[12] *Id.* at 522.
[13] 925 F.3d 503 (D.C. Cir. 2019).
[14] *Id.* at 506.
[15] *Id.* at 507.
[16] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

As the Uncompensated Care DSH issue is the only issue in the CIRP group appeal, the Board hereby closes the referenced appeal and removes it from its docket.

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

Board Members Participating:

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Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA
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For the Board:

6/19/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Decision***
St. Luke's Hospital (Prov. No. 05-0055)
FYE 12/31/2005
Case No. 17-1756

Dear Mr. Jaeger and Ms. Frewert,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above-captioned appeal in response to the Medicare Contractor's jurisdictional challenge. The pertinent facts of the case, the Parties' positions and the Board's jurisdictional determination are set forth below.

**Pertinent Facts**

By letter dated June 20, 2017, the Provider submitted an appeal request appealing a revised Notice of Program Reimbursement ("NPR") dated December 29, 2016. The Provider's appeal request included the following nine (9) issues[1]:

1. DSH SSI Ratio, Realignment
2. DSH SSI Ratio, Accurate Data[2]
3. DSH Inclusion of Medicare Part C Managed Care Days in the SSI Ratio Issued March 2012[3]
4. DSH Inclusion of Medicare Dual Eligible Part A Days in the SSI Ratio Issued March 16, 2012[4]
5. DSH SSI MMA Section 951 Applicable to SSI Ratio Issue March 2012[5]
6. DSH Medicaid Eligible Days, Restricted Aid Code 2&3 w/o State Aid Code
7. DSH Code MB 2&3 w/o State Aid Code

[1] *See* Medicare Contractor's Jurisdictional Challenge at 1 (Nov. 9, 2018).
[2] Issue 2 transferred to Case No. 19-0160GC.
[3] Issue 3 transferred to Case No. 19-0158GC, therefore, the Board will not review jurisdiction in the subject appeal.
[4] Issue 4 transferred to Case No. 19-0148GC.
[5] Issue 5 transferred to Case No. 19-0161GC.

8. Medicare DSH Understated – Dual Eligible Part C
9. Medicare DSH Understated – Dual Eligible Part A Exhausted

Only Issues 1, 6, 7, 8, and 9 remain pending in this appeal following transfer of the other 4 issues.

On November 9, 2018, the Medicare Contractor filed a jurisdictional challenge over issues 1, 3, 6, 7, 8, and 9. On November 27, 2018, the Provider filed a jurisdictional response which only addressed jurisdiction over Issue 3, the SSI Fraction/Part C Days issue. As this issue was transferred to a group appeal, the Board is only addressing the challenges to Issues 1 and 6 through 9 in this determination.

## Medicare Contractor's Position

*A. Challenge to Issue 1 -- DSH SSI Percentage - Realignment issue*

The Medicare Contractor contends that the decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. The Provider has not requested to use its fiscal year end to recalculate the SSI percentage.

The Medicare Contractor contends that the Provider's appeal of the SSI Realignment issue is premature as it did not make a determination with respect to the SSI Realignment issue. To date, the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). The Medicare Contractor requests that the Board dismiss this issue consistent with recent jurisdictional decisions.[6]

*B. Challenge to Issues 6 through 9*

The Medicare Contractor contends that although the Provider timely appealed these issues, the Provider failed to address these issues in its Preliminary Position Paper dated February 15, 2018. As such, these issues should be considered abandoned and the Board should dismiss them from the case.[7, 8]

## Board Analysis and Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2014), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if: (a) it is dissatisfied with the final determination of the Medicare contractor; (b) the amount in

[6] Medicare Contractor's Jurisdictional Challenge at 2 (November 9, 2018).
[7] *Id.* at 1.
[8] The Provider's Opposition to Intermediary Jurisdictional Challenge only addressed Issue 3, DSH SSI Part C Managed Care Inclusion in SSI Ratio, which was transferred to a group appeal.

controversy is $10,000 or more (or $50,000 for a group); and (c) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

*A. Challenge to Issue 1 -- DSH SSI Percentage - Realignment issue*

As set forth below, Issue 1 -- DSH/SSI Percentage (Provider Specific) issue contains two aspects and the Board is dismissing Issue 1 in its entirety.

The two aspects of Issue 1 are: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

The first aspect of Issue No. 1—the Provider disagreeing with how CMS computed the SSI percentage that would be used to determine the DSH percentage—is *duplicative* of Issue 2 (the DSH SSI Ratio Inaccurate Data issue) that was transferred to Case No. 19-0160GC on December 17, 2018.

In the SSI Ratio Realignment issue the Provider "specifically contends" that the SSI percentage as generated by the Social Security Administration and put forth by CMS is understated. The Provider uses identical language in its SSI Ratio Accurate Data issue which has since been transferred to a group. Further, the Provider did not respond to the Medicare Contractor's Jurisdictional Challenge to Issues 6 through 9 and, pursuant to Board Rule 44.4, the Board must make its findings based on the information in the record. Based on this scant record, the Board is unable to distinguish between Issues 1 and 2 and finds the SSI Ratio Realignment issue in this appeal is duplicative of the SSI Ratio Accurate Data issue in Case No. 19-0160GC. Because the issue is duplicative, and the pursuit of "duplicate" issues appealed from the same final determination in separate appeals is prohibited by Board Rule 4.5 (2015),[9] the Board dismisses this first aspect of the SSI Ratio Realignment issue pursuant to its authority under 42 C.F.R. § 405.1868.

The second aspect of Issue 1 concerns the realignment of the Provider's SSI ratio from the Federal fiscal year to the Provider's fiscal year. Specifically, in its SSI Ratio Realignment issue statement, the Provider points out that 42 C.F.R. § 412.106(b) provides that the Provider may choose to use its cost reporting period instead of the Federal fiscal year.[10] 42 C.F.R. § 412.106(b)(3) states "if a hospital prefers that CMS use its cost reporting data instead of the Federal Fiscal Year, it must furnish to CMS, through its intermediary, a written request…" Without a written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for purposes of appeal. Additionally, even if the

[9] Board Rule 4.5 (2015) states: "A Provider may not appeal an issue from a final determination in more than one appeal." Issue 1 is duplicative of Issue 2 because they are the same issue and the Provider transferred Issue 2 to a separate group appeal. Accordingly, the Provider is pursuing duplicate issues in two separate appeals.
[10] Medicare Contractor's Jurisdictional Challenge at Exhibit C-2 page 11 of 20.

Provider has requested (and received) a realignment of its SSI percentage, that is not a final determination from which the Provider can appeal, or with which the Provider can be dissatisfied, as required by 42 C.F.R. § 405.1835(a). Therefore, the Board finds that it does not have jurisdiction over the second aspect of Issue 1 and dismisses the second aspect of Issue 1 pursuant to its authority under 405.1835(b).[11]

*B. Abandonment of Issues 6 through 9*

The Board finds that the Provider failed to brief Issues 6 through 9 in its PPP as required under Board Rules and, as a result, the Provider abandoned Issues 6 through 9. In support of its position that the Provider abandoned these issue, the Medicare Contractor submitted as Exhibit C-2 an excerpt from the Provider's Preliminary Position Paper ("PPP") submitted on February 15, 2018. This excerpt clearly identifies in the "Procedural History" section of the PPP the remaining issues that are being contested in this appeal. Specifically, it identified only Issues 1 to 5 as being in the subject appeal.[12]

As explained in 42 C.F.R. § 405.1868, the Board has the authority both to establish procedural rules governing proceedings before the Board and to enforce these rules:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal.
>
> (b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may—
>
> (1) Dismiss the appeal with prejudice;

In this regard, Board Rule 25.A.1 (2015) specifically lays out the *content* that must be included in the Provider's preliminary position paper:

> 1. For each issue, state the material facts that support your claim. . . .[13]

Similarly, the Commentary to Board Rule 25.A.1 (2015) states: "Unlike the prior practice, preliminary position papers now are expected to present ***fully*** developed positions of the parties

[11] Pursuant to 42 C.F.R. § 405.1835(b), the Board has the authority to dismiss an appeal due to its failure to comply with "the requirements for a Board hearing as specified in" § 405.1835(a) which includes the requirement that the provider's "right to hearing" is limited to appeals of "specific items . . . covered by a final contractor or Secretary ***determination***." (Emphasis added.)

[12] Medicare Contractor's Jurisdictional Challenge at Exhibit C-3 page 2 of 2.

[13] (Emphasis in original.)

and, therefore, require analysis well in advance of the filing deadline."[14] Pursuant to Board Rule 41.2 (2015), "[t]he Board may . . . dismiss a case . . . if it has a reasonable basis to believe that the issues have been fully settled or abandoned. . . [; or] upon failure of the Provider to comply with Board procedures (see 42. C.F.R. § 405.1868)."

The record before the Board is clear that the Provider did not discuss or brief in its PPP the following issues: Issue 6 – DSH Code 2&3 w/o State Aid Code; Issue 7 – DSH Code MB 2&3 w/o State Aid Code; Issue 8 –DSH Understated – Dual Eligible Part C; and Issue 9 –DSH Understated – Dual Eligible Part A. Further, the Provider did not respond to the Medicare Contractor's Jurisdictional Challenge to Issues 6 through 9 and, pursuant to Board Rule 44.4, the Board must make its findings based on the information in the record.[15] As such, the Board must conclude that the Provider does not dispute the Medicare Contractor's characterization of the PPP as supported by the PPP excerpt included at Exhibit C-2. Accordingly, based on the record before the Board, it is clear that the Provider abandoned Issues 6 through 9 and the Board dismisses these issues pursuant to its authority under Board Rule 41.2 and 42 C.F.R. § 405.1868.

**Conclusion**

As explained above, the Board dismisses Issues 1, 6, 7, 8, and 9 from the subject appeal. As there are no more issues remaining in the Case No. 17-1756, the Board hereby closes it 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

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA
Robert Evarts, Esq.
Susan Turner, Esq.

FOR THE BOARD

6/19/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

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

[14] (Emphasis added.)
[15] Board Rule 44.4 (2015) states, in pertinent part: "The responding party must file a response within 30 days of the Intermediary's jurisdictional challenge. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

DEPARTMENT OF HEALTH & HUMAN SERVICES

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**Via Electronic Delivery**

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John Bloom
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RE: ***Dismissal Due to Untimely Filing***
Essentia Health FFY 2019 IPPS Standardized Rate CIRP Group
FFY 2019
Case No. 19-1155GC

Dear Ms. Kim and Mr. Bloom:

The Group Representative, Toyon Associates, Inc. ("Toyon"), established the above-referenced common issue related party ("CIRP") group appeal with six providers that it directly added to the CIRP group appeal. Toyon recognizes that these six providers were not timely added but, notwithstanding, requests that the Provider Reimbursement Review Board ("Board") accept its untimely appeal. As set forth more fully below, the Board is dismissing this appeal as the Providers failed to timely appeal and Toyon has not demonstrated good cause for the untimely appeals (*i.e.*, direct adds).

**Pertinent Facts:**

By electronic submission dated February 13, 2019, the group representative submitted a *Request to Form Group Appeal* ("Request for Hearing" or "RFH") through the Office of Hearings Case and Document Management System ("OH CDMS") in order to establish group appeal assigned to Case No. 19-1155GC. This appeal is based on a Federal Register Notice ("the Notice") dated August 17, 2018. The appeal was established ***exactly*** 180 days after the issuance of the Notice (*i.e.*, February 13, 2019 is the 180th day following August 17, 2018).[1] This

On April 25, 2019, the Medicare Contractor noted that the deadline to file appeals of the Notice was February 13, 2019 and raised concern that there were allegedly no provider included in the group as of the February 13, 2019 filing deadline.[2] In this regard, the Medicare Contractor asserted that the six providers in this CIRP group were *not* added until March 21, 2019, the 216th day following August 17, 2018 (*i.e.*, well after the February 13, 2019 filing deadline).

[1] *See* Provider Request for Appeal, Case No. 19-1155GC (Feb. 13, 2019).
[2] *See* MAC Review of Group Formation Document, Case No. 19-1155GC (Apr. 25, 2019).

Accordingly, the Medicare Contractor maintains that ***all*** of the providers in the group appeals were added on an untimely bases and should be dismissed.[3]

On May 31, 2019, the Group Representative filed a response regarding its apparent untimely submission. The Group Representative maintains that they did attempt to timely add Providers to their appeal on February 13, 2019, 180 days after the issuance of the Notice; however, the Group Representative received a number of errors from the OH CDMS system.[4] As a result, the Group Representative contacted the OH CDMS help desk on February 13, 2019 after logging into the OH CDMS system and seeing that their attempts to add providers on February 13, 2019, was consistently resulting in errors.[5] The resulting Help Desk Ticket and associated assistance is attached as **Exhibit A**.[6]

Notwithstanding having reported the problem right away to the Help Desk, the Group Representative did continue to try and add providers.[7] However, the Group Representative maintains that they continued to experience problems with adding providers to the group via the online system *through the end of March 2019.*[8] The Group Representative recognizes that they were able to add the 6 providers to this appeal on March 21, 2019 after many unsuccessful attempts.

The record from the OH CDMS Help Desk (*see* Attachment A) demonstrates that, starting on February 13, 2019, the OH CDMS Help Desk worked with the Provider to resolve the reported issue, and, in this regard, issued instructions to the Group Representative to permit third-party cookies in their web browser. On March 5, 2019, the OH CDMS Help Desk notified the Group representative that it considered the incident resolved as the Help Desk was unable to replicate the issue.[9]

**Board's Determination:**

The Board's enabling statute at 42 U.S.C. § 1395oo(a)(3) requires an appeal be filed "*within 180 days after notice of the . . . Secretary's final determination*."[10] Similarly, pursuant to 42 C.F.R. § 405.1835(a)(3), the Board must receive a Provider's hearing request no later than 180 days after the date of receipt of the final determination, unless pursuant to 42 C.F.R. § 405.1836, a Provider qualifies for a good cause extension. Here, the Providers appealed a Federal Register Notice which was the Secretary's final notice of the IPPS rates for the Federal fiscal year 2019. As explained below, a provider is presumed to receive Federal Register Notices upon their

[3] *Id*.
[4] *See* Provider Response to MAC Review (May 21, 2019).
[5] *Id*., Attachment A.
[6] The OH CDMS Help Desk opened Ticket 562 to track the issue and include the emails sent to the caller, summaries of phone calls, and development notes (hereinafter "Help Desk Ticker"), attached as Exhibit A.
[7] *Id*.
[8] *See* provider Response to Medicare Contractor Review at 1.
[9] *Id*., Attachment B. (The Help Desk could not replicate the issue, and recommended a course of action for future issues related to this incident).
[10] (emphasis added).

publication, and, as such, the deadline for filing an appeal of a Federal Register Notice is 180-days from the publication date of that notice.

The Board is bound by all of the provisions of Title XVIII of the Act (the Social Security Act, as amended) and the regulations issued thereunder.[11] The Board cannot apply a regulation or instruction which is contrary to a statute and other regulations that deal specifically with the matter at hand: the date a provider is deemed to have notice of the contents of the Federal Register. In this case, the laws and regulations governing the publication of Federal Register notices specifically define the time of notice as that of publication. These laws and regulations have been incorporated into Title XVIII.

The Secretary[12] has enacted Part 401 of Title 42 of the Code of Federal Regulations which is entitled "General Administrative Requirements." Subpart B, sections 401.101(a)(1) and (2) of this Part states that "[t]he regulations in this subpart: (1) Implement section 1106(a)[13] of the Social Security Act [relating to disclosure of information] as it applies to [CMS] . . . [and] (2) Relate to the availability to the public, under 5 U.S.C. § 552,[14] of records of CMS." These laws and regulations set out which records are available and how they may be obtained, and they supplement the regulations of CMS relating to the availability of information. Section 401.106 of this subpart, which deals with publication of materials under 5 U.S.C. § 552, *requires publication to serve as notice and identifies the Federal Register as the vehicle to be used to give notice.* Section 552(a) states in part that:

> (1) Each agency shall separately state and currently publish in the Federal Register for the guidance of the public-
>
> ****
>
> (D) substantive rules of general applicability adopted as authorized by law, and statements of general policy or interpretations of general applicability formulated and adopted by the agency; and
>
> (E) each amendment, revision, or repeal of the foregoing.

In order to comply with the statutes and regulations requiring that public notice be given, CMS publishes the schedules of the Prospective Payment System ("PPS") rates in the Federal Register pursuant to the requirements of 42 C.F.R. § 412.8(b)(2). This regulation was created to comply with 5 U.S.C. § 552 of the Freedom of Information Act which requires that agencies publish regulations and notices in the Federal Register.[15]

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[11] *See* 42 C.F.R. § 405.1867.
[12] Of the Department of Health and Human Services.
[13] 42 U.S.C. § 1306(a).
[14] 5 U.S.C. § 550 *et seq.* contains the Administrative Procedures Act; 5 U.S.C. § 552 deals with the availability of government information and is known as the Freedom of Information Act (FOIA).
[15] *See also* 42 C.F.R. Part 401, Subpart B.

With regard to the notices published in the Federal Register, 44 U.S.C. § 1507 states in part that:

> A document required. . .to be published in the Federal Register is not valid as against a person who has not had actual knowledge of it until the duplicate originals or certified copies of the document have been filed with the Office of the Federal Register and a copy made available for public inspection as provided by section 1503. . . . *[F]iling of a document, required or authorized to be published [in the Federal Register] by section 1505. . .is sufficient to give notice* of the contents of the document to a person subject to or affected by it.[16]

Reflecting new technology and the ability to transmit information immediately upon publication, the Government Printing Office ("GPO") promulgated 1 C.F.R. § 5.10 which authorizes publication of the Federal Register on the internet on the GPO website.[17] The GPO website containing the Federal Register is updated daily at 6 a.m. Monday through Friday, except holidays.[18] Consequently, ***the Provider is deemed to have notice of the standardized amount on the date the Federal Register was published and made available online***.[19]

With respect to statutes and regulations dealing with the Federal Register, the Supreme Court has found that:

> Congress has provided that the appearance of rules and regulations in the Federal Register give legal notice of their contents . . . .
>
> Regulations [are] binding on all who sought to come within the [Act], regardless of actual knowledge of what is in the Regulations or of the hardship resulting from innocent ignorance.[20]

The statutes governing the Board (44 U.S.C. § 1507 as applied through the requirements of 42 C.F.R. § 401.101 and the Administrative Procedures Act ("APA")) are clear on their face: the date of publication of the Federal Register is the date the Providers are deemed to have notice of the IPPS rules including the Standardized Amount. The Board is bound by all of the provisions of Title XVIII which includes, by reference, the provisions of the Administrative Procedures Act and the Public Printing and Documents law which require that CMS publish its notices and

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[16] (Emphasis added).
[17] *See also* 44 U.S.C. § 4101 (the Superintendent of Documents is to maintain an electronic director and system of online access to the Federal Register).
[18] *See* http://www.gpo.gov/help/index.html#about_federal_register.htm.
[19] While there is the official publication date (*e.g.*, the official publication date of the FY 2019 IPPS final rule is August 17, 2018), it is the Board's understanding that the GPO (or the sponsoring agency) may post a copy of a rulemaking several days in advance of the official publication date. The Board considers the official publication date as the official notice to the public and, as such, 180-day clock starts from the official publication date regardless of whether it may have been posted in advance.
[20] *Fed. Crop Ins. Corp. v. Merrill*, 332 U.S. 380, 385 (1947).

regulations in the Federal Register. In publishing materials in the Federal Register, CMS must comply with the statutes and regulations governing the Superintendent of Documents and the Governing Printing Office. Pursuant 42 U.S.C. § 1395oo(a)(3), the Board's enabling statute, providers have 180 days "after *notice* of the Secretary's final determination" to file an appeal. In this case, the notice of the Secretary's determination is, by law, the date the Federal Register is issued by the Superintendent of Documents. This is reflected in Board Rule 4.3.2 which states:

> The date of receipt of a Federal Register Notice is the date the Federal Register is published. The appeal period begins on the date of publication and ends 180 days from that date.

As a result, each of the Providers in the above-captioned group appeal needed to file its hearing request within 180 days of the publication of the Federal Register notice. In this appeal, the 180th day fell on February 13, 2019. While the Group Representative established these group appeal on the February 13, 2019 filing date, the Group Representative did not add any of the provider by this deadline. Accordingly, the question becomes whether the Group Representative has established good cause to warrant extension of this time limit in accordance with 42 C.F.R. § 405.1836.

In its response to the Medicare Contractor's challenge, the Group Representative asserts that the groups were untimely filed:

> [T]he Board's rules provide for the fact that groups may be formed with no providers, at least initially. The "Commentary" in the Board Rules for Rule 12.2 specifically states that "if a group is to be formed solely through transfers, it may initially be established in OH CDMS with no participating providers." While this case involved direct additions of providers, rather than transfers, clearly the Board acknowledges that groups are able to be formed without providers, and the Board did not say such groups would be considered improperly initiated until providers were added.[21]

However, the Board finds that the Group Representative made an incomplete analysis of Board Rules. In this regard, the Board notes that Board Rule 12.6 simply addresses the *number* of Providers required establish a group. In connection with CIRP groups, Board Rule 12.6.1 states that: "[a] CIRP group may be initiated by a single provider under common ownership or control, but at least two different providers must be in the group upon full formation.[22] Similarly, in connection with optional groups, Board Rule 12.6.2 states that: "[o]ptional group appeals must have a minimum of two different providers, both at inception and at full formation of the group."[23] These Board Rules do not (and cannot) alter the statutory and regulatory requirement

[21] *See* Providers' Response to Medicare Contractor Review at 2.
[22] PRRB Rule 12.6.1 (Aug. 29, 2018).
[23] *Id.* at Rule 12.6.2.

that each provider participating within a group must meet the 180-day filing requirement. In this regard, Board Rule 16.2.1 states:

> Direct add requests submitted through OH CDMS may be initiated in conjunction with a new group appeal request or within an existing group. *The request must include the same information required for a provider filing* ***an individual appeal***, including the determination and issue-specific information addressed in Rule 7, plus a copy of the representative letter associated with the group appeal.[24]

Further, the Board notes that the Group Representative failed to recognize in its analysis the remaining content of the Commentary to Board Rule 12.1 which states the following:

> Accordingly, if a group is to be formed solely through transfers, it may initially be established in OH CDMS with no participating providers. In such cases, the *providers* ***must*** *be transferred immediately following the establishment of the group case in order to fulfill the regulatory requirement for the minimum number of providers* per Rule 12.6. The Board will close all group cases that do not meet the minimum participant requirements.[25]

With regard to a good cause extension, 42 C.F.R. § 405.1836(b) (2019), states in pertinent part:

> The Board may find good cause to extend the time limit only if the provider demonstrates in writing it *could not reasonably be expected to file timely due to extraordinary circumstances beyond its control* (such as a natural or other catastrophe, fire, or strike), and the provider's written request for an extension is received by the Board within a reasonable time (as determined by the Board under the circumstances) after the expiration of the applicable 180-day limit . . . .[26]

As noted above, the Providers filed correspondence along with the Request for Hearing noting that they completed and submitted the online application for all the above mentioned appeals on February 13, 2019, but were unable to add at least one provider in all but one appeal on that same day.[27] The Group Representative claims that, when they attempted to directly add the Providers, OH CDMS malfunctioned and did not allow them to add the providers.[28] The Group

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[24] (Emphasis added).
[25] PRRB Rule 12.1 Commentary (emphasis added).
[26] 42 C.F.R. § 405.1836(b) (emphasis added).
[27] Providers' Response to Medicare Contractor Jurisdictional Review.
[28] *Id.*

Representative has submitted to the Board the "incident" ticket from the OH CDMS help desk, dated February 13, 2019.

In addition to reporting the problem immediately to the Help Desk on February 13, 2019, the Group Representative claims that they continued to try and add providers unsuccessfully for the most part. As previously noted, the OH CDMS Help Desk immediately assisted the Group Representative and, following this help, notified the Group Representative on March 5, 2019 that it considered the Group Representative's incident resolved after the Help Desk was unable to replicate the issue. Significantly, the records establish that following the Help Desk's March 5, 2019 notice, the Group Representative did not contact the Help Desk with any other issues.

Notwithstanding, the Group Representative claims to have experienced continued problems with adding providers to the group via the online system through the end of March 2019. In this regard, the Group Representative insists that it directly added all of the providers to each of the above-captioned groups as soon as possible once the computer issues were resolved and they could get the system to work. They claim that any purportedly untimely addition of providers to this group appeal was not their fault and to hold them responsible as such would be extremely prejudicial and inequitable.[29] Finally, the Group Representative provided an email noting previous systems issues that they had with OH CDMS.

The Board finds that March 5, 2019 is the inflection point for the Provider's request for good cause exception because this is the date that the Help Desk reported that the Group Representative's filing issue had been resolved and because, subsequent to that date, the Group Representative did not report ***any*** continued filing difficulties to the Help Desk. Accordingly, the Board finds that there is no good cause to excuse untimely filing for the providers in this appeal as they were directly added after March 21, 2019 because such providers were directly added well after the Help Desk Ticket was closed on March 5, 2019.

Based on the above, the Board hereby dismisses all six of the providers in this CIRP group appeal, pursuant to Board Rule 12.6 and 42 C.F.R. §§ 405.1835(b),[30] 405.1836 and 405.1868. As there are no remaining providers in Case No. 19-1155GC, the Board closes it and removes it 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.

[29] *Id.*
[30] Pursuant to 42 C.F.R. § 405.1835(b), the Board has the authority to dismiss an appeal due to its failure to comply with "the requirements for a Board hearing as specified in" § 405.1835(a) which includes the 180-day filing requirement in paragraph (a)(3).

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

6/19/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

**Via Electronic Delivery**

Corinna Goron
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Pam VanArsdale
Nat'l Gov. Servs., Inc.
MP: INA 101-AF42
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RE: ***Jurisdictional Challenges***
NYU Langone Hospitals (Prov. No. 33-0214)
FYE 12/31/06
Case No. 19-2022

Central Maine Medical Center (Prov. No. 20-0024)
FYE 06/30/07,
Case No. 19-2103

Dear Ms. Goron and Ms. VanArsdale:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the jurisdictional documents in the above-referenced appeals. The Board finds that it does not have jurisdiction over the standardized payment amount issue in the above-referenced appeals.

**Background**

On October 25, 2018, the Medicare Contractor issued a Notice of Reopening of Cost Report ("NOR") to Central Maine Medical Center ("Central") for its fiscal year ending ("FYE") June 30, 2007 ("FY 2007"). The NOR provided: "we are hereby reopening your cost report for the following reason(s):

- To include the allowable Medicare crossover bad debts that relate to unpaid deductibles and coinsurance amounts for dual eligible QMB patients for both Inpatient and Outpatient in accordance with Medicare regulation 42 CFR Section 413.89. . . ."

Similarly, on November 2, 2018, the Medicare Contractor issued a NOR to NYU Langone Hospitals ("NYU") for its FYE December 31, 2006 ("FY 2006"). The NOR provided: "we are hereby reopening your cost report for the following reason(s):

- To review the DSH payment calculation for the realigned SSI based on the cost reporting period[.]"

Subsequently, the Medicare Contractor issued a revised NPR to NYU on December 11, 2018, and a revised NPR to Central on December 20, 2018. As a result, NYU and Central timely filed an appeal with the Board from their revised NPRs on June 7, 2019 and June 24, 2019 respectively. Both providers appealed one issue: the standardized payment amount issue for Inpatient Prospective Payment System ("IPPS"). The Board assigned Case No. 19-2022 to NYU's appeal and Case No. 19-2103 to Central's appeal.

On February 26, 2020, the Medicare Contractor filed a jurisdictional challenge in Case No. 19-2022; and on May 20, 2020, the Medicare Contractor filed a jurisdictional challenge in Case No. 19-2103. Both jurisdictional challenges contest the Board's jurisdiction over the standardized payment amount issue. On March 27, 2020, NYU filed a response to the Medicare Contractor's jurisdictional challenge.

**Medicare Contractor's Position**

In both jurisdictional challenges the Medicare Contractor contends that the Board does not have jurisdiction over the standardized payment amount issue because it did not make an adjustment to this amount in the revised NPRs. The Medicare Contractor argues an appeal of a revised final determination is limited to the matters specifically revised in that determination.[1]

The Medicare Contractor maintains in Case No. 19-2022, NYU's NOR letter indicates that the reopening is "to review the [disproportionate share hospital] DSH payment calculation for the realigned [Supplemental Security Income] SSI based on the cost reporting period." The Medicare Contractor contends the revised NPR audit adjustment report includes the following adjustments:

1. Adjustment No. 1 – To adjust the Supplemental Security Income (SSI) percentage and Medicare Disproportionate Share Hospital (DSH) percentage for operating DSH on Worksheet E, Part A 2.
2. Adjustment No. 2 – To report previous payment data 3.
3. Adjustment No. 3 – To adjust the SSI percentage for capital DSH on Worksheet L

The Medicare Contractor argues it did not render a final determination over the standardized payment amount in the revised NPR;[2] the adjustments made for the revised NPR do not render a final determination over the standardized payment amount issue.[3] The Medicare Contractor contends the Board holds jurisdiction only over issues that have been specifically revised in a revised NPR.[4] As such, NYU's appeal of this issue is improper and should be dismissed.[5]

[1] The Medicare Contractor February 26, 2020 and May 20, 2020 Jurisdictional Challenges at 1.
[2] The Medicare Contractor February 26, 2020 Jurisdictional Challenge at 1-2.
[3] *Id.* at 4.
[4] *Id.* at 5.
[5] *Id.* at 2, 5.

Similarly, the Medicare Contractor maintains that, in Case No. 19-2103, Central filed its appeal based on the revised NPR that was issued December 20, 2018; the revised NPR was issued as a result of an administrative resolution of group Case No. 14-4046G. The Medicare Contractor contends Central's NOR letter issued on October 25, 2018, indicates that the purpose of the reopening is to "include the allowable Medicare crossover bad debts that relate to unpaid deductibles and coinsurance amounts for dual eligible QMB patients for both Inpatient and Outpatient . . . [t]his implements the Administrative Resolution dated 9/12/2018, for PRRB Case 14-4046G." The Medicare Contractor maintains the only adjustment it proposed pertained to Medicare crossover bad debts related to unpaid deductibles and coinsurance amounts for dual eligible QMB patients. The Medicare Contractor argues it did not render a final determination over the standardized payment amount in the revised NPR;[6] the adjustments for the revised NPR do not render a final determination over the standardized payment amount issue.[7] As such, Central's appeal of this issue is improper and should be dismissed.[8]

**Providers' Position**

Central has not filed a jurisdictional response to the Medicare Contractor's jurisdictional challenge.

In its response, NYU contends the Board has jurisdiction over the standardized payment amount issue appealed from the revised NPR based on *Bethesda Hosp. Assoc. v. Bowen*, 485 U.S. 399 (1988). NYU maintains under § 1395oo(a)(1)(A)(i), a provider's dissatisfaction with the amount of total reimbursement is a condition to the Board's jurisdiction. NYU asserts the Medicare statute at 42 U.S.C. § 1395ww(d)(2) states that the standardized amount must reflect the allowable operating costs per discharge incurred by hospitals nationwide for the base year in which it is calculated.

NYU contends the Secretary attempted to comply with this directive by dividing hospitals' standardized allowable-Medicare costs as reported in their 1981 cost reports by their number of Medicare discharges during the same period. However, the 1981 cost report data did not distinguish between true discharges, where the patient's acute care treatment is complete, and transfers, where a patient is sent to another department or hospital because the patient requires further treatment beyond the capabilities of the original admitting facility. NYU argues as a result, the number of discharges used in the calculation of the standardized amount was overstated; because this error has not been corrected, the flawed data has remained embedded in the IPPS system and hospital's total Medicare reimbursement has been understated in each succeeding year, continuing today.

NYU maintains the initial computational error at the inception of the IPPS has never been corrected. As each year's standardized amount is updated based on the previous year's amount, the standardized amount has been lower than it should have been in every year since the

[6] The Medicare Contractor May 20, 2020 Jurisdictional Challenge at 1-2.
[7] *Id.* at 4.
[8] *Id.* at 2.

inception of IPPS. NYU contends providers do not have access to the underlying data required to determine precise amount of additional Medicare reimbursement due to it as a result of the above-referenced errors amounting in at least one percent. NYU concludes that the Board does have jurisdiction over it as the requirements for dissatisfaction have been met.[9]

**Decision of the Board**

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885(a)(1) (2018) provides in relevant part:

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

42 C.F.R. § 405.1889 (2018) explains the effect of a cost report revision:

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

In the instant case, the Medicare Contractor issued a NOR to NYU which stated that it was reopening NYU's cost report for the FYE December 31, 2006, to review the DSH payment calculation for the realigned SSI based on the cost reporting period. The Medicare Contractor

[9] Provider's March 27, 2020 Jurisdictional Response at 1-2. NYU cites to *Norwalk Hospital v. Blue Cross Blue Shield Association/National Government Services, Inc.*, PRRB Dec. 2012-D14 (March 19, 2012) "the practical difficulties in getting information" creates circumstances in which a provider may demonstrate it is dissatisfied with the Intermediary's determination of reimbursement despite not having made a claim on the cost report.

made an adjustment to NYU's SSI percentage and DSH percentage (Audit Adjustment No. 1) in their revised NPR. No adjustment was made by the Medicare Contractor to the standardized payment amount. Similarly, the Medicare Contractor also issued a NOR to Central which stated that the Medicare Contractor was reopening Central's cost report for the FY 2007, to include the allowable Medicare crossover bad debts that relate to unpaid deductibles and coinsurance amounts for dual eligible QMB patients for both inpatient and outpatient. The Medicare Contractor made an adjustment to reimbursable bad debts and reimbursable bad debts for dual eligible beneficiaries (Audit Adjustment No. 6) in their revised NPR. No adjustment was made by the Medicare Contractor to the standardized payment amount.

The regulation at 42 C.F.R. § 405.1889 makes it clear that only those matters that are *specifically* revised in a revised determination are within the scope of any appeal of the revised determination. Any matter that is not specifically revised may not be considered in any appeal of the revised determination. NYU and Central have appealed the standardized payment amount issue from their revised NPRs, however this issue was not specifically revised by the Medicare Contractor in their revised NPRs. As such, the Board finds that it lacks jurisdiction over the standardized payment amount issue and dismisses the issue from both Case Nos. 19-2022 and 19-2103. As the standardized payment amount issue is the only issue in these appeals, the Board hereby closes Case Nos. 19-2022 and 19-2103 and removes them 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.

Board Members participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA
Robert Evarts, Esq.
Susan Turner, Esq.

FOR THE BOARD

6/19/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

**Via Electronic Delivery**

Nancy Repine
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Morgantown, WV 26506

**RE:** ***Jurisdictional Challenge***
West Virginia University Hospitals, Inc. (51-0001)
FYE: 12/31/2014
PRRB Case: 17-2208

Dear Ms. Repine,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above referenced appeal and finds that it does not have jurisdiction over the DSH/SSI – Provider Specific issue. The jurisdictional decision of the Board is set forth below.

**Pertinent Facts:**

On September 14, 2017, the Board received the Provider's Individual Appeal Request appealing their March 17, 2017 Notice of Program Reimbursement ("NPR") for fiscal year ending December 31, 2014. The initial appeal contained two (2) issues.[1] The DSH/SSI Systemic errors issue has been transferred to a group appeal (Case No. 18-1332GC). The issue remaining in the appeal is the DSH/SSI Provider Specific issue.

The Provider summarizes its DSH/SSI – Provider Specific issue as follows:

> The provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[2]

[1] Model Form B – Group Appeal Request (Aug. 14, 2018).
[2] *See* Exhibit I-3.

The Provider described its DSH/SSI issue, which has been transferred to a group appeal for DSH/SSI Systemic Errors, as "as "[w]hether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage." More specifically, Provider lists the following reasons for challenging its SSI percentage:

1. Availability of MEDPAR and SSA records,
2. Paid days vs. Eligible Days,
3. Not in agreement with provider's records,
4. Fundamental problems in the SSI percentage calculation,
5. Covered days vs. Total days and
6. Failure to adhere to required notice and comment rulemaking procedures.[3]

On August 14, 2018, the Board received a jurisdictional challenge filed on behalf of the Medicare Contractor which argued that the Board lacks jurisdiction over the DSH/SSI Provider Specific issue because it is duplicative of the issue which was transferred to case 18-1332GC. The Medicare Contractor also argues that the decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election, not an appealable Medicare Contractor determination, and since the Provider did not request an SSI realignment, appealing this issue is premature since there was no final determination.[4]

**Board Decision**

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2017), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Board finds that it does not have jurisdiction over the DSH/SSI Percentage (Provider Specific) issue. The jurisdictional analysis for Issue No. 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage (Systemic Errors) issue that was transferred to Group Case No. 18-1332GC.

The DSH/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital Calculation."[5] The Provider's legal basis for its DSH/SSI (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[6] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . specifically disagrees with the [Medicare Contractor]'s calculation of the

[3] Exhibit I-4 at 14.
[4] Medicare Administrative Contractor's Jurisdictional Challenge (Aug. 14, 2018).
[5] Model Form A – Individual Appeal Request (Sep. 14, 2017).
[6] *Id.*

computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[7]

The Provider's DSH SSI Percentage (Systemic Errors) issue in group Case No. 18-1332GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F) and 42 C.F.R. § 412.106. Thus, the Board finds that the DSH SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH SSI Percentage (Systemic Errors) issue in Case No. 18-1332GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.5 (2015), the Board dismisses this aspect of the DSH/SSI Percentage (Provider Specific) issue.

The second aspect of the DSH SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board for lack of jurisdiction. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment.

As the SSI Provider Specific issue is the last issue in the appeal, Case No. 17-2208 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.

Board Members:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

6/22/2020

X Gregory H. Ziegler

Gregory H. Ziegler, CPA
Board Member
Signed by: Gregory H. Ziegler -S

cc: Wilson C. Leong, Esq., Federal Specialized Services
Laurie Polson, Palmetto GBA c/o National Government Services, Inc. (J-M)

[7] *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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**Via Electronic Delivery**

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RE: ***Rescinding 6/19/20 Jurisdictional Decision and Issuing Revised Jurisdictional Decision***
NYU Langone Hospitals (Prov. No. 33-0214)
FYE 12/31/2006
PRRB Case No. 19-2022

Dear Ms. Goron and Ms. VanArsdale:

On June 19, 2020, the Provider Reimbursement Review Board ("PRRB" or "Board") issued a jurisdictional decision in both the above-referenced appeal and Case No. 19-2103, Central Maine Medical Center, Provider No. 20-0024, fiscal year end ("FYE") 06/30/07 and therein found that it does not have jurisdiction over the standardized payment amount issue in these appeals. The Board hereby rescinds its June 19, 2020 jurisdictional decision because the jurisdictional decision as it pertains to *Case No.* ***19-2103*** was issued ***in error*** since that the appeal had already been withdrawn and closed on June 4, 2020.[1] The Board reissues its jurisdictional decision for ***Case No. 19-2022 only***. The Board's jurisdictional decision for Case No. 19-2022 is set forth below.

**Background**

On November 2, 2018, the Medicare Contractor issued a Notice of Reopening of Cost Report ("NOR") to NYU Langone Hospitals ("NYU") for its FYE December 31, 2006 ("FY 2006"). The NOR provided: "we are hereby reopening your cost report for the following reason(s):

- To review the DSH payment calculation for the realigned SSI based on the cost reporting period[.]"

Subsequently, on December 11, 2018, the Medicare Contractor issued a revised Notice of Program Reimbursement ("NPR") to NYU. As a result, on June 7, 2019, NYU timely filed an appeal with the Board from its revised NPR and the appeal contained only one issue – the standardized payment amount issue for Inpatient Prospective Payment System ("IPPS"). The Board assigned Case No. 19-2022 to NYU's appeal.

[1] The Board concurrently is issuing notice in Case No. 19-2103 of this rescission.

On February 26, 2020, the Medicare Contractor filed a jurisdictional challenge in Case No. 19-2022. The jurisdictional challenge contests the Board's jurisdiction over the standardized payment amount issue. On March 27, 2020, NYU filed a response to the Medicare Contractor's jurisdictional challenge.

**Medicare Contractor's Position**

In the jurisdictional challenge the Medicare Contractor contends that the Board does not have jurisdiction over the standardized payment amount issue because it did not make an adjustment to this amount in the revised NPR. The Medicare Contractor argues an appeal of a revised final determination is limited to the matters specifically revised in that determination.[2]

The Medicare Contractor maintains in Case No. 19-2022, NYU's NOR letter indicates that the reopening is "to review the [disproportionate share hospital] DSH payment calculation for the realigned [Supplemental Security Income] SSI based on the cost reporting period." The Medicare Contractor contends the revised NPR audit adjustment report includes the following adjustments:

1. Adjustment No. 1 – To adjust the Supplemental Security Income (SSI) percentage and Medicare Disproportionate Share Hospital (DSH) percentage for operating DSH on Worksheet E, Part A 2.
2. Adjustment No. 2 – To report previous payment data 3.
3. Adjustment No. 3 – To adjust the SSI percentage for capital DSH on Worksheet L

The Medicare Contractor argues that it did not render a final determination over the standardized payment amount in the revised NPR[3] and that the adjustments made for the revised NPR do not render a final determination over the standardized payment amount issue.[4] The Medicare Contractor contends that, pursuant to the regulations at 42 C.F.R. § 405.1889 governing appeals of revised determinations, the Board has jurisdiction only over issues that have been specifically revised in a revised NPR.[5] As such, NYU's appeal of this issue is improper and should be dismissed.[6]

**Provider's Position**

In its response, NYU contends the Board has jurisdiction over the standardized payment amount issue appealed from the revised NPR based on *Bethesda Hosp. Assoc. v. Bowen*, 485 U.S. 399 (1988). NYU maintains under § 1395oo(a)(1)(A)(i), a provider's dissatisfaction with the amount of total reimbursement is a condition to the Board's jurisdiction. NYU asserts the Medicare statute at 42 U.S.C. § 1395ww(d)(2) states that the standardized amount must reflect the

[2] The Medicare Administrative Contractor February 26, 2020 Jurisdictional Challenge at 1.
[3] *Id.* at 1-2.
[4] *Id.* at 4.
[5] *Id.* at 5.
[6] *Id.* at 2, 5.

allowable operating costs per discharge incurred by hospitals nationwide for the base year in which it is calculated.

NYU contends the Secretary attempted to comply with this directive by dividing hospitals' standardized allowable-Medicare costs as reported in their 1981 cost reports by their number of Medicare discharges during the same period. However, the 1981 cost report data did not distinguish between true discharges, where the patient's acute care treatment is complete, and transfers, where a patient is sent to another department or hospital because the patient requires further treatment beyond the capabilities of the original admitting facility. NYU argues as a result, the number of discharges used in the calculation of the standardized amount was overstated; because this error has not been corrected, the flawed data has remained embedded in the IPPS system and hospital's total Medicare reimbursement has been understated in each succeeding year, continuing today.

NYU maintains the initial computational error at the inception of the IPPS has never been corrected. As each year's standardized amount is updated based on the previous year's amount, the standardized amount has been lower than it should have been in every year since the inception of IPPS. NYU contends providers do not have access to the underlying data required to determine precise amount of additional Medicare reimbursement due to it as a result of the above-referenced errors amounting in at least one percent. NYU contends that the Board does have jurisdiction over it as the requirements for dissatisfaction have been met.[7]

**Decision of the Board**

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885(a)(1) (2018) provides in relevant part:

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

42 C.F.R. § 405.1889 (2018) explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in § 405.1885 of this subpart, the

[7] Provider's March 27, 2020 Jurisdictional Response at 1-2. NYU cites to *Norwalk Hospital v. Blue Cross Blue Shield Association/National Government Services, Inc.*, PRRB Dec. 2012-D14 (March 19, 2012) "the practical difficulties in getting information" creates circumstances in which a provider may demonstrate it is dissatisfied with the Intermediary's determination of reimbursement despite not having made a claim on the cost report.

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

In the instant case, the Provider appealed the standardized payment amount from a revised NPR. The Provider described the standardize payment amount issue as follows:

> The base rate used 1981 hospital cost reporting data, and was first developed in 1983 for use in the 1984 fiscal year. The base rate was partially determined by the average cost-per-discharge. 42 U.S.C. § 1395ww(d)(2). The base year 1981 data did not distinguish between patient discharges and patient transfers. Both were classified as discharges. Therefore, the 1981 data over-counted discharges, by including both discharges and transfers in the baseline data.
>
> The result of this error was to spread total operating costs over an artificially high number of discharges, thereby yielding a lower average cost-per-discharge. This in turn lead to a base rate that was lower than it would have been had the total number of patient discharges been accurately computed. As this error in the base rate has never been corrected, the standardized payment amount has been lower than it should have been in every year since 1984. Accordingly, for the reason stated above, provider hereby appeals the standardized payment amount for the years at issue in this cost report.

To reopen the original NPR, the Medicare Contractor issued a NOR to NYU which stated that it was reopening NYU's cost report for the FYE December 31, 2006, to review the DSH payment calculation for the realigned SSI based on the cost reporting period. The Medicare Contractor made an adjustment to NYU's SSI percentage and DSH percentage (Audit Adjustment No. 1) in its revised NPR. However, no adjustment was made by the Medicare Contractor to the standardized payment amount.[8]

[8] The Federal rates originally paid on the DRG payments for FY 2006 remained the same.

The regulation at 42 C.F.R. § 405.1889 makes it clear that only those matters that are *specifically* revised in a revised determination are within the scope of any appeal of the revised determination. Any matter that is not specifically revised may not be considered in any appeal of the revised determination. NYU has appealed the standardized payment amount issue from its revised NPR; however this issue was not specifically revised by the Medicare Contractor in its revised NPR. As such, the Board finds that it lacks jurisdiction over the standardized payment amount issue and dismisses the issue from Case No. 19-2022. As the standardized payment amount issue is the only issue in this appeal, the Board hereby closes Case No. 19-2022 and removes it 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.

Board Members participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA
Robert Evarts, Esq.
Susan Turner, Esq.

FOR THE BOARD

6/29/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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**Via Electronic Delivery**

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RE: **Rescission of June 19, 2020 Jurisdictional Decision**
Central Maine Medical Center (Prov. No. 20-0024)
FYE 06/30/07
PRRB Case No. 19-2103

Dear Ms. Goron and Ms. VanArsdale:

On June 19, 2020, the Provider Reimbursement Review Board ("PRRB or Board") issued a jurisdictional decision addressing both the above-referenced appeal and Case No. 19-2022, NYU Langone Hospitals, Provider No. 33-0214, fiscal year end ("FYE") 12/31/06 and therein found that it does not have jurisdiction over the standardized payment amount issue in these appeals.

However, the Board issued the jurisdictional decision for *Case No. 19-2103* ***in error*** because, on June 4, 2020, the Provider Representative submitted a request to the Board to withdraw Case No. 19-2103 and, on the same day, the Board immediately processed the Provider Representative's withdrawal request and closed the case. Accordingly, the Board rescinds its June 19, 2020 jurisdictional decision for Case No. 19-2103 and Case No. 19-2103 remains closed.

Board Members:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

6/29/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

cc: Wilson Leong, Federal Specialized Services