DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: N2-19-25
Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

Healthcare Reimbursement Services, Inc.
Corinna Goron
C/O Appeals Department
17101 Preston Rd., Ste. 220
Dallas, TX 75248-1372

Novitas Solutions, Inc. (J-H)
Justin Lattimore
707 Grant Street, Suite 400
Pittsburgh, PA 15219

RE: ***Jurisdictional Decision***
Lafayette General Health CY 2011 Standardized Payment Amount CIRP Group
Case No. 19-1934GC

Dear Ms. Goron and Mr. Lattimore,

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

Background

The group appeal that was filed by the Provider[1] with the Board contains the following group issue statement:

> The Provider(s) contend(s) that the MAC's determination for their standardized payment amount was calculated improperly and set too low based on erroneous methodology.
>
> Under the Inpatient Prospective Payment System, hospitals are paid a fixed amount for each Medicare beneficiary that they treat, "regardless of the actual operating costs they incur." *See Sebelius v. Auburn Reg'l Med. Ctr.*, 568 U.S. 145, 133 S. Ct. 817, 822, 184 L. Ed. 2d 627 (2013). This fixed amount is calculated by starting with a base rate that is then adjusted in various ways for each specific beneficiary at each specific hospital. See 42 U.S.C. § 1395ww(d)(2).
>
> 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.

[1] There is currently only one participant in this group appeal.

> 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.

There is one Participant in this group appeal. This Participant has appealed from a Revised Notice of Program Reimbursement ("RNPR").

Participant #1 – Lafayette General Medical Center

Lafayette General Medical Center was added to the group case on May 17, 2019. The Notice of Reopening of Cost Report (March 27, 2018) states the cost report was reopened with the intent to "review Medicaid eligible days (and total days, if necessary) used in the calculation of the Disproportionate Share Hospital (DSH) Adjustment. We will then recalculate the DSH Payment Percentage."

Lafayette General Medical Center's RNPR, dated November 19, 2018, included adjustments "To adjust the hospital DSH payment percentage to include the allowable additional Medicaid eligible days."

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is $10,000 or more (or $50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

Relevant Regulations – Revised NPRs

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), which 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) of this subpart) 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. . . .

Additionally, 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.[2]

Similarly, 42 C.F.R. § 405.1835 incorporates these limitations into the provider's right to a Board hearing:

> (a) *Right to hearing on final contractor determination.* A provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. Exception: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).

The Board finds that it does not have jurisdiction under 42 C.F.R. § 405.1835(a) over the participant in this appeal because the participant appealed from a RNPR that did not adjust the standardized payment amount (*i.e.*, the base rates underling the DRG rates published annually in the Federal Register).

[2] (Emphasis added.)

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[3] The audit adjustments associated with the RNPR under appeal clearly only related to and adjusted the DSH percentage (specifically only adjusted the Medicaid eligible days used in the Medicaid fraction of the DSH adjustment calculation). The Notice of Reopening explicitly stated the reason for reopening, namely to "review Medicaid eligible days (and total days, if necessary) used in the calculation of the Disproportionate Share Hospital (DSH) Adjustment." Since the matters specially revised in the revised NPR were adjustments related to DSH percentage adjustments (rather than the standardized payment amount), the Board finds that it does not have jurisdiction under 42 C.F.R. § 405.1835(a) over the participant in the subject group appeal. The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[4]

In conclusion, Lafayette General Medical Center is dismissed from the appeal because they do not have the right to appeal the RNPR at issue under 42 C.F.R. §§ 405.1835(a) and 405.1889. As there are no participants remaining, the Board hereby closes Case No. 19-1934GC and removes it from the Board's docket.

Board Members Participating:

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

FOR THE BOARD:

9/2/2020

X Clayton J. Nix

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

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

[3] 42 C.F.R. § 405.1889(b)(1).
[4] *See also St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

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Novitas Solutions, Inc. (J-H)
Justin Lattimore
707 Grant Street, Suite 400
Pittsburgh, PA 15219

RE: ***Jurisdictional Decision***
Memorial Hermann CY 2013 Standardized Payment Amount CIRP Group
Case No. 20-0255GC

Dear Ms. Goron and Mr. Lattimore,

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

Background

October 29, 2019, the Providers filed this group appeal with the Board. The group issue statement as submitted is:

> The Provider(s) contend(s) that the MAC's determination for their standardized payment amount was calculated improperly and set too low based on erroneous methodology.
>
> Under the Inpatient Prospective Payment System, hospitals are paid a fixed amount for each Medicare beneficiary that they treat, "regardless of the actual operating costs they incur." *See Sebelius v. Auburn Reg'l Med. Ctr.*, 568 U.S. 145, 133 S. Ct. 817, 822, 184 L. Ed. 2d 627 (2013). This fixed amount is calculated by starting with a ***base rate*** that is then adjusted in various ways for each specific beneficiary at each specific hospital. See 42 U.S.C. § 1395ww(d)(2).
>
> 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.[1]

There are two Participants in this group appeal. The Participants have appealed from Revised Notices of Program Reimbursement ("RNPR").

A. Background on Participant #1 – Memorial Hermann Memorial City Medical Center

On August 8, 2017, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Memorial Hermann Memorial City Medical Center. This reopening notice states that the cost report was reopened for the following reasons:

- To review indigent Medicare bad debt accounts not previously reported on the cost report, in order to determine if the related deductibles and/or coinsurance amounts are allowable for reimbursement.
- To incorporate settlement amounts from the previous cost report settlement to ensure proper determination of payments, as necessary.
- To address cost report software updates and edits and correct cost report mathematical and flow errors, as necessary.

Memorial Hermann Memorial City Medical Center received its RNPR on May 6, 2019. The RNPR included adjustments, "To adjust allowable DSH % in include the additional Medicaid eligible days."

B. Background on Participant #2 – Memorial Hermann Katy Hospital

On June 14, 2019, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Memorial Hermann Katy Hospital. This reopening notice states that the cost report was reopened for the following reasons:

[1] Group Appeal Request Issue Statement (Oct. 29, 2019) (emphasis added).

- To implement the administrative resolution of PRRB case 17-0263. Specifically to allow additional documented Medicaid eligible days in Disproportionate Share payments.
- To incorporate settlement amounts from the previous cost report settlement to ensure proper determination of payments, as necessary.
- To address cost report software updates and edits and correct cost report mathematical and flow errors, as necessary.

Memorial Hermann Katy Hospital received its RNPR on July 9, 2019. The RNPR included adjustments, "To adjust to revised Medicaid eligible days and adjust the DSH percentage accordingly."

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is $10,000 or more (or $50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

Relevant Regulations – Revised NPRs

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), which 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) of this subpart) 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. . . .

Additionally, 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.

Similarly, 42 C.F.R. § 405.1835 incorporates these limitations into the provider's right to a Board hearing:

> (a) *Right to hearing on final contractor determination*. A provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. Exception: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).

The Board finds that it does not have jurisdiction under 42 C.F.R. § 405.1835(a) over the participants in this appeal because the participants appealed from a RNPR that did *not* adjust the standardized payment amount (*i.e.*, the base rates underling the DRG rates published annually in the Federal Register).

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[2] The Notice of Reopening explicitly stated the reasons for reopening for the participants. The cost report for Participant #1 was reopened to "review indigent Medicare bad debt accounts," incorporate settlement amounts, and to address cost report software updates and edits. The cost report for Participant #2 was reopened to "implement the administrative resolution of PRRB case 17-0263," incorporate settlement amounts, and to address cost report software updates and edits. Since the matters specially revised in the revised NPR were adjustments related to DSH percentage adjustments (rather than the standardized payment amount), the Board finds that it does not have jurisdiction over the participants in the subject group appeal. The Board notes that

[2] 42 C.F.R. § 405.1889(b)(1).

Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[3]

In conclusion, Memorial Hermann Memorial City Medical Center and Memorial Hermann Katy Hospital are dismissed from the appeal because they do not have the right to appeal the RNPR at issue under 42 C.F.R. §§ 405.1835(a) and 405.1889. As there are no participants remaining, the Board hereby closes Case No. 20-0255GC and removes it from the Board's docket.

Board Members Participating:

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

FOR THE BOARD:

9/2/2020

X Clayton J. Nix

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

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

[3] *See also St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

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Justin Lattimore
707 Grant Street, Suite 400
Pittsburgh, PA 15219

RE: ***Jurisdictional Decision***
Memorial Hermann CY 2011 Standardized Payment Amount CIRP Group
Case No. 20-0518GC

Dear Ms. Goron and Mr. Lattimore,

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

Background

On December 17, 2019, the Providers filed this group appeal with the Board. The group issue statement as submitted is:

> The Provider(s) contend(s) that the MAC's determination for their standardized payment amount was calculated improperly and set too low based on erroneous methodology.
>
> Under the Inpatient Prospective Payment System, hospitals are paid a fixed amount for each Medicare beneficiary that they treat, "regardless of the actual operating costs they incur." *See Sebelius v. Auburn Reg'l Med. Ctr.*, 568 U.S. 145, 133 S. Ct. 817, 822, 184 L. Ed. 2d 627 (2013). This fixed amount is calculated by starting with a ***base rate*** that is then adjusted in various ways for each specific beneficiary at each specific hospital. See 42 U.S.C. § 1395ww(d)(2).
>
> 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.[1]

There is one Participant in this group appeal. This Participant has appealed from a Revised Notice of Program Reimbursement ("RNPR").

Background on Participant #1 – Memorial Hermann Texas Medical Center

On July 10, 2019, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Memorial Hermann Texas Medical Center. This reopening notice states that the cost report was reopened for the following reasons:

- To implement the administrative resolution of PRRB case 17-2104. Specifically, to allow additional Medicaid days in the disproportionate payment computations.
- To incorporate settlement (final, tentative, or HITECH) or lump sum amounts from the previous cost report settlement to ensure proper determination of payments, as necessary.
- To address cost report software updates and edits and correct cost report mathematical and flow errors, as necessary.

Memorial Hermann Texas Medical Center received its RNPR on July 22, 2019. The RNPR included adjustments, "To adjust the allowable DSH% to include the additional Medicaid eligible days."

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is $10,000 or more (or $50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

[1] Group Appeal Request Issue Statement (Dec. 17, 2019) (emphasis added).

Relevant Regulations – Revised NPRs

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), which 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) of this subpart) 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. . . .

Additionally, 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.

Similarly, 42 C.F.R. § 405.1835 incorporates these limitations into the provider's right to a Board hearing:

> (a) *Right to hearing on final contractor determination*. A provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. Exception: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be**

> **limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).

The Board finds that it does not have jurisdiction under 42 C.F.R. § 405.1835(a) over the above participant in this appeal because the participant appealed from a RNPR that did *not* adjust the standardized payment amount (*i.e.*, the base rates underling the DRG rates published annually in the Federal Register).

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[2] The Notice of Reopening explicitly stated the reasons for reopening. The cost report was reopened to "implement the administrative resolution of PRRB case 17-2104," to incorporate settlement or lump sum amounts, and to address cost report software updates and edits. Since the matters specially revised in the RNPR were adjustments related to DSH percentage adjustments (rather than the standardized payment amount), the Board finds that it does not have jurisdiction over the participant in the subject group appeal. The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[3]

In conclusion, the Board hereby dismisses Participant #1, Memorial Hermann Texas Medical Center, from the appeal because they do not have the right to appeal the RNPR at issue under 42 C.F.R. §§ 405.1835(a) and 405.1889. As there are no participants remaining, the Board hereby closes Case No. 20-0518GC and removes it from the Board's docket.

Board Members Participating:

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

FOR THE BOARD:

9/2/2020

X Clayton J. Nix

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

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

[2] 42 C.F.R. § 405.1889(b)(1).
[3] *See also St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

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Justin Lattimore
707 Grant Street, Suite 400
Pittsburgh, PA 15219

RE: ***Jurisdictional Decision***
Texas Health Resources CY 2012 Standardized Payment Amount CIRP Group
Case No. 20-0703GC

Dear Ms. Goron and Mr. Lattimore,

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

Background

On January 22, 2020, the Providers filed this group appeal with the Board. The group issue statement as submitted is:

> The Provider(s) contend(s) that the MAC's determination for their standardized payment amount was calculated improperly and set too low based on erroneous methodology.
>
> Under the Inpatient Prospective Payment System, hospitals are paid a fixed amount for each Medicare beneficiary that they treat, "regardless of the actual operating costs they incur." *See Sebelius v. Auburn Reg'l Med. Ctr.*, 568 U.S. 145, 133 S. Ct. 817, 822, 184 L. Ed. 2d 627 (2013). This fixed amount is calculated by starting with a ***base rate*** that is then adjusted in various ways for each specific beneficiary at each specific hospital. See 42 U.S.C. § 1395ww(d)(2).
>
> 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.[1]

There is one Participant in this group appeal. This Participant has appealed from Revised Notices of Program Reimbursement ("RNPR").

Background on Participant #1 – Texas Health Harris Methodist Hospital Fort Worth

On April 2, 2018, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Texas Health Harris Methodist Hospital Fort Worth. This reopening notice states that the cost report was reopened for the following reasons:

- To review the inclusion of Inpatient and Outpatient Crossover Dual Eligible Bad Debt not previously reported.
- To incorporate settlement amounts from the previous cost report settlement to ensure proper determination of payments, as necessary.
- To address cost report software updates and edits and correct cost report mathematical and flow errors, as necessary.

Texas Health Harris Methodist Hospital Fort Worth received its RNPR on August 2, 2019. The RNPR included adjustments, "To add the settlement amount from the NPR'd Cost Report."

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is $10,000 or more (or $50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

[1] Group Appeal Request Issue Statement (Jan. 22, 2020) (emphasis added).

Relevant Regulations – Revised NPRs

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), which 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) of this subpart) 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. . . .

Additionally, 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.

Similarly, 42 C.F.R. § 405.1835 incorporates these limitations into the provider's right to a Board hearing:

> (a) *Right to hearing on final contractor determination.* A provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the

> provider, as set forth in the contractor's written notice specified under § 405.1803. Exception: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).[2]

The Board finds that it does not have jurisdiction under 42 C.F.R. § 405.1835(a) over the participant in this appeal because the participant appealed from a RNPR that did *not* adjust the standardized payment amount (*i.e.*, the base rates underling the DRG rates published annually in the Federal Register).

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[3] The audit adjustments associated with the RNPR under appeal included adjustments to add the settlement amount. The Notice of Reopening explicitly stated the reasons for reopening. The cost report was reopened to "review the inclusion of Inpatient and Outpatient Crossover Dual Eligible Bad Debt not previously reported," incorporate settlement amounts, and address cost report software updates and edits. Since the matters specially revised in the revised NPR were adjustments related to adding settlement amount for otherwise resolved/settled matters (and the record is devoid of any evidence establishing any adjustments related to the standardized payment amount),[4] the Board finds that it does not have jurisdiction over the participant in the subject group appeal. The

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[2] (Bold emphasis added.)

[3] 42 C.F.R. § 405.1889(b)(1).

[4] The Board notes that 42 C.F.R. § 405.1835(b) places the burden on the Provider to establish the Board's jurisdiction and requires the Provider to include documentation with its appeal to establish that jurisdiction. Specifically, this subsection states in pertinent part:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing to the Board, and the request must include the elements described in paragraphs (b)(1) through (b)(4) of this section. If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (b)(2), or (b)(3) of this section, the Board may dismiss with prejudice the appeal or take any other remedial action it considers appropriate.
>
> (1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section, including a specific identification of the final contractor or Secretary determination under appeal. . . .
>
> (3) **A copy of the final contractor or Secretary determination under appea**l **and any other documentary evidence the provider considers necessary to satisfy** the hearing request requirements of paragraphs (b)(1) and (b)(2) of this section. . . .

(Bold underline emphasis added.) To this end, Board Rule 7.1.2.1 specifies that, when a provider appeals an RNPR, it not only must attach the RNPR to its appeal request but also must "[a]ttach the reopening request that preceded the revised NPR (if applicable) and the reopening notice issued by the Medicare contractor" and "identify the issuance dates of the original NPR." Here, the Provider failed to demonstrate with this documentation (and any other documentation in the record) that it met the requirements of § 405.1835(a), resulting in the Board's dismissal.

Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[5]

In conclusion, the Board hereby dismisses Texas Health Harris Methodist Hospital Fort Worth from the appeal because they do not have the right to appeal the RNPR at issue under 42 C.F.R. under 42 C.F.R. §§ 405.1835(a) and 405.1889. As there are no participants remaining, the Board hereby closes Case No. 20-0703GC and removes it from the Board's docket.

Board Members Participating:

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

FOR THE BOARD:

9/2/2020

X Clayton J. Nix

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

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

[5] *See also St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Mail

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Washington, DC 20006

Geoff Pike
First Coast Service Options, Inc.
Provider Audit and Reimbursement Dept.
532 Riverside Ave.
Jacksonville, FL 32202

RE: ***Jurisdictional Determination***
Case No. 14-2151G – King & Spalding 2009 Low Income Pool Sec. 1115 Rehab DSH Waiver Days Group
Case No. 14-3340G – King & Spalding 2010 Low Income Pool Sec. 1115 Rehab DSH Waiver Days Group
Case No. 14-4057G – King & Spalding 2011 Low Income Pool Sec. 1115 Rehab DSH Waiver Days Group

Dear Mr. Polston and Mr. Pike:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above optional group appeals pursuant to the June 8, 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] Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Providers' Inpatient Rehabiliation Facilities – Low Income Payment ("IRF-LIP") Section 1115 Waiver Days issue and dismisses the appeals.

Pertinent Facts

The Providers, all located in the state of Florida, filed appeals with the Board seeking to have patient days associated with the Florida Low Income Pool approved § 1115 Medicaid waiver included in the numerator of the Medicaid fraction for their Medicare LIP adjustments.

On October 3 and 4, 2016, the Board conducted a consolidated live hearing on these appeals, as well as several others. On October 24, 2016, and January 26, 2017, the Board issued decisions dismissing the Providers' appeals for lack of jurisdiction, as the Provider's failed to make a claim for the waiver days on their as-filed cost reports. For Case Nos. 14-2151G, 14-3340G, and 14-4057G, the Board dismissed all of the providers and closed the cases. As noted above, the dismissal was for failure to claim the days on the cost report (did not claim for payment or

[1] *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062 (June 8, 2018).

protest). As the FYE's under appeal were 2009-2011, the Board found that the Provider's failed to make the claim required under 42 C.F.R. 405.1835(a)(1)(ii) (2009).

Subsequently, the Providers filed Civil Action No.: 1:16-cv-02515CKK in the U.S. District Court for the District of Columbia. In this civil action, the parties entered a Settlement Agreement which agreed to vacate the Board's jurisdictional decisions and to remand the appeals to the Secretary for further proceedings before the Board. The Settlement Agreement also stated that no additional discovery, legal briefing, or hearing is necessary, and that the Board shall issue a hearing decision on the merits *to the extent* that it does "does not dismiss any providers or cases on the basis of a law or provision not relied upon in the original jurisdictional decisions."

The U.S. District Court ordered that the Plaintiffs' cases be remanded to the Secretary with instructions to return the matter to the Board for further proceedings. Pursuant to the U.S. District Court Order, on May 2, 2019, the Principal Deputy Administrator of the Centers for Medicare and Medicaid Services ("CMS") ordered that the Board shall take actions consistent with the Settlement Agreement and the Court Order in this case, and that the decision of the Board is subject to the provisions of 42 C.F.R. § 405.1875.

Pursuant to the Administrator's Order, the Board reopened these appeals on October 23, 2019.

Board's Analysis and Decision

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 ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar*, answers this question and clarifies what is shielded from review in its analysis of this issue.[2]

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."[3] 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.[4] The D.C. Circuit concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory

[2] *Id*.
[3] *Id.* at 1064.
[4] *Mercy Hosp., Inc. v. Burwell*, 206 F. Supp. 3d 93, 102 (D.D.C. 2016).

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.[5]

In the instant appeals, the Providers seek Board review of one of the components utilized by the Medicare Contractor to determine the Providers' LIP adjustments, namely its Medicaid Ratio of the DSH calculation. The Providers are requesting that the Florida Low Income Pool Days be included in the LIP Medicaid ratio for payment. 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 LIP adjustment and dismisses the issue in the instant appeals that challenge this adjustment. In making this finding, the Board notes that the D.C. Circuit's decision in *Mercy* is controlling precedent because the Providers could bring suit in the D.C. Circuit.[6] As the Board lacks jurisdiction to hear the issue under appeal in each of these group appeals, the Board hereby dismisses them 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 A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

9/2/2020

X Clayton J. Nix

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

cc: Edward Lau, Esq., Federal Specialized Services
Wilson Leong, Federal Specialized Services

[5] *Mercy*, 891 F.3d at 1068.

[6] 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

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Via Electronic Delivery

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Lorraine Frewert
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Fargo, ND 58108-6782

RE: ***Dismissal for Improper Filing***
San Antonio Regional Hospital (Prov. No. 05-0099)
FYE: 12/31/2015
Case No. 18-1861

Dear Ms. Heilgeist and Ms. Frewert:

The Provider Reimbursement Review Board ("Board" or "PRRB") has reviewed the documents in Case No. 18-1861 and finds that the Provider did not timely file its complete Preliminary Position Paper with the Board. The decision of the Board is set forth below.

Background

On September 21, 2018, San Antonio filed an appeal with the Board from a Notice of Program Reimbursement ("NPR") dated March 29, 2018 challenging the inclusion of Medicare Part C days in the supplemental security income ("SSI") percentage ("issue 1") and the exclusion of Dual Eligible Part C days from the Medicaid percentage ("issue 2"). The Board assigned this appeal to Case No. 18-1861.

On October 10, 2018, the Board issued San Antonio an Acknowledgement and Critical Due Dates Notice which stated that a Proposed Joint Scheduling Order ("PJSO") or a Preliminary Position Paper was due to the Board by May 19, 2019. On May 08, 2019, San Antonio filed the first page of its Preliminary Position Paper ("cover page") and its Table of Exhibits and Authorities with the Board.

On December 9, 2019, San Antonio requested to transfer issue 1, the inclusion of Medicare Part C days in the SSI percentage issue, to Case No. 19-0038G, Toyon Associates CY 2015 DSH Inclusion of Medicare Part C Days in SSI Ratio Group, and requested to transfer issue 2, the exclusion of Dual Eligible Part C days from the Medicaid percentage issue, to Case No. 19-0037G, Toyon Associates CY 2015 DSH Dual Eligible Part C Days- Medicaid Ratio group. On June 19, 2020, the Board closed Case No. 18-1861 because all of the issues had been transferred to group appeals.

Decision of the Board

Effective August 29, 2018, the Board updated its Rules. The updated Rules superseded all previous rules and instructions and included an updated version of Board Rule 23. The Commentary to Board Rule 23 as revised states the following:

> **Rule 23 Proposed Joint Scheduling Orders ("PJSO") and Preliminary Position Papers**[1]
>
> **COMMENTARY:**
>
> The Board is *continuing* to offer two briefing options: (1) each party filing a preliminary position paper OR (2) the parties jointly establish the deadlines in a PJSO. *The Board has made rule changes for both options as noted below*.
>
> **Option 1 – Preliminary Position Papers:**
>
> In the past, the parties exchanged with each other full copies of the preliminary position paper but provided the Board only a copy of the cover sheet, listing of exhibits, and good faith statement. However, with the implementation of OH CDMS, *parties are now required to file the complete preliminary position paper* with the narrative, listing of exhibits, and all exhibits. As the Board will now obtain a *full* copy of the preliminary position paper, which is required to have the *fully* developed position and identification of the controlling authority needed to support each issue in the appeal, final position papers will be optional for new appeals filed on or after the effective date of the rules. Final position papers are still mandatory for all appeals that were filed prior to that date. . . .

Further, Board Rule 25.3 (effective 8/29/18) provides:

> **25.3 Filing Requirements to Board**[2]
>
> 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 . . . *Any issue*

[1] (Bold in original and italics and underline emphasis added.)
[2] (Bold in original and italics and underline emphasis added.)

appealed, but not briefed by the Provider in its position paper will be considered withdrawn.

COMMENTARY:

Note that this is a change in previous Board practice. Failure to file a *complete* preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (See Rule 23.4)

In addition, the Board issued an Alert to all external users and stakeholders regarding the August 29, 2018 change in the Board rules, both by email blast as well as an Alert posted on the "Current Alerts" section of the Board's website. This alerted highlighted specific important changes including the requirement that a full preliminary position paper be filed: "[r]equire the filing of the ***full*** preliminary position paper to both the opposing party and the Board (currently the preliminary position paper is only filed on the opposing party with only a cover letter to the Board)."[3]

In making this change, the Board Rule 23.3 notes that preliminary position papers required under the Critical Due Dates Notice must comply with Preliminary Position Papers requirements in Board Rule 25, and the associated Commentary again emphasizes the requirement for a fully developed position paper with all exhibits:

23.3 Preliminary Position Papers Required if PJSO Is Not Executed[4]

If the parties do not jointly execute and file a PJSO by the due date, the position paper deadline established in the acknowledgement letter will control Both parties *must file preliminary position papers that comply with Rule 25* (and exchange documentation by their respective due dates.

[3] ALERT 15: Revised PRRB Rules (Aug. 29, 2018), Current Alerts, PRRB Review, https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Alerts.html (emphasis added).
[4] (Underline and italics emphasis added.)

COMMENTARY:

The regulations and Board Rules impose preliminary position paper requirements that ensure *full* development of the parties' positions in order to foster efficient use of the administrative review process. The due date timeframe is set to give the parties the optimal opportunity to develop their case. Because the date for adding issues will have expired and transfers are to be made prior to filing the preliminary position papers, *the Board requires preliminary position papers to be fully developed and include all available documentation* necessary to provide a thorough understanding of the parties' positions.

Moreover, the Board notes that Board Rule 4.7.3 make it clear that "[t]he Board expects that transfers of issues from individual appeals to group appeals will be effectuated prior to submission of the preliminary position paper. (*see* Rule 12.11)."[5] Similarly, Board Rule 23.6 make clear that pending (or impending) requests for transfers does not suspend filing requirements.[6]

In the instant case, the Provider filed its appeal on September 21, 2018 and the Board sent San Antonio an Acknowledgment and Critical Due Dates Notice ("Critical Due Dates Notice") on October 10, 2018. Both the filing of the appeal *and* the issuance of the Board's Critical Due Dates Notice occurred ***after*** the new Board Rules became effective on August 29, 2018 and the Critical Due Dates Notice required the Provider to file a PJSO or Preliminary Position Paper by May 19, 2019. On May 8, 2019, San Antonio made an insufficient filing as it included only the first page of an alleged Preliminary Position Paper ("cover page") and its Table of Exhibits and Authorities. San Antonio did not file with the Board a ***complete*** Preliminary Position Paper that includes a fully developed narrative on *each* remaining issue and all relevant exhibits as required by Board Rules 23, 25, and 25.3. In this regard, Board Rue 25.3 requires the filing of the complete position paper and makes clear: "Any issue appealed, *but not briefed* by the Provider in its position paper will be considered withdrawn."

Pursuant to 42 C.F.R. § 405.1868 (a)(b)(1) (2018), 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 § 1878 of the Act and of

[5] Board Rule 12.11 states, in pertinent part: "Providers transferring issues from an individual appeal to a group appeal should do so as soon as possible, generally prior to filing the individual appeal's preliminary position paper."
[6] Board Rule 23.6 states: "Pending requests (such as transfers, requests for abeyance, expedited judicial review, mediation, jurisdictional challenges, discovery, or other motions), until complete or ruled on favorably by the Board where applicable, will not suspend these filing requirements. If a motion or request is not complete or has not been ruled on, you must proceed as if it will not occur or will not be granted. If an issue is not timely addressed as required in this rule because the parties have relied on an incomplete action or a pending request that is not yet ruled on, it is subject to dismissal at any time during the proceedings."

the regulations. 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. Specifically, if a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may dismiss the appeal with prejudice. Similarly, 42 C.F.R. § 405.1853(b) confirms the Board's authority to set deadlines on the parties for the filing of position papers with the Board and, in this regard, the regulation makes clear in Paragraph 2 that "[e]ach 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."[7]

Because San Antonio failed to file a ***complete*** Preliminary Position Paper with the Board by the May 19, 2019 filing deadline (specifically none of the remaining issues were briefed and are considered withdrawn), the Board concludes that San Antonio's Preliminary Position Paper was not filed in accordance with Board Rules. Therefore, the Board reopens Case No. 18-1861 and dismisses the appeal and closes the case.

As part of this reopening, the Board also *denies the transfer* of issue 1, the inclusion of Medicare Part C days in the SSI percentage issue, *to Case No. 19-0038G*, Toyon Associates CY 2015 DSH Inclusion of Medicare Part C Days in SSI Ratio Group, ***and*** *denies the transfer* of issue 2, the exclusion of Dual Eligible Part C days from the Medicaid percentage issue, *to Case No. 19-0037G*, Toyon Associates CY 2015 DSH Dual Eligible Part C Days- Medicaid Ratio group, as these issues were transferred on December 9, 2019, after the improper filing was made with the Board on May 8, 2019. Further, Board Rules 4.7.3 and 23.6 (*see* above) make clear that these transfers should have been completed *prior to* the preliminary position paper due date and that pending (or impending) requests for transfers do not suspend the preliminary position paper filing requirement. As a result, the Provider ***must be removed from the Schedule of Providers for Case Nos. 19-0037G and 19-0038G.*** To this end, the Board is sending a carbon copy of this dismissal to the Group Representative for Case Nos. 19-0038 and 19-0037G.

In summary, the Board reopens Case No. 18-1861 and denies the transfer of issue 1, the inclusion of Medicare Part C days in the SSI percentage issue, to Case No. 19-0038G and denies the transfer of issue 2, the exclusion of Dual Eligible Part C days from the Medicaid percentage issue, to Case No. 19-0037G. The Board dismisses the appeal in Case No. 18-1861 and closes the case. *The Board further instructs the Group Representative for Case Nos. 19-0037G and 19-0038G to remove the Provider from the Schedule of Providers for these two groups*.

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.

[7] (Emphasis added.)

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:

9/3/2020

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services
Dylan Chinea, Toyon Associates, Inc. (Group Rep. in Case Nos. 19-0037G & 19 0038G)

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RE: ***Evidentiary Ruling in Case No. 18-0556***
AnMed Health Medical Center

Dear Ms. Straub Williams and Mr. Lau:

As you aware, theProvider Reimbursement Review Board ("Board") held an *accelerated* hearing in the above-captioned case on February 23, 2019. During the hearing, the Board ruled from the bench on the admission of Exhibits C-10 through C-20 after reviewing AnMed Health Medical Center's ("AnMed" or "Provider") "Provider's Motion to Exclude Exhibits C-10 though C-20" ("Motion"), the "MAC Response [sic] to Provider's Motion to Exclude Exhibits C-10 through C-20" ("MAC Response"), and the "MAC Supplement to MAC Response to Provider's Motion to Exclude Exhibits C-10 through C-20" ("MAC Supplement"). Due to the time constraints surrounding the circumstances and at the request of Federal Specialized Services ("FSS"), the representative of the Medicare Administrative Contractor ("MAC"), the Board elected to provide a written explanation for that ruling following the hearing as set forth below.

Factual and Procedural Background Relevant to the Motion:

On January 23, 2018, AnMed filed its Hearing Request. On November 19, 2018, AnMed filed a Request for Accelerated Hearing pursuant to Board Rule 31 stating that, after reviewing the MAC's Preliminary Position Paper, it did not believe the case would be settled and that the MAC did not object to the request. The Board granted AnMed's request for an accelerated hearing and, on November 20, 2018, issued a "Notice of Hearing and Critical Due Dates" for this appeal with the following schedule:

January 23, 2019	Due date for AnMed's Final Position Paper
February 22, 2019	Due date for the MAC's Final Position Paper
March 24, 2019	Due date for the AnMed's (Optional) Responsive Brief, and Due date for the Witness List from each party
April 23, 2019	Date of the Board hearing[1]

[1] The Board's November 20, 2018 Notice of Hearing and Critical Due Dates is attached hereto as Attachment A.

This Notice further specified that the MAC's Final Position Paper "***must*** . . . *include any exhibits* the Medicare Contractor will use to support its position. See Board Rule 27 for more specific content requirements. If the Medicare Contractor fails to meet its deadline, the Board will take actions described under 42 C.F.R. § 405.1868."[2] Finally, this Notice included the following warning to the parties if they failed to comply with the due dates:

> ***The parties*** are responsible for pursuing the appeals in accordance with the Board Rules and ***must meet the above due dates*** *regardless of any outstanding jurisdictional challenges, motions, subpoena requests, or the expectation of an administrative resolution*. If a party fails to follow the Board's rules and procedures, the Board will take actions described under 42 C.F.R. § 405.1868.

At 3:13 pm, on Thursday, April 18, 2019, FSS, on behalf of the MAC, filed in OH CDMS additional Exhibits (C-10 – C-20) to the MAC's Final Position Paper. AnMed filed the Motion on Friday, April 19, 2019. On Monday, April 22, 2019, the Board requested additional information from FSS to be filed by close of business. As a result, on that same day, FSS filed the MAC Response. On Tuesday, April 23, 2019 (the day of the hearing), FSS filed the MAC Supplement with an additional Exhibit C-21.

Parties Contentions

AnMed's Motion raises several objections to Exhibits C-10 through C-20 (the "Challenged Exhibits"). First, there is the general objection that the MAC failed to comply with Board Rules 25.2.1, 25.2.2, 27.2, and 35.3 and filed the additional exhibits well beyond the deadline for submission of additional evidentiary exhibits. In sum, the late submission prejudiced AnMed.

C-10 through C-14 were certain CMS emails having both internal and external exchanges. AnMed complained that the untimely filing of these exhibits "severely prejudices the Provider's case."[3] In particular, due to the late submission of these emails, AnMed was precluded from conducting discovery on the emails to determine the factual context for them, determine if C-10 to C-14 represented the universe of CMS emails on this subject, and "cross examine the authors or otherwise test the credibility of the authors."[4] AnMed also averred that C-10 to C-14 are irrelevant and unreliable.[5] In this regard, AnMed stated:

1. Several of the exhibits are internal, incomplete emails among employees of the Centers for Medicare and Medicaid Services and do not relate to Provider; and
2. One email is between CMS employees and private individuals not related to Provider.[6]

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[2] (Underline emphasis in original and bold italics emphasis added.)
[3] Provider's Motion to Exclude Exhibits C-10 through C-20 (April 19, 2019).
[4] *Id.*
[5] *Id.*
[6] *Id.*

C-15, C-16, C-17, C-19 and C-20 are documents that pertain directly to AnMed. AnMed maintained that C-15, C-17 and C-19 are irrelevant. With respect to C-20, AnMed stated that the source is unknown and it is unclear what new facts it presents.

FSS countered AnMed's objections by asserting that Exhibits C-10 through C-14 "were very recently and directly obtained from a Ms. Tehila Lipschultz from CMS" who "works in the CMS Hospital Ambulatory Payment Group, and is knowledgeable about issues involving Sole Community Hospitals and related matters."[7] FSS also represented that "Exhibits C-10 through C-14 were only very recently obtained *after **much** effort* and address the Provider's claim that CMS did not have a prior policy of including the Provider's remote location in the measurement of distance to the nearest like hospital, and that the 2019 Final Rule was not a 'clarification' of prior policy."[8] FSS further represented that "[t]he current MAC, NGS, had to go through Palmetto GBA for some of these records which took additional time and effort."[9]

FSS argues that Exhibits C-15 through C-20 are relevant to the issue and relate specifically to AnMed. Specifically, Exhibit C-15 is a letter approving AnMed's "provider-based" status for its remote location.[10] Similarly, Exhibit C-16 contains letters from November and December 2010 denying Anmed's request for status as a "sole community hospital;" Exhibits C-17 through C-19 are screenshots from AnMed's websites; and Exhibit C-20 is a screenshot from the State of South Carolina showing licensure of AnMed.[11]

The Board requested that FSS supplement the MAC response with additional information related to FSS attempts to obtain C-10 to C-14, when FSS received these communications, and FSS's efforts to comply with Board Rules 25.2.1, 25.2.2, and 35.3. In response, the MAC filed additional information on Monday April 22, 2019. Specifically, the MAC clarified that Palmetto GBA was the MAC that made the initial determination to deny AnMed's SCH designation and that "Palmetto was contacted approximately 5 weeks ago for assistance in this appeal and that Palmetto was slow to respond and took 3 weeks to locate the files, which were off site."[12] With regard to C-10 to C-15, Mr. Lau at FSS represented that he "reached out to CMS for assistance over a month ago" and that he "received emails C-10 through C-14 from Ms. Tehila Lipshultz from CMS between April 5, 2019 and April 10, 2019."[13] FSS maintains that "[t]here was no delay or attempt to surprise the Provider and the exhibits were disclosed as soon as possible."[14]

Legal Authority and Relevant Board Rules

Pursuant to 42 U.S.C. § 1395oo, "[t]he Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this subchapter or regulations of

[7] MAC Response.
[8] *Id.* (Emphasis added.)
[9] MAC Supplement, Nos. 1 and 2.
[10] MAC Response, No. 6.
[11] MAC Response, No. 12.
[12] MAC Supplement, No. 2.
[13] MAC Supplement, No. 4.
[14] MAC Supplement, No. 7.

the Secretary, which are necessary or appropriate to carry out the provisions of this section. . . ." In furtherance of this directive, CMS has promulgated regulations as the foundation for the Board Rules. The regulation at 42 C.F.R. § 405.1853(a)(3) addresses prehearing activities such as development of the issues and discovery and requires the MAC to:

> Ensure that the evidence it considered in making its determination or, where applicable, the evidence the Secretary considered in making his or her determination, is included in the record.

Similarly, § 405.1853(b)(1) specifies that position papers of the parties are due no later than the deadlines established by the Board and are intended to further narrow the issues. With respect to exhibits for the Board record, § 405.1853(b)(3) specifies that the Board has the authority to set deadlines for their submission:

> In the absence of a Board order or general instructions to the contrary. . . . Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to the specific case or through general instructions.[15]

Finally, 42 C.F.R. § 405.1868 confirms that the Board is authorized to take appropriate action when a party to an appeal fails to follow Board Rules:

> 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. . . .[16]

The Board's Rules provide more detail regarding the submission of documentary evidence. Rule 23.3 states, in relevant part, "Both parties must file preliminary position papers that ***comply*** *with Rule 25* (***and exchange documentation***) by their respective due dates."[17] Furthermore, the Commentary to Rule 23.3 states, "Because the date for adding issues will have expired and transfers are severely limited, the Board expects preliminary position papers to be fully developed and *include* ***all available documentation*** *necessary to give the parties a thorough understanding of their opponent's position*."[18] Further, Rule 25.2.1 requires:

> With the position papers, *the parties must exchange* ***all*** *available documentation* as exhibits to fully support your position. The

[15] 42 C.F.R. §405.1853(b)(3).
[16] 42 C.F.R. § 405.1868(a).
[17] (Emphasis added.)
[18] (Emphasis added.)

> Medicare contractor must also give the provider all evidence the Medicare contractor considered in making the determination (see 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.[19]

Rule 25.2.2 provides guidance when documents may be unavailable at the time of filing the position papers:

> 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****.***[20]

Board Rule 27.2 confirms that the "***minimum requirements***" for exhibits included with the final position paper "are the same as those outlined for preliminary position papers at Rule 25."

Rule 35.3 addresses the admission of documentary evidence at the time of hearing:

> *Except on agreement of the parties****, documentary evidence*** relevant to fact disputes ***must*** *be* identified and *exchanged **by the deadline** established* in the PJSO or ***by these rules***. . . .
>
> **** * * ****
>
> *Upon objection* or the Board's own motion***,*** the Board will determine the propriety of permitting late filed exhibits***, taking into account*** the reasons for the late filing, the requirements of Procedures 23 through 27 and ***prejudice to the opposing party***.[21]

Discussion

Board Rule 35.3 sets the following balancing test for the Board's review of objections to admitting late-filed exhibits: "the Board will determine the propriety of permitting late filed exhibits***, taking into account the reasons*** for the late filing, the requirements of Procedures 23 through 27 ***and prejudice to the opposing party***."[22] Accordingly, the Board has reviewed the Challenged Exhibits and applied this balancing test to each proposed exhibit. Set forth below is the Board's ruling on the admissibility of the Challenged Exhibits.

[19] (Emphasis added.)
[20] (Emphasis added.)
[21] (Emphasis added.)
[22] (Emphasis added.)

The Board has determined that the Challenged Exhibits fall into two categories: (1) Exhibits C-10 through C-14 ("CMS Emails"); and (2) Exhibits C-15 through C-20 ("Known Information"). The CMS Emails consist of four email exchanges (both internal and external) involving various CMS employees discussing the process of certifying a provider as a Sole Community Hospital when the provider has more than one location. The Known Information consists of correspondence either received by or transmitted by AnMed (C-15 and C-16), information available on websites controlled by AnMed (C-17 through C-19) or information from the South Carolina Department of Health and Environmental Control's public hospital licensure listing (C-20).

The record is clear that the MAC and FSS failed to comply with their obligations under 42 C.F.R. § 405.1853 and Board Rules governing the submission of evidence in this case. On November 20, 2018, the Board granted the Provider's request for an *accelerated* hearing date and set the hearing for April 23, 2019 (roughly 5 months later). The Board Rule 31 governs *accelerated* hearing requests and states:

> **31.1 Request**
> *When a party is fully prepared to present its case,* it may request that the case be set at the earliest possible date (or within a specified range of dates). *The request shall demonstrate that the case has no impediments to a hearing (such as outstanding motions or discovery requests) and* ***the documentation exchange is complete***. The request must also state whether the non-moving party concurs. If granted, the Board may establish such deadlines or impose such conditions as may be appropriate.
>
> **31.2 Firm Hearing Date**
> If the Board grants the request, the parties are expected to meet any deadlines that may need to be accelerated to accommodate the accelerated date (see Rule 30). *Hearing dates will be considered* ***firm***.

Significantly, a requisite to an accelerated hearing is that the documentation exchange be "*complete.*" Further, neither FSS nor the MAC objected to an accelerated hearing and were on notice under Board Rule 31, governing accelerated hearings, that due dates and the hearing date would be strictly adhered to when an accelerated hearing is granted.

Under the accelerated scheduling notice, the MAC needed to file its final position paper by February 22, 2019.[23] Consistent with 42 C.F.R. § 405.1853(a)(3) and Board Rules 25.2.1, 25.2.2, and 27.2, the Board notice setting this due date specified that the MAC's final position paper "*must . . . include* ***any exhibits*** the Medicare Contractor will use to support its position."[24]

[23] *See,* Attachment A.
[24] *Id.*

On February 15, 2019, the MAC filed its final position paper, including Exhibits C-1 to C-10, with the Board. Within its final position paper, the MAC responded to the Provider's allegation that "before the FY 2019 IPPS Final Rule policy regarding measuring distance from remote locations, CMS had no such policy in place." In this regard, the MAC contended that "per FY 2019 IPPS Final Rule, 83 Fed Reg. 41370 is reiterating current policy that was in effect . . . ." Significantly, the final position paper does not discuss or suggest that there may other evidence discussing or confirming what CMS's policy was during the time at issue.

By its own admission, FSS did not contact CMS until some point in time "over a month" before April 18, 2019, when C-10 to C-20 were submitted.[25] Similarly, Palmetto GBA "was contacted" for assistance with this appeal on approximately March 15, 2019 (although it is unclear whether it was the MAC or FSS that made this contact).[26] Thus, neither the MAC nor FSS contacted CMS or Palmetto GBA until approximately three weeks after the MAC's Final Position Paper had been filed with the Board.[27] Indeed, FFS filed its Witness List with the Board on March 14, 2019 – about the same time that it initiated this CMS and Palmetto outreach effort. However, FFS did not notify either the Board or opposing counsel of its efforts to locate additional documents and evidence in support of its position consistent with Board Rule Rule 25.2.2.

Finally, FSS stated that it received the CMS Emails between April 5 and April 10, 2019. However, for some unknown reason, FSS waited between one and two weeks after receipt of the CMS Emails before notifying the Board and the Provider by filing them at 3:13 pm on Thursday, April 18, 2019,[28] over two months after the MAC submitted its Final Position Paper and only 2 business days prior to the accelerated hearing date. Obviously, this left both the Board and the Provider with little time to address the new exhibits prior to the accelerated hearing.

Notwithstanding these general issues and concerns, the Board admits the Known Information marked as Exhibits C-15 through C-20. In applying the three-pronged balance test under Board Rule 35.2, the Board finds that, while there is little justification for the late filing and the requirements of Procedures 23 through 27 were not met, there is little prejudice to the Provider. Specifically, because the Known Information was (or should have been) readily available to the Provider prior to the MAC's submission of the Challenged Exhibits and the Provider has not claimed any specific prejudice related to their admission, the Board finds that AnMed suffered no unfair prejudice as a result of the MAC's submission of the Known Information after the deadline imposed by the Rules and the Notice of Critical Due Dates. Therefore, the Known Information (Exhibits C-15 through C-20) is admitted to the record over AnMed's objection.[29]

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[25] MAC Supplement, No. 2.
[26] *Id.* at No. 4.
[27] *Id.* at Nos. 2 and 4.
[28] *Id.* at No. 4.
[29] It must also be noted that the MAC submitted an additional exhibit, C-21, on the day before the hearing consisting of the Board's decision in *Maine Coast Memorial Hospital v. Blue Cross Blue Shield Association, PRRB Decision 2013-D5*. Although not objected to by AnMed, the Board would consider Exhibit C-21 to fall into the Known Information category and admit C-21 to the record. Admission of C-21 is also consistent with Rule 35.3, "[g]enerally, additional legal authorities or summaries will not be subject these time limits.

On the other hand, the Board agrees with AnMed and will not admit the CMS Emails, marked Exhibits C-10 through C-14, to the record in this case.

First, unlike the Known Information, the CMS Emails were *not* available to the public and AnMed had neither prior knowledge of nor access to the CMS Emails. None of the CMS Emails discuss AnMed specifically nor were any AnMed employees or representatives identified as sending or receiving the CMS Emails.

Second, the evidentiary value of the CMS Emails is unclear and AnMed maintains that it would have been prejudiced absent an opportunity to pursue discovery, time permitting.[30] The MAC asserts that the CMS Emails are intended to contradict AnMed's position that CMS did not have a policy regarding factoring remote locations into the Sole Community Hospital distance requirements.[31] Yet, the CMS Emails are not publicly-available statements of that policy and the MAC laid no foundation for admission of those emails at this late date. As indicated by AnMed, the CMS Emails were sent by multiple CMS employees whose roles and responsibilities were not adequately explained and it is unclear whether the CMS Emails are complete and/or contain the entire email chain and related content. In this regard, FSS offered little, or no, information as to the identity of the CMS Emails authors and laid no foundation for the accuracy or completeness of the CMS Emails. Similarly, the CMS Emails discuss certain specific provider fact situations and suggest certain agency actions but these emails themselves do not constitute the agency's final determination (if any) relative to those situations and actions. Finally, the MAC did not offer to provide, as witnesses, any of the authors of the CMS Emails so that they might answer any of these questions.

Third, Board Rule 30 makes clear that an ***accelerated*** hearing is appropriate when the documentation exchange is complete and the MAC and FSS ***did not object*** to the ***accelerated*** hearing. To this end, Board Rule 30 makes clear that, under the accelerated hearing process, the hearing date is "***firm***" and the parties are expected to meet any deadlines to accommodate the accelerated hearing date.

Notwithstanding the mandates of Board Rule 30, the MAC and FSS (without notifying the Board or Provider) was still conducting its own evidentiary discovery process long after consenting to the accelerated hearing and after the submission of the MAC's final position paper. AnMed's Final Position Paper had as a central argument that CMS had no prior policy and this paper was submitted to the Board (and served on the MAC) on or about January 23, 2019.[32] This allowed the MAC and FSS a full month, before the MAC's Final Position Paper was due, to seek CMS assistance in countering this argument. In fact, FSS represents that it consulted with CMS nearly a month and a half ***after*** the MAC received AnMed's Final Position Paper. The MAC and FSS have offered no explanation for: (1) the delay in seeking assistance from CMS for evidence;

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[30] Motion, p. 3.
[31] MAC Response, No. 5.
[32] Given that the MAC did not object to its inclusion in AnMed's Final Position Paper as an expansion of the scope of the arguments, the no prior policy argument was more than likely asserted in AnMed's preliminary position paper. If this is true, the MAC and FSS had ***more than five months*** to seek CMS and Palmetto's assistance in identifying evidence to counter this argument, after consenting to the Request for Accelerated Hearing.

(2) the submission of the Challenged Exhibits at the 11th hour, leaving virtually no time prior to the *accelerated* hearing for the Board or the Provider to address and/or resolve the resulting evidentiary issues; and, (3) why they did not initiate the internal discovery process prior to the filing of their final position paper. The lack of communication and transparency is all that more troubling given the fact that this evidence was offered to rebut one of the primary arguments of the Provider.

FSS maintains that "[t]here was no delay or attempt to surprise the Provider and the exhibits were disclosed as soon as possible." However, the Board finds that the record establishes multiple delays by FSS and/or the MAC in conducting the ongoing internal discovery (*e.g.*, delay in contacting CMS and Palmetto for discovery assistance, delay in notifying the Board and AnMed of the ongoing discovery, delay in submitting the Challenged Exhibits, etc.). The result of these delays, in the context of an ***accelerated*** hearing, did in fact create both surprise and prejudice to the Provider. In this regard, it is undisputed that the MAC submitted the CMS Emails after the deadline established in the Board's Notice of Hearing and Critical Due Dates.[33] The MAC's Final Position Paper also did not identify the CMS Emails as unavailable documents, explain any efforts to obtain them and identify when they would be available consistent with Board Rule 25.2.2. Moreover, even after the MAC and FSS started receiving additional documentation from CMS, they failed to "promptly forward" them to the Board and AnMed consistent with Board Rule 25.2.2. In this regard, FSS states that it received the CMS Emails between April 5 and April 10, 2019 but did not submit them or notify AnMed of their existence for between one and two weeks after their receipt notwithstanding the impending ***accelerated*** hearing date of April 23, 2019.[34] Based on these undisputed facts, the Board finds that the MAC violated Board Rules 23.3, 25.2.1, 25.2.2 and 35.3.

In applying the three-pronged balancing test under Board Rule 35.2 to Exhibit C-10 to C-14, it is clear that the first two prongs are met. With respect to the first prong, it is clear that the MAC and FSS have no satisfactory "reasons for the late filing." They really give none and their submission only points to somewhat normal discovery issues that arise in the context of an otherwise *tardy* internal discovery process. With respect to the second prong, it is clear that, as discussed above, the MAC and FSS failed to meet "the requirements of Procedures 23 through 27."

The only remaining prong or element to determine is whether admission of the CMS Emails prejudices AnMed. Based on the somewhat unique and extraordinary facts and circumstance of this case, the Board agrees with AnMed and finds that the late filing of the CMS Emails substantially prejudiced AnMed. The CMS Email were put forward to rebut one the Provider's central arguments; however, because the Provider was served with copies of the CMS Emails at 3:13 pm on April 18, 2019, the Provider had only two full business days before the *accelerated* hearing date. AnMed desired to conduct discovery related to the CMS Emails but it was impossible for AnMed to have reviewed the CMS Emails, investigated their source, and conducted discovery as to the author[s] and the regulatory situations they addressed[35] in order to

[33] *See* Attachment A.
[34] MAC Supplement, No. 4.
[35] Assuming discovery of CMS employees was even permitted under the *Touhy* regulations. *See*, 45 C.F.R. Part 2.

fully prepare for the *accelerated* hearing. Moreover, the Board itself had little time to act on AnMed's Motion prior to the accelerated hearing. To have delayed the hearing and/or to allow discovery on a post-hearing basis with a potential follow up hearing would only reward the lack of diligence by FSS and the MAC and their failure to properly consider and manage the *accelerated* hearing process. Indeed, that concern is materially and substantially heightened by the fact that the evidentiary issue occurred in the context of an *accelerated* hearing and this fact is a critical factor in the Board majority's ruling and its determination that this evidentiary issue was *extraordinary*.

Pursuant to the provisions of 42 C.F.R. § 405.1868, the Board is empowered to take appropriate action when a party to an appeal fails to comply with Board rules and orders.[36] CMS addressed the late filing of evidence by a MAC in response to a comment for the Final Rule implementing 42 C.F.R. § 405.1868:

> The commenter suggested that the final rule should require the Board to bar an intermediary from submitting late evidence and arguments, unless there is a showing of good cause.[37]

In its response, CMS confirmed the Board's authority to exclude exhibits filed late by a Medicare contactor:

> As to the commenters' suggestions regarding the possible exclusion of evidence, we note that it is within the Board's discretion to decide whether a party should be barred from submitting *late* evidence and arguments.[38]

Given the *extraordinary* circumstances of this case including, but not limited to, the clear violation of Board Rules, the lack of good cause for delay, the real prejudice to AnMed, the nature of an *accelerated* hearing, and the clear guidance from CMS, the Board hereby excludes the CMS Emails marked as Exhibits C-10 through C-14 from the record in the above-captioned case.

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[36] 42 C.F.R. §405.1868(a).
[37] 73 Fed. Reg. 30190, 30225 (May 23, 2008).
[38] *Id.* (emphasis added). Similarly, another commenter "noted that, when an intermediary fails to comply with a Board order or deadline, and the Board issues a decision based on the written record, upon review, the Administrator will remand all these cases back to the Board to consider additional arguments. The commenter suggested that, due to intermediary non- compliance, when the Board decides to close the record and issues a decision based on the written record to that point, the Administrator should not be able to remand the case to the Board or consider the arguments not in the record." *Id.* In response, CMS stated that: "We do not agree that in this situation the Administrator would always remand a case back to the Board to consider any missing arguments. We believe that if the Board issues an early decision based on the written record because of an intermediary violation, the Administrator, on review, may regard the intermediary violation in a negative light. Therefore, *we would not expect that the Administrator would necessarily remand the matter to the Board for further evidence*, ***unless the Administrator believes that the Board's decision to close the record itself was erroneous***." *Id.* (emphasis added).

BOARD MEMBERS:

Clayton J. Nix, Esq.
Charlotte F. Benson, C.P.A. (*Dissenting in Part*)
Gregory H. Ziegler, C.P.A
Robert A. Evarts, Esq.
Susan A. Turner, Esq. (*Dissenting in Part*)

FOR THE BOARD:

9/4/2020

X Clayton J. Nix

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

Attachment A

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

Nancy Repine
West Virginia University Health System
3040 University Avenue
P.O. Box 8261
Morgantown, WV 26506
US

RE: ***Jurisdictional Challenge***
Reynolds Memorial Hospital (Prov. No. 51-0013)
FYE: 9/30/2015
PRRB Case: 19-2649

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. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

On March 8, 2019, The Provider was issued a final Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2015.

On September 9, 2019, the Board received the Provider's individual appeal request. The Individual Appeal Request contained three (3) issues:

1. DSH/SSI Percentage – Provider Specific
2. DSH/SSI Percentage – Systemic Errors
3. Standardized Payment Amount

Issue 2, DSH/SSI Percentage – Systemic Errors, was transferred to Group Case No. 20-0064GC and Issue 3, Standardized Payment Amount, was transferred to Group Case No. 20-0065GC. Only Issue 1, DSH/SSI Percentage – Provider Specific, remains.

In their Individual Appeal Request, 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.[1]

Provider described its DSH/SSI – Systemic Errors issue, which has been transferred to a group appeal, as whether the Medicare/SSI Fraction used to calculate their DSH payment accurately and correctly counted the number of patient days to be included therein. More specifically, Provider lists the following reasons for challenging its SSI percentage:

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

The Board received a Jurisdictional Challenge filed on behalf of the Medicare Administrative Contractor ("MAC") on July 22, 2020 which argued that the Board lacks jurisdiction over the DSH/SSI Percentage - Provider Specific issue because it is duplicative of the issue which was transferred to case 20-0064GC. They also argue 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.[3]

Board Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), 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 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 Error issue that was transferred to 20-0064GC.

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[1] Model Form A – Individual Appeal Request, Tab 3 at 1 (Sep. 9, 2019).
[2] *Id.* at 1-2.
[3] Medicare Administrative Contractor's Jurisdictional Challenge (July 22, 2020).

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."[4] 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)."[5] 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."[6]

The Provider's DSH/SSI Percentage - Systemic Errors issue in group Case No. 20-0064GC 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 the DSH/SSI Percentage – Provider Specific issue in this appeal is duplicative of the DSH/SSI Percentage - Systemic Errors issue in Case No. 20-0064GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6, 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.

Since no other issues remain, the Board hereby closes Case No. 19-2649 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.

[4] Model Form A – Individual Appeal Request, Tab 3 at 2 (Sep. 9, 2019).
[5] *Id.*
[6] *Id.*

Board Members Participating:

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

For the Board:

9/10/2020

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)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Decision***
OhioHealth CY 2008 Part C Days CIRP Group
Case No. 20-0044GC

Dear Mr. Johnston and Ms. Cummings,

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

Background

On October 4, 2019, the Providers filed this group appeal with the Provider Reimbursement Review Board ("Board"). The group issue statement as submitted is, in part:

> Statement of the Issue: The group members believe the MAC erred by not properly including Medicare Part C days when calculating the group members' DSH percentage calculation.
>
> Brief Description of Issue: The group members believe the MAC incorrectly failed to properly include appropriate bed days associated with certain Medicare Part C patients in the calculation of the group members' DSH percentages, including the impact on the Medicare and Medicaid fractions.
>
> Legal Basis for Appeal: The group members believe that the applicable Medicare DSH regulation defines the numerator of the Medicare fraction as the number of days the hospital spent caring for Part A-entitled patients who were also entitled to income support payments under the Social Security Act. See, respectively, 42 C.F.R. § 412.106(b)(4) and 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The group members believe that the MAC's treatment of bed days, specifically for those patients who are receiving benefits from the Medicare Part C (Medicare Advantage) program, in the Medicare and Medicaid fractions of the DSH calculation is in violation of the

> plain language of the applicable regulations, including but not limited to, 42 C.F.R. § 412.106(b)(4) and the Supreme Court's recent holding in *Azar v. Allina Health Services*, 139 S. Ct. 1804 (2019).[1]

There are three Participants in this group appeal. The Participants have appealed from Revised Notices of Program Reimbursement ("RNPR").

A. Background on Participant #1 – Marion General Hospital

On June 20, 2014, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Marion General Hospital. This reopening notice states that the cost report was reopened to "request a change to the Supplemental Security Income (SSI) percentage in the disproportionate share (DSH) payment calculation. Specifically, we are submitting a request to recalculate the SSI percentage *based on the Hospital's fiscal year rather than the federal fiscal year*."

Marion General Hospital received its RNPR on April 10, 2019. The RNPR included adjustments, "To update the SSI% and payment factor in accordance with CMS' SSI *realignment* calculation."

B. Background on Participant #2 – Grady Memorial Hospital

On June 20, 2014, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Grady Memorial Hospital. This reopening notice states that the cost report was reopened to "request a change to the Supplemental Security Income (SSI) percentage in the disproportionate share (DSH) payment calculation. Specifically, we are submitting a request to recalculate the SSI percentage *based on the Hospital's fiscal year rather than the federal fiscal year*."

Grady Memorial Hospital received its RNPR on October 2, 2019. The RNPR included adjustments, "To update the SSI% and payment factor in accordance with CMS' SSI *realignment* calculation."

C. Background on Participant #3 – OhioHealth Mansfield Hospital

On April 24, 2015, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for OhioHealth Mansfield Hospital. This reopening notice states that the cost report was reopened to "request a change to the Supplemental Security Income (SSI) percentage in the disproportionate share (DSH) payment calculation. Specifically, we are submitting a request to recalculate the SSI percentage *based on the Hospital's fiscal year rather than the federal fiscal year*."

[1] Group Appeal Request Issue Statement (Oct. 4, 2019).

OhioHealth Mansfield Hospital received its RNPR on December 19, 2019. The RNPR included adjustments, "To update the SSI% and payment factor in accordance with CMS' SSI *realignment* calculation."

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is $10,000 or more (or $50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

Relevant Regulations – Revised NPRs

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), which 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) of this subpart) 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. . . .

Additionally, 42 C.F.R. § 405.1889 (2018)[2] 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.

[2] *See also St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Services of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

Finally, 42 C.F.R. § 405.1835(a)(1) provides:

> If a final contractor determination is reopened under §405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination (§§405.1887(d), 405.1889(b), and the "Exception" in §405.1873(c)(2)(i)).

The Board finds that, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b), it does *not* have jurisdiction over the participants in this appeal because the Providers each appealed from RNPRs that did not adjust the issue under appeal.

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are *specifically* revised[.]"[3] The reopenings in this case were a result of the Providers' requests to realign their SSI percentages from the Federal Fiscal Year End to their individual cost reporting fiscal year ends pursuant to the process permitted under 42 C.F.R. § 412.106(b)(3). The audit adjustments associated with the RNPRs under appeal clearly only revised the SSI percentages for each Provider in order to realign it from a federal fiscal year to the providers' respective fiscal year.[4] The Notices of Reopening explicitly stated the reasons for reopening. The cost reports were reopened to "request a change to the Supplemental Security Income (SSI) percentage in the disproportionate share (DSH) payment calculation. Specifically, we are submitting a request to recalculate the SSI percentage based on the Hospital's fiscal year rather than the federal fiscal year." Since the matters specially revised in the revised NPRs were adjustments related to recording the latest RNPR

[3] 42 C.F.R. § 405.1889(b)(1) (emphasis added).

[4] CMS does not utilize a new or different data match process when it issues a realigned SSI percentage. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010) (describing the data match process CMS uses). Further, as noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data on a month-by-month basis. As a result, the month-by-month data underlying the relevant published SSI percentages remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. For example, if a provider has a fiscal year ending ("FYE") December 31st and requested that the SSI percentage for its FYE 12/31/2012 be realigned from FFY 2012 (*i.e.*, October 1, 2011 through September 30, 2012) to the provider's FYE 12/31/2012 (*i.e.*, January 2012 through December 2012), CMS would use the month-by-month data for January 2012 through December 2012 that underlie the relevant published FFY SSI percentages which, in this example, would be the SSI percentages for FFY 2012 and FFY 2013 since the provider's fiscal year spans those FFYs (*i.e.*, the new SSI percentage realigned to the provider's FYE 12/31/2012 would be based on: a) the monthly data for January 2012 through September 2012 which was used in the published FFY 2012 SSI percentage; and b) the monthly data for October 2012 through December 2012 which was used in the published FFY 2013 SSI percentage). *See* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction *using SSI and Medicare data* ***derived from*** the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period. (emphasis added)); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

payment and DSH percentage adjustments, the Board finds that, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b), it does not have jurisdiction over the participants in the subject group appeal. The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[5]

In conclusion, Marion General Hospital, Grady Memorial Hospital, and OhioHealth Mansfield Hospital are dismissed from the appeal because they do not have the right to appeal the RNPR at issue pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b). As there are no participants remaining, the Board hereby closes Case No. 20-0044GC and removes it from the Board's docket.

Board Members Participating:

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

FOR THE BOARD:

9/16/2020

X Clayton J. Nix

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

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

[5] *See also St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Services of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Decision***
OhioHealth CY 2009 Part C Days CIRP Group
Case No. 20-0177GC

Dear Mr. Johnston and Ms. Cummings,

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

Background

On October 21, 2019, the Providers filed this group appeal with the Board. The group issue statement as submitted, in part, is:

> Statement of the Issue: The group members believe the MAC erred by not properly including Medicare Part C days when calculating the group members' DSH percentage calculation.
>
> Brief Description of Issue: The group members believe the MAC incorrectly failed to properly include appropriate bed days associated with certain Medicare Part C patients in the calculation of the group members' DSH percentages, including the impact on the Medicare and Medicaid fractions.
>
> Legal Basis for Appeal: The group members believe that the applicable Medicare DSH regulation defines the numerator of the Medicare fraction as the number of days the hospital spent caring for Part A-entitled patients who were also entitled to income support payments under the Social Security Act. *See*, respectively, 42 C.F.R. § 412.106(b)(4) and 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The group members believe that the MAC's treatment of bed days, specifically for those patients who are receiving benefits from the Medicare Part C (Medicare Advantage) program, in the Medicare and Medicaid fractions of the DSH calculation is in violation of the plain language of the applicable regulations,

including but not limited to, 42 C.F.R. § 412.106(b)(4) and the Supreme Court's recent holding in *Azar v. Allina Health Services*, 139 S. Ct. 1804 (2019).[1]

There are three Participants in this group appeal. The Participants have appealed from Revised Notices of Program Reimbursement ("RNPR").

A. Background on Participant #1 – Doctors Hospital

On June 20, 2014, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Doctors Hospital. This reopening notice states that the cost report was reopened to "request a change to the Supplemental Security Income (SSI) percentage in the disproportionate share (DSH) payment calculation. Specifically, we are submitting a request to recalculate the SSI percentage *based on the Hospital's fiscal year rather than the federal fiscal year*."

Doctors Hospital received its RNPR on April 24, 2019. The RNPR included adjustments, "To update the SSI% and payment factor in accordance with CMS' SSI *realignment* calculation."

B. Background on Participant #2 – Grant Medical Center

On June 20, 2014, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Grant Medical Center. This reopening notice states that the cost report was reopened to "request a change to the Supplemental Security Income (SSI) percentage in the disproportionate share (DSH) payment calculation. Specifically, we are submitting a request to recalculate the SSI percentage *based on the Hospital's fiscal year rather than the federal fiscal year*."

Grant Medical Center received its RNPR on September 4, 2019. The RNPR included adjustments, "To update the SSI% and payment factor in accordance with CMS' SSI *realignment* calculation."

C. Background on Participant #3 – Riverside Methodist Hospital

On June 20, 2014, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Riverside Methodist Hospital. This reopening notice states that the cost report was reopened to "request a change to the Supplemental Security Income (SSI) percentage in the disproportionate share (DSH) payment calculation. Specifically, we are submitting a request to recalculate the SSI percentage *based on the Hospital's fiscal year rather than the federal fiscal year*."

[1] Group Appeal Request Issue Statement (Oct. 21, 2019).

Riverside Methodist Hospital received its RNPR on October 2, 2019. The RNPR included adjustments, "To update the SSI% and payment factor in accordance with CMS' SSI *realignment* calculation."

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is $10,000 or more (or $50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

Relevant Regulations – Revised NPRs

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), which 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) of this subpart) 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. . . .

Additionally, 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.

Finally, 42 C.F.R. § 405.1835(a)(1) provides:

> If a final contractor determination is reopened under §405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination (§§405.1887(d), 405.1889(b), and the "Exception" in §405.1873(c)(2)(i)).

The Board finds that, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b), it does *not* have jurisdiction over the participants in this appeal because the Providers appealed from RNPRs that did not adjust the issue under appeal.

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are *specifically* revised[.]"[2] The reopenings in this case was a result of the Providers' request to realign their SSI percentages from the Federal Fiscal Year End to its individual cost reporting fiscal year end pursuant to the process permitted under 42 C.F.R. § 412.106(b)(3). The audit adjustments associated with the RNPRs under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the providers' respective fiscal year.[3] The cost reports were reopened to "request a change to the Supplemental Security Income (SSI) percentage in the disproportionate share (DSH) payment calculation. Specifically, we are submitting a request to recalculate the SSI percentage based on the Hospital's fiscal year rather than the federal fiscal year." Since the matters specially revised in the revised NPRs were adjustments related to recording the latest RNPR payment and DSH

[2] 42 C.F.R. § 405.1889(b)(1) (emphasis added).

[3] CMS does not utilize a new or different data match process when it issues a realigned SSI percentage. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010) (describing the data match process CMS uses). Further, as noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data on a month-by-month basis. As a result, the month-by-month data underlying the relevant published SSI percentages remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. For example, if a provider has a fiscal year ending ("FYE") December 31st and requested that the SSI percentage for its FYE 12/31/2012 be realigned from FFY 2012 (*i.e.*, October 1, 2011 through September 30, 2012) to the provider's FYE 12/31/2012 (*i.e.*, January 2012 through December 2012), CMS would use the month-by-month data for January 2012 through December 2012 that underlie the relevant published FFY SSI percentages which, in this example, would be the SSI percentages for FFY 2012 and FFY 2013 since the provider's fiscal year spans those FFYs (*i.e.*, the new SSI percentage realigned to the provider's FYE 12/31/2012 would be based on: a) the monthly data for January 2012 through September 2012 which was used in the published FFY 2012 SSI percentage; and b) the monthly data for October 2012 through December 2012 which was used in the published FFY 2013 SSI percentage). *See* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction *using SSI and Medicare data* ***derived from*** the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period. (emphasis added)); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

percentage adjustments, the Board finds that, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b), it does not have jurisdiction over the participants in the subject group appeal. The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[4]

In conclusion, Doctors Hospital, Grant Medical Center, and Riverside Methodist Hospital are dismissed from the appeal because they do not have the right to appeal the RNPR at issue pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b). As there are no participants remaining, the Board hereby closes Case No. 20-0177GC 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.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

9/16/2020

X Clayton J. Nix

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

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

[4] *See also St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Services of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Decision***
Palomar Health Downtown Campus (Prov. No. 05-0115)
FYE 06/30/2014
Case No. 20-1915

Dear Ms. Ellis and Ms. Frewert,

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

Background

On August 21, 2019, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Palomar Health Downtown Campus ("Provider"). This reopening notice states that the cost report was reopened for the following reasons:

- To correct mathematical and flow through errors in cost reporting forms and pages as necessary.
- To make adjustments to correct for cost report software updates and edits as necessary.
- To adjust previous cost report settlement payments as necessary.
- To adjust the SSI ratio used to calculate the provider's Disproportionate Share Adjustment *based on data from the hospital's actual cost reporting period rather than the federal fiscal year* and to amend the Disproportionate Share Adjustment account for the change in the SSI ratio.

On February 10, 2020, the Provider received its RNPR. The RNPR included the following adjustment related to the disproportionate share calculation ("DSH"): "To adjust the SSI% and the Disproportionate Share Amount based on the latest CMS Letter of SSI% Realignment."

On July 27, 2020, the Provider filed this appeal with the Board with the following two issues:

- DSH Accuracy of CMS Developed SSI Ratio; and

- DSH Inclusion of Medicare Part C Days in the SSI Ratio

Later, the Provider timely requested to add a third issue to the appeal:

- DSH Inclusion of Medicare Part A Unpaid Days in SSI Ratio

Board Decision:

The Board has reviewed jurisdiction over this appeal on its own motion. Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. Relevant Regulations – Revised NPRs

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2019), which 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) of this subpart) 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. . . .

Additionally, 42 C.F.R. § 405.1889 (2019)[1] 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.

[1] *See also St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Services of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

> (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.

Finally, 42 C.F.R. § 405.1835(a)(1) provides:

> If a final contractor determination is reopened under §405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination (§§ 405.1887(d), 405.1889(b), and the "Exception" in §405.1873(c)(2)(i)).

The Board finds that, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889, it does *not* have jurisdiction over any of the three issues in this appeal because the adjustment included in the RNPR and that is the subject of this appeal, clearly shows it was as a result of an SSI realignment that changed the 12-month time period for the SSI fraction from the FFY ending September 30 to the Provider's cost reporting period. The Provider in this appeal is not challenging that the Medicare Contractor or CMS didn't calculate the realigned SSI ratio correctly for those dates, but instead challenges the data match used by the Agency and the access to those records used in the data match process. CMS does not utilize a new or different data match process when it issues a realigned SSI percentage[2] and, in addition, all of the underlying data (which is gathered on a month-by-month basis) remains the same. The realigned SSI percentage simply reflects a different 12-month time period being used.[3] More specifically, the realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously

[2] Provider's issue statement.

[3] *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010) (describing the data match process CMS uses). Further, as noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data on a month-by-month basis. As a result, the month-by-month data underlying the relevant published SSI percentages remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. For example, if a provider has a fiscal year ending ("FYE") December 31st and requested that the SSI percentage for its FYE 12/31/2012 be realigned from FFY 2012 (*i.e.*, October 1, 2011 through September 30, 2012) to the provider's FYE 12/31/2012 (*i.e.*, January 2012 through December 2012), CMS would use the month-by-month data for January 2012 through December 2012 that underlie the relevant published FFY SSI percentages which, in this example, would be the SSI percentages for FFY 2012 and FFY 2013 since the provider's fiscal year spans those FFYs (*i.e.*, the new SSI percentage realigned to the provider's FYE 12/31/2012 would be based on: a) the monthly data for January 2012 through September 2012 which was used in the published FFY 2012 SSI percentage; and b) the monthly data for October 2012 through December 2012 which was used in the published FFY 2013 SSI percentage). *See* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction *using SSI and Medicare data* ***derived from*** the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period. (emphasis added)); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY.

Since the matters specially revised in the RNPR were not related to the SSI data match, Part C Days in the SSI Ratio, or Dual Eligible Days in the SSI ratio, the Board finds that, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889, it does not have jurisdiction over the issues and dismisses them from the appeal. The Board hereby closes Case No. 20-1915 and removes it from the Board's docket.

Board Members Participating:

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

FOR THE BOARD:

9/16/2020

X Clayton J. Nix

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

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

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RE: ***Jurisdictional Decision***
Stanford Health Care (05-0441), FYE 08/31/2010
Case No. 20-1957

Dear Ms. Ellis and Ms. Frewert,

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

Background

On August 2, 2019, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Stanford Health Care ("Provider"). This reopening notice states that the cost report was reopened for the following reasons:

- To correct mathematical and flow through errors in cost reporting forms and pages as necessary.
- To make adjustments to correct for cost report software updates and edits as necessary.
- To adjust previous cost report settlement payments as necessary.
- To adjust the SSI ratio used to calculate the provider's Disproportionate Share Adjustment *based on data from the hospital's actual cost reporting period* rather than the federal fiscal year and to amend the Disproportionate Share Adjustment account for the change in the SSI ratio.

The Provider received its revised Notice of Program Reimbursement ("RNPR") on February 25, 2020. The RNPR included adjustments, "To adjust the SSI% and the Disproportionate Share Amount based on the latest CMS Letter of SSI% Realignment."

On August 7, 2020, the Board received the Provider's request for hearing, which included the following two issues:

- DSH – Accuracy of CMS Developed SSI Ratio

- DSH – Inclusion of Medicare Part C Days in the SSI Ratio

The Provider later requested to add the following third issue to the appeal:

- DSH Inclusion of Medicare Part A Unpaid Days in the SSI Ratio

Board Decision

The Board has reviewed jurisdiction of this appeal on its own motion. Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2020), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

Relevant Regulations – Revised NPRs

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2019), which 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) of this subpart) 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. . . .

Additionally, 42 C.F.R. § 405.1889 (2019)[1] 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.

[1] *See also St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Services of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

> (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.

Finally, 42 C.F.R. § 405.1835(a)(1) provides:

> If a final contractor determination is reopened under §405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination (§§ 405.1887(d), 405.1889(b), and the "Exception" in §405.1873(c)(2)(i)).

The Board finds that, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889, it does *not* have jurisdiction over the Provider in this appeal because the Provider appealed from the RNPR that did not adjust the SSI percentage.

The Board finds that it does *not* have jurisdiction over any of the three issues in this appeal because the adjustment included in the RNPR and that is the subject of this appeal, clearly shows it was as a result of SSI realignment that changed the 12-month time period from the FFY ending September 30 to the Provider's cost reporting period. The Provider in this appeal is not challenging that the Medicare Contractor or CMS didn't calculate the realigned SSI ratio correctly for those dates, but instead challenges the data match used by the Agency and the access to those records used in the data match process. CMS does not utilize a new or different data match process when it issues a realigned SSI percentage[2] and, in addition, all of the underlying data (which is gathered on a month-by-month basis) remains the same. The realigned SSI percentage simply reflects a different 12-month time period being used.[3] More specifically,

---

[2] Provider's issue statement.

[3] *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010) (describing the data match process CMS uses). Further, as noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data on a month-by-month basis. As a result, the month-by-month data underlying the relevant published SSI percentages remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. For example, if a provider has a fiscal year ending ("FYE") December 31st and requested that the SSI percentage for its FYE 12/31/2012 be realigned from FFY 2012 (*i.e.*, October 1, 2011 through September 30, 2012) to the provider's FYE 12/31/2012 (*i.e.*, January 2012 through December 2012), CMS would use the month-by-month data for January 2012 through December 2012 that underlie the relevant published FFY SSI percentages which, in this example, would be the SSI percentages for FFY 2012 and FFY 2013 since the provider's fiscal year spans those FFYs (*i.e.*, the new SSI percentage realigned to the provider's FYE 12/31/2012 would be based on: a) the monthly data for January 2012 through September 2012 which was used in the published FFY 2012 SSI percentage; and b) the monthly data for October 2012 through December 2012 which was used in the published FFY 2013 SSI percentage). *See* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction *using SSI and Medicare data* ***derived from*** the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period. (emphasis added)); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal

the realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY.

Since the matters specially revised in the RNPR were not related to the SSI data match, Part C Days in the SSI Ratio, or Dual Eligible Days in the SSI ratio, the Board finds that, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889, it does not have jurisdiction over the issues and dismisses them from the appeal. The Board hereby closes Case No. 20-1915 and removes it from the Board's docket.

Board Members Participating:

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

FOR THE BOARD:

9/16/2020

X Clayton J. Nix

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

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

year. This request may be made only once per cost reporting period, and *the hospital **must accept** the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Decision in Part***
Union Hospital (36-0010)
FYE: 12/31/2006
PRRB Case No.: 13-3476

Dear Mr. Hettich and Ms. Cummings,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the MAC's Jurisdictional Challenge of Union Hospital's ("Provider") Part C Days issue in its individual appeal from its revised Notice of Program Reimbursement ("NPR"). The Board's decision is set forth below.

Background:

The Board received the Provider's Request for Hearing dated September 3, 2013, from a revised NPR dated March 1, 2013.[1] The Provider's appeal request contained the following five issues:

> Medicare Advantage - Medicare Fraction days;
> Medicare Advantage - Medicaid Fraction days;
> Dual Eligible/ Medicare Secondary Payor (MSP) - Medicare Fraction days;
> Dual Eligible/ MSP - Medicaid Fraction days;
> SSI Data Matching.[2]

On April 30, 2014, the Provider transferred the SSI Ratio Data Matching issue into group appeal 14-2296G; and transferred the Dual Eligible Exhausted Days issues (Medicare and Medicaid fractions) into the optional group under Case No. 14-2301G.

The Medicare Administrative Contractor ("MAC") filed a jurisdictional challenge on May 20, 2014, stating that the Board does not have jurisdiction over the Medicare Advantage days – Medicaid Fraction or Dual Eligible / MSP days - Medicaid Fractions issues included in the above

[1] Provider's Request for Appeal (Sep. 3, 2013), PRRB Case No. 13-3476.
[2] *Id.* at Tab 3 (Issue Statement).

referenced case because the MAC did not make an adjustment related to the days in question. The MAC requests that the Board dismiss the issues.

Medicare Contractor's Jurisdictional Challenge

The MAC asserts that it did not make an adjustment to Medicaid days on the revised cost report.[3] In accordance with the Provider Reimbursement Manual, CMS Pub. 15-1, § 115, the Provider included $188,995 in protest items on the as-filed cost report and the MAC removed this amount on the finalized cost report via Adjustment No. 14. Due to the transition between NGS and the current MAC, the MAC does not have the finalized workpapers to identify what these protest items related to. However, the MAC argues that the exact issues are a moot point as the Provider did not file an appeal of the finalized cost report. The Provider's appeal relates only to the Revised NPR, where the *sole* adjustment was to revise the SSI percentage to include Medicare Advantage days and dual eligible days in accordance with CMS Ruling 1498-R.[4]

On February 5, 2014, the Board issued a decision on the jurisdictional challenge of Case No. 07-0916. In that case, the MAC argued that the Board did not have jurisdiction over the case because the Intermediary did not make a final determination related to the IME/GME FTE's that the Provider forgot to claim (*i.e.*, unclaimed costs) on its as-filed cost report.[5]

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

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. §§405.1811, 405.1834, 405. 1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> **(b)(l) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.**
>
> (b)(2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.[6]

The Board has upheld 42 C.F.R. § 405.1889(b)(1) above in the recent jurisdictional challenge decision of Case No. 13-1767, holding "that the revised NPR issued in this case was specific to the SSI ratio and there was no evidence to support an adjustment to the patient days in the Medicaid fraction of the DSH calculation. Therefore, the Board did not have jurisdiction over the Medicaid Fraction Labor Room days and Medicaid Fraction Dual Eligible days issues." The

[3] MAC's Jurisdictional Challenge, at 1 (May 20, 2014).
[4] *Id*. at 2.
[5] *Id*. at 3.
[6] Emphasis added in MAC's Jurisdictional Challenge.

Board issued similar decisions in Case Nos. 04-0760G, 14-0305, 09-l924G for Provider Nos. 05-0277 and 13-1504.[7]

The MAC did not make an adjustment to the Medicare Advantage - Medicaid days or Dual Eligible/MSP - Medicaid days on the revised cost report. The sole adjustment was to revise the SSI percentage to include Medicare Advantage days and dual eligible days in accordance with CMS Ruling 1498-R. Therefore, the MAC has not made a determination with respect to the provider for the issues appealed. The MAC requests that the PRRB dismiss these issues.[8]

Board's Analysis and Decision

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2011) provides in relevant part:

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

42 C.F.R. § 405.1889 (2011) explains the effect of a cost report revision:

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

Finally, 42 C.F.R. § 405.1835(a)(1) provides:

[7] *Id*.
[8] *Id*.

> If a final contractor determination is reopened under §405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination (§§405.1887(d), 405.1889(b), and the "Exception" in §405.1873(c)(2)(i)).

The Board finds that it has jurisdiction over Union's appeal from a revised NPR, but only for the Part C Days issue, as the Medicare fraction was specifically adjusted in the Provider's revised NPR.

Union's revised NPR was issued as the result of a reopening:

> To revise the Medicare-SSI fraction in the DSH calculation to ensure the accurate inclusion of Medicare Advantage data submitted by providers, which will be included in revised SSI ratios to be published by CMS.

The revised NPR regulations make clear that a Provider can only appeal items that are specifically adjusted from a revised NPR. Here, the Board finds that it has jurisdiction over the Part C days issue, because the Part C days included must go in either the Medicare or Medicaid fraction and the SSI fraction was adjusted in the revised NPR as required by 42 C.F.R. § 405.1889 as the D.C. Circuit explained in 2014 in *Allina Health Servs. v. Azar*,[9] and the Provider is dissatisfied with where the additional Part C days were included.

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 Participating:

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

For the Board:

9/18/2020

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[9] 746 F.3d 1102, 1108 (D.C. Cir. 2014).

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RE: ***Jurisdictional Decision***
West George Medical Center (Prov. No. 11-0016)
FYE 9/30/2006
Case No. 13-1412

Dear Mr. Horne and Ms. Huggins,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the Medicare Administrative Contractor's ("MAC") Jurisdictional Challenge over West Georgia Medical Center's ("Hospital" or "Provider") individual appeal from its revised Notice of Program Reimbursement ("NPR"). The Board's decision is set forth below.

Background

The Board received the Provider's Request for Hearing dated April 10, 2013, from a revised NPR dated October 16, 2012.[1] The provider's appeal request contained the following issue statement:

> [W]hether the Medicare Administrative Contractor was correct in including Medicare+Choice/Medicare Advantage Days in the SSI/Medicare fraction of the provider's DSH calculation…. [Provider] contends any Medicare Part C days removed from the Medicare fraction of the DSH patient percentage should be considered, when Medicaid eligible, as part of the Medicaid fraction for the calculation of the Disproportionate share adjustment and reimbursement.[2]

[1] Provider's Request for Appeal (Apr. 10, 2013), PRRB Case No. 13-1412.
[2] *Id.* at 2 (Issue Statement).

On March 19, 2014, the MAC filed a jurisdictional challenge stating that no adjustment was made other than the SSI percentages, and that no work was performed on the Medicaid fraction, thus it is not subject to appeal. The MAC requests that the Board dismiss the issue.

Medicare Contractor's Jurisdictional Challenge

The MAC asserts that the original issue statement challenged is whether CMS, through the MAC, was correct in excluding Medicare Part C Days in the Medicaid Fraction of the Provider's DSH calculation.

Specifically, the MAC notes:

> As noted in the April 6, 2011, Notice of Reopening, the cost report was reopened "To revise the Medicare SSI fraction in the DSH calculation to ensure that accurate inclusion of Medicare Advantage data submitted by providers, which will be included in revised SSI ratios to be published by the CMS." As noted in the adjustment report and workpaper, the only adjustments proposed by the MAC were the revisions to the SSI percentages. The only issue that can be addressed in this appeal is specific to the SSI fraction. Because no work was performed on the Medicaid fraction, it is not subject to appeal.[3]

The MAC acknowledges that it made an adjustment to update the SSI/Medicare Fraction, but argues that these adjustments do not render a final determination with respect to the exclusion of Medicare Part C days from the Medicaid fraction.[4]

Board's Analysis and Decision

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2011) provides in relevant part:

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

42 C.F.R. § 405.1889 (2011) explains the effect of a cost report revision:

[3] MAC's Jurisdictional Challenge, at 2 (Mar. 19, 2014), PRRB Case No. 13-1412.
[4] *Id*.

> (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.

Finally, 42 C.F.R. § 405.1835(a)(1) provides:

> If a final contractor determination is reopened under §405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination (§§405.1887(d), 405.1889(b), and the "Exception" in §405.1873(c)(2)(i)).

The Board finds that it has jurisdiction over West Georgia's appeal from a revised NPR that adjusted the Part C Days in the SSI/Medicare Fraction.

West Georgia's revised NPR was issued as the result of a reopening:

> To revise the Medicare-SSI fraction in the DSH calculation to ensure the accurate inclusion of Medicare Advantage data submitted by providers, which will be included in revised SSI ratios to be published by CMS.

The MAC noted that, in the adjustment report and workpapers, the only adjustments proposed by the MAC were the revisions to the SSI percentages. Thus, the only issue that can be addressed in this appeal is specific to the SSI fraction.

The revised NPR regulations make clear that a Provider can only appeal items that are specifically adjusted from a revised NPR. Here, the Board finds that it has jurisdiction over the Part C days issue, because the Part C days included must go in either the Medicare or Medicaid fraction and the SSI fraction was adjusted in the revised NPR as required by 42 C.F.R. § 405.1889 as the D.C. Circuit explained in 2014 in *Allina Health Servs. v. Azar*,[5] and the Provider is dissatisfied with where the additional Part C days were included. The Part C days is the sole remaining issue in Case No. 13-1412 and, accordingly, it remains open.

[5] 746 F.3d 1102, 1108 (D.C. Cir. 2014).

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 Participating:

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

For the Board:

9/23/2020

X Clayton J. Nix

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cc: Wilson Leong, Federal Specialized Services

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Nashville, TN 37202

RE: ***Jurisdictional Decision***
Cleveland Clinic Fdn. CY 2008 DSH Medicaid Fraction Medicare Managed Care Part C Days CIRP Group
Case No. 20-1545GC

Dear Ms. Goron and Ms. Cummings,

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

Pertinent Facts

On April 6, 2020, a Provider filed this group appeal with the Board. The group issue statement as submitted:

> 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.

Statement of the Legal Basis

> The Providers contend that the Lead MACs' treatment of the MA days is not in accordance with the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). The MAC failed to include patient days applicable to MA patients who were also eligible for Medicaid in the Medicaid fraction of the Medicare DSH payment adjustment, and instead included those days in the SSI or Medicare fraction.
>
> The key legal issue to be determined is whether dual eligible MA patients are "entitled to benefits under Part A." If these patients are not entitled to benefits under Part A, the hospital days associated with these patients should be included in the Medicaid fraction.

> It is clear from the statute that MA patients are not "entitled to benefits under Part A." Under the Medicare statute, "entitlement of an individual to [Medicare part A] benefits for a month shall consist of entitlement to have payment made under, and subject to the limitations in, [Medicare] part A . . . on his behalf for [certain] services." *See* 42 U.S.C § 426(c)(1). A person may only enroll in a MA plan if he is entitled to benefits under Medicare Part A. *See* 42 U.S.C. § 1395w-21(a)(3)(A). However, upon enrollment in a MA plan, an individual is no longer "entitle[d] to have payments made under, and subject to the limitations in, [Medicare] part A." Rather, "payments under a contract with a Medicare+Choice organization…with respect to an individual electing a Medicare+Choice plan offered by the organization shall be ***instead*** of the amounts which (in the absence of the contract) would otherwise be payable under [Medicare] parts A and B." *See* 42 U.S.C. § 1395w-21(i)(1) (emphasis added). *See also* 42 U.S.C. § 1395w-21(a)(1) ("Each [MA] eligible individual . . . is entitled to receive benefits . . . (A) through the original Medicare fee-for-service program under parts A and B . . . , **or** (B) through enrollment in a Medicare+Choice plan under [MA]." (Emphasis added)).[1]

There is only one participant in this group appeal and it appealed from a Revised Notice of Program Reimbursement ("RNPR").

A. Background on Participant #1 – Fairview Hospital

On March 3, 2016, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Fairview Hospital. This reopening notice states that the cost report was reopened solely for the following issue:

> To update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42CFR 412.106(b)(3) and the provider's request received 3/2/2016.[2]

Fairview Hospital received its RNPR on October 2, 2019. The RNPR included adjustments "to update the SSI% and payment factor in accordance with CMS' SSI realignment calculation."[3]

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is $10,000 or more (or $50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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[1] Group Appeal Issue Statement (April 6, 2020) (emphasis added)
[2] Fairview's Notice of Intent to Reopen Cost Report included in Group Appeal Request (April 6, 2020).
[3] Fairview's Audit Adjustment Report included in Group Appeal Request (April 6, 2020).

Relevant Regulations – Revised NPRs

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), which 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) of this subpart) 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. . . .

Additionally, 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.

Finally, 42 C.F.R. § 405.1835(a)(1) provides:

> If a final contractor determination is reopened under §405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination (§§405.1887(d), 405.1889(b), and the "Exception" in §405.1873(c)(2)(i)).

The Board finds that it does not have jurisdiction over the participant in this appeal because it appealed from a RNPR that did not adjust the DSH Medicaid Fraction Medicare Managed Care Part C Days.

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[4] The reopening in this case was a result of the Provider's request to realign its SSI percentage from the Federal Fiscal Year End to its individual cost reporting fiscal year end. The audit adjustments associated with the RNPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year and did not adjust any of the monthly data underlying the SSI percentage (*i.e.*, there is no change in or revision dual eligible days since the underlying monthly data remains the same).[5] The audit adjustment report explicitly stated that the adjustments were, "To update the SSI% and payment factor in accordance with CMS' SSI realignment calculation." The Notice of Reopening for Fairview Hospital explicitly stated that the purpose of the reopening was "to update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the provider's request ..." In other words, the determination was only being reopened to include realigned SSI percentage. Since the only matters specifically revised in the RNPR was adjustments related to realigning SSI percentages from federal fiscal year to provider fiscal year, the Board does not have jurisdiction over Fairview Hospital in the subject group appeal pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b). The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[6]

In conclusion, the Board dismisses Fairview Hospital from the appeal because, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b), it does not have the right to appeal the RNPR at issue. As there are no participants remaining, the Board hereby closes Case No. 20-1545GC 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.

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[4] 42 C.F.R. § 405.1889(b)(1).

[5] CMS does not utilize a new or different data match process when it issues a realigned SSI percentage. 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). All of the underlying data which is gathered on a month-by-month basis remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[6] *See also St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

Board Members Participating:

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

FOR THE BOARD:

9/23/2020

X Clayton J. Nix

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

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

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P.O. Box 20020
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RE: ***Jurisdictional Decision***
Cleveland Clinic Fdn. CY 2012 DSH Medicaid Fraction Dual Eligible Days CIRP Grp
Case No. 20-1581GC

Dear Ms. Goron and Ms. Cummings,

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

Pertinent Facts

On April 15, 2020, the Providers filed this group appeal with the Board. The group issue statement as submitted:

> Whether patient days associated with Medicare Part A and Title XIX eligible patients should be included in the Medicaid percentage of the Medicare Disproportionate Share Hospital ("DSH") calculation. Further, whether the MAC should have included in the Medicaid fraction of the DSH calculation patient days applicable to patients who were eligible for both Medicare and Medicaid where Medicare Part A did not make a payment.

Statement of the Legal Basis

The Providers contend that the Lead MAC did not allow patient days associated with certain Medicare Part A and Title XIX dual eligible patients to be included in the numerator of either the SSI percentage or the Medicaid Percentage of the Medicare DSH calculation. These patients were eligible for Medicare Part A benefits, however, no payments were made by Medicare Part A for these patients. The MAC did not allow the days to be included in the Medicaid Proxy and CMS did not include the days in the calculation of the SSI percentage. In some instances, such days were included in the denominator of the SSI percentage.

> CMS has represented to several Federal courts that the Medicare/SSI fraction only counts Medicare paid days. See, e.g., Legacy Emanuel Hospital & Health Center v. Shalala, 97 F.3d 1261, 1265 (9th Cir. 1996).
>
> While CMS has stated that the SSI fraction would only include patient days paid by Medicare Part A, intermediaries have refused to recognize these dual eligible patient days, which lack Medicare Part A payments, in the Medicaid percentage of the Medicare DSH payment calculation. Since CMS has stated that only "paid" days will be used in the SSI percentage, the Provider contends that the terms **paid** and **entitled** must be consistent with one another due to the usage of the two terms in 42 C.F.R. § 412.106(b) and CMS testimony. The numerator of the SSI percentage requires SSI payments to have been made, thus the denominator should also require Part A payment.
>
> It is the Providers' contention that these days must be included in the Medicaid percentage.[1]

There is only one participant in this group appeal and it appealed from a Revised Notice of Program Reimbursement ("RNPR").

A. Background on Participant #1 – Fairview Hospital

On November 14, 2016, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Fairview Hospital. This reopening notice states that the cost report was reopened solely for the following issue related to the disproportionate share hospital ("DSH") adjustment calculation:

> To update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42CFR 412.106(b)(3) and the provider's request received 11/10/2016.[2]

Fairview Hospital received its RNPR on December 4, 2019. The RNPR included adjustments "to update the SSI% and payment factor in accordance with CMS' SSI *realignment* calculation."[3]

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is $10,000 or more (or $50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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[1] Group Appeal Issue Statement (April 23, 2020) (emphasis added)
[2] Fairview's Notice of Intent to Reopen Cost Report included in Group Appeal Request (April 15, 2020).
[3] (Emphasis added.)

Relevant Regulations – Revised NPRs

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), which 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) of this subpart) 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. . . .

Additionally, 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.

Finally, 42 C.F.R. § 405.1835(a)(1) provides:

> If a final contractor determination is reopened under §405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination (§§405.1887(d), 405.1889(b), and the "Exception" in §405.1873(c)(2)(i)).

The Board finds that it does not have jurisdiction over the participant in this appeal because it appealed from a RNPR that did not adjust the DSH Medicaid Fraction for Dual Eligible Days.

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[4] The reopening in this case was a result of the Provider's request to realign its SSI percentage from the Federal Fiscal Year End to its individual cost reporting fiscal year end. The audit adjustments associated with the RNPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year and did not adjust any of the monthly data underlying the SSI percentage (*i.e.*, there is no change in or revision dual eligible days since the underlying monthly data remains the same).[5] The audit adjustment report explicitly stated that the adjustments were "To update the SSI% and payment factor in accordance with CMS' SSI realignment calculation." The Notice of Reopening for Fairview Hospital explicitly stated that the purpose of the reopening was "to update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the provider's request ..." In other words, the determination was only being reopened to include realigned SSI percentage. Since the only matters specifically revised in the RNPR was adjustments related to realigning SSI percentages from federal fiscal year to provider fiscal year, the Board does not have jurisdiction over Fairview Hospital in the subject group appeal pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b). The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[6]

In conclusion, the Board dismisses Fairview Hospital from the appeal because, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b), it does not have the right to appeal the RNPR at issue. As there are no participants remaining, the Board hereby closes Case No. 20-1581GC 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.

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[4] 42 C.F.R. § 405.1889(b)(1).

[5] CMS does not utilize a new or different data match process when it issues a realigned SSI percentage. 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). All of the underlying data which is gathered on a month-by-month basis remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[6] *See also St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

Board Members Participating:

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

FOR THE BOARD:

9/23/2020

X Clayton J. Nix

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

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

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Nashville, TN 37202

RE: ***Jurisdictional Decision***
Cleveland Clinic Fdn. CY 2010 DSH Medicaid Fraction Dual Eligible Days CIRP Grp.
Case No. 20-1597GC

Dear Ms. Goron and Ms. Cummings,

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

Pertinent Facts

On April 23, 2020, the Providers filed this group appeal with the Provider Reimbursement Review Board ("Board"). The group issue statement as submitted relates to one component of the calculation of the disproportionate share hospital ("DSH") adjustment:

> Whether patient days associated with Medicare Part A and Title XIX eligible patients should be included in the Medicaid percentage of the Medicare Disproportionate Share Hospital ("DSH") calculation. Further, whether the MAC should have included in the Medicaid fraction of the DSH calculation patient days applicable to patients who were eligible for both Medicare and Medicaid where Medicare Part A did not make a payment.

Statement of the Legal Basis

> The Providers contend that the Lead MAC did not allow patient days associated with certain Medicare Part A and Title XIX dual eligible patients to be included in the numerator of either the SSI percentage or the Medicaid Percentage of the Medicare DSH calculation. These patients were eligible for Medicare Part A benefits, however, no payments were made by Medicare Part A for these patients. The MAC did not allow the days to be included in the Medicaid Proxy and CMS did not include the days in the

> calculation of the SSI percentage. In some instances, such days were included in the denominator of the SSI percentage. CMS has represented to several Federal courts that the Medicare/SSI fraction only counts Medicare paid days. See, e.g., Legacy Emanuel Hospital & Health Center v. Shalala, 97 F.3d 1261, 1265 (9th Cir. 1996).
>
> While CMS has stated that the SSI fraction would only include patient days paid by Medicare Part A, intermediaries have refused to recognize these dual eligible patient days, which lack Medicare Part A payments, in the Medicaid percentage of the Medicare DSH payment calculation. Since CMS has stated that only "paid" days will be used in the SSI percentage, the Provider contends that the terms **paid** and **entitled** must be consistent with one another due to the usage of the two terms in 42 C.F.R. § 412.106(b) and CMS testimony. The numerator of the SSI percentage requires SSI payments to have been made, thus the denominator should also require Part A payment.
>
> It is the Providers' contention that these days must be included in the Medicaid percentage.[1]

There are *only* two participants in this group appeal and both of these participants appealed from Revised Notices of Program Reimbursement ("RNPRs").

A. Background on Participant #1 – Euclid Hospital

On December 4, 2019, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Euclid Hospital. Euclid Hospital received its RNPR on December 10, 2019. The RNPR included adjustments "to update the SSI% and payment factor in accordance with CMS' SSI *realignment* calculation."[2]

B. Background on Participant #2 – Huron Hospital

On November 14, 2016, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Huron Hospital. This reopening notice states that the cost report was reopened solely for the following issue:

> To update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the provider's request received 11/09/2016.[3]

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[1] Group Appeal Issue Statement (April 23, 2020) (emphasis added).
[2] (Emphasis added.)
[3] Huron Hospital's Notice of Intent to Reopen Cost Report included in Group Appeal Request (April 23, 2020).

Huron Hospital received its RNPR on March 18, 2020. The RNPR included adjustments "to update the DSH payment factor" as a result of the realigning the SSI fraction from federal fiscal year to the provider's fiscal year.

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is $10,000 or more (or $50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. Relevant Regulations – Revised NPRs

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), which 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) of this subpart) 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. . . .

Additionally, 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.

Finally, 42 C.F.R. § 405.1835(a)(1) provides:

> If a final contractor determination is reopened under §405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination (§§405.1887(d), 405.1889(b), and the "Exception" in §405.1873(c)(2)(i)).

The Board finds that, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b), it does not have jurisdiction over the two participants in this appeal because they each appealed from RNPRs that did not adjust the DSH Medicaid Fraction for Dual Eligible Days.

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[4] The reopenings in this case were a result of the Providers' request to realign their SSI percentage from the Federal Fiscal Year End to its individual cost reporting fiscal year end. The audit adjustments associated with the RNPRs under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year and did not otherwise change the underlying data for the SSI percentage (*i.e.*, there is no change in or revision to dual eligible days since the underlying data remains the same).[5] The audit adjustment report for Euclid Hospital explicitly stated that the adjustments were "To update the SSI% and payment factor in accordance with CMS' SSI realignment calculation." The Notice of Reopening for Huron Hospital explicitly stated that the purpose of the reopening was "to update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the provider's request ..." In other words, the determinations were only being reopened to include realigned SSI percentages. Since the only matters *specifically* revised in the RNPRs were adjustments related to realigning the time period covered by the SSI percentages, the Board does not have jurisdiction over either participant in the subject group appeal pursuant

[4] 42 C.F.R. § 405.1889(b)(1).

[5] CMS does not utilize a new or different data match process when it issues a realigned SSI percentage. 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). All of the underlying data which is gathered on a month-by-month basis remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital **must accept** the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b). The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[6]

In conclusion, the Board dismisses both participants from the appeal because, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b), they do not have the right to appeal the RNPRs at issue. As there are no participants remaining, the Board hereby closes Case No. 20-1597GC and removes it from the Board's docket.

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

Board Members Participating:

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

FOR THE BOARD:

9/23/2020

X Clayton J. Nix

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

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

[6] *See also St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

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Cleveland Clinic Fdn. CY 2010 DSH Medicaid Fraction Dual Eligible Days CIRP Grp.
Case No. 20-1597GC

Dear Ms. Goron and Ms. Cummings,

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

Pertinent Facts

On April 23, 2020, the Providers filed this group appeal with the Provider Reimbursement Review Board ("Board"). The group issue statement as submitted relates to one component of the calculation of the disproportionate share hospital ("DSH") adjustment:

> Whether patient days associated with Medicare Part A and Title XIX eligible patients should be included in the Medicaid percentage of the Medicare Disproportionate Share Hospital ("DSH") calculation. Further, whether the MAC should have included in the Medicaid fraction of the DSH calculation patient days applicable to patients who were eligible for both Medicare and Medicaid where Medicare Part A did not make a payment.

Statement of the Legal Basis

> The Providers contend that the Lead MAC did not allow patient days associated with certain Medicare Part A and Title XIX dual eligible patients to be included in the numerator of either the SSI percentage or the Medicaid Percentage of the Medicare DSH calculation. These patients were eligible for Medicare Part A benefits, however, no payments were made by Medicare Part A for these patients. The MAC did not allow the days to be included in the Medicaid Proxy and CMS did not include the days in the

> calculation of the SSI percentage. In some instances, such days were included in the denominator of the SSI percentage. CMS has represented to several Federal courts that the Medicare/SSI fraction only counts Medicare paid days. See, e.g., Legacy Emanuel Hospital & Health Center v. Shalala, 97 F.3d 1261, 1265 (9th Cir. 1996).
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> While CMS has stated that the SSI fraction would only include patient days paid by Medicare Part A, intermediaries have refused to recognize these dual eligible patient days, which lack Medicare Part A payments, in the Medicaid percentage of the Medicare DSH payment calculation. Since CMS has stated that only "paid" days will be used in the SSI percentage, the Provider contends that the terms **paid** and **entitled** must be consistent with one another due to the usage of the two terms in 42 C.F.R. § 412.106(b) and CMS testimony. The numerator of the SSI percentage requires SSI payments to have been made, thus the denominator should also require Part A payment.
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> It is the Providers' contention that these days must be included in the Medicaid percentage.[1]

There are *only* two participants in this group appeal and both of these participants appealed from Revised Notices of Program Reimbursement ("RNPRs").

A. Background on Participant #1 – Euclid Hospital

On December 4, 2019, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Euclid Hospital. Euclid Hospital received its RNPR on December 10, 2019. The RNPR included adjustments "to update the SSI% and payment factor in accordance with CMS' SSI *realignment* calculation."[2]

B. Background on Participant #2 – Huron Hospital

On November 14, 2016, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Huron Hospital. This reopening notice states that the cost report was reopened solely for the following issue:

> To update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the provider's request received 11/09/2016.[3]

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[1] Group Appeal Issue Statement (April 23, 2020) (emphasis added).
[2] (Emphasis added.)
[3] Huron Hospital's Notice of Intent to Reopen Cost Report included in Group Appeal Request (April 23, 2020).

Huron Hospital received its RNPR on March 18, 2020. The RNPR included adjustments "to update the DSH payment factor" as a result of the realigning the SSI fraction from federal fiscal year to the provider's fiscal year.

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is $10,000 or more (or $50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. Relevant Regulations – Revised NPRs

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), which 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) of this subpart) 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. . . .

Additionally, 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.

Finally, 42 C.F.R. § 405.1835(a)(1) provides:

> If a final contractor determination is reopened under §405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination (§§405.1887(d), 405.1889(b), and the "Exception" in §405.1873(c)(2)(i)).

The Board finds that, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b), it does not have jurisdiction over the two participants in this appeal because they each appealed from RNPRs that did not adjust the DSH Medicaid Fraction for Dual Eligible Days.

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[4] The reopenings in this case were a result of the Providers' request to realign their SSI percentage from the Federal Fiscal Year End to its individual cost reporting fiscal year end. The audit adjustments associated with the RNPRs under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year and did not otherwise change the underlying data for the SSI percentage (*i.e.*, there is no change in or revision to dual eligible days since the underlying data remains the same).[5] The audit adjustment report for Euclid Hospital explicitly stated that the adjustments were "To update the SSI% and payment factor in accordance with CMS' SSI realignment calculation." The Notice of Reopening for Huron Hospital explicitly stated that the purpose of the reopening was "to update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the provider's request ..." In other words, the determinations were only being reopened to include realigned SSI percentages. Since the only matters *specifically* revised in the RNPRs were adjustments related to realigning the time period covered by the SSI percentages, the Board does not have jurisdiction over either participant in the subject group appeal pursuant

[4] 42 C.F.R. § 405.1889(b)(1).

[5] CMS does not utilize a new or different data match process when it issues a realigned SSI percentage. 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). All of the underlying data which is gathered on a month-by-month basis remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital **must accept** the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b). The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[6]

In conclusion, the Board dismisses both participants from the appeal because, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b), they do not have the right to appeal the RNPRs at issue. As there are no participants remaining, the Board hereby closes Case No. 20-1597GC and removes it from the Board's docket.

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

Board Members Participating:

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

FOR THE BOARD:

9/23/2020

X Clayton J. Nix

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

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

[6] *See also St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Decision***
Western Arizona Regional Medical Center (Prov. No. 03-0101)
FYE: 08/31/2012
PRRB Case No.: 18-1422

Dear Messrs. Summar and 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 issues appealed. The Board's decision is set forth below.

Background

On January 2, 2018, the Medicare Contractor issued a Notice of Correction of Program Reimbursement ("revised NPR" or "RNPR") for the fiscal year ending ("FYE") August 31, 2012 to Western Arizona Regional Medical Center ("Western"). The revised NPR was issued "[t]o review the SSI percentage based on the approval of the SSI% Realignment as calculated by CMS."[1] An adjustment was made to the Cost Report on Worksheet E, Part A, Line 30.00, Column 1 to "adjust the cost report to include the hospital's Realignment SSI percentage as calculated by CMS." And an adjustment was also made "[t]o adjust the hospital DSH payment percentage on Worksheet E, Part A, Line 33.00, Column 1 based on the hospital's Realignment SSI percentage as calculated by CMS."[2] On July 5, 2018, Western filed an appeal from the revised NPR appealing the following three issues:

1) Disproportionate Share Hospital ("DSH") Supplemental Security Income ("SSI") Percentage (Provider Specific) including SSI realignment
2) DSH SSI Percentage (Systemic Errors)
3) DSH Medicaid Eligible Days

The Board assigned Case No. 18-1422 to the appeal. On September 14, 2018, the Medicare

[1] Medicare Administrative Contractor May 30, 2019 Preliminary Position Paper at Exhibit C-1.
[2] Provider's July 5, 2018 Individual Appeal Request at Tab 4 Adj. Nos. 5 and 6.

Contractor filed a Jurisdictional Challenge contesting the Board's jurisdiction over the portion of Issue 1 related to SSI data accuracy and individuals who are eligible for SSI but did not receive SSI payment and contesting jurisdiction over issues 2 and 3. On October 12, 2018, Western filed a response to the Medicare Contractor's Jurisdictional Challenge. On February 21, 2019, Western transferred Issue 2, the DSH SSI Percentage issue, to Case No. 19-1196GC, CHS CY 2012 DSH SSI Percentage CIRP Group. On February 22, 2019, Western filed its Preliminary Position Paper. On May 30, 2019, the Medicare Contractor filed its Preliminary Position Paper.

Medicare Contractor's Position

The Medicare Contractor contends that Issue 1, the DSH SSI Percentage (Provider Specific) issue, has three components: SSI data accuracy, individuals who are eligible for SSI but did not receive SSI payment and SSI realignment. The Medicare Contractor maintains the portion of Issue 1 concerning SSI data accuracy is duplicative of Issue 2, the DSH SSI Percentage (Systemic Errors) issue, which was transferred to Case No. 19-1196GC, CHS CY 2012 DSH SSI Percentage CIRP Group. The Medicare Contractor asserts that, pursuant to 42 C.F.R. § 405.1887(d) and 42 C.F.R. § 405.1889, the Board does not have jurisdiction over the following issues because they were not specifically revised in the RNPR: (1) the portion of Issue 1 related to SSI data accuracy: (2) the portion of Issue 1 related to individuals who are eligible for SSI but did not receive SSI payment; (3) Issue 2; and (4) Issue 3.[3] The Medicare Contractor contends that the RNPR incorporates the following six adjustments:

Adjustment #1: To complete all cost reporting forms and pages
Adjustment #2: To correct mathematical and flow through errors
Adjustment #3: To apply lower of cost or charges
Adjustment #4: To include prior settlement amounts-i.e, tentative settlements
Adjustment #5: To include the realigned SSI percentage as calculated by CMS
Adjustment #6: To adjust the allowable disproportionate share percentage based on the realigned SSI percentage

The Medicare Contractor maintains the RNPR incorporates Western's realigned SSI percentage as calculated by CMS. The Medicare Contractor contends it did not propose adjustments to the underlying data used to calculate the SSI percentage in the RNPR nor did it propose adjustments to DSH Medicaid eligible days in the RNPR. The Medicare Contractor asserts in accordance with 42 C.F.R. § 405.1887(d) and 42 C.F.R. § 405.1889, the Board lacks jurisdiction over the portion of issue 1 related to SSI data accuracy and individuals who are eligible for SSI but did not receive SSI payment and over issues 2 and 3 because it did not render a determination over these issues in the RNPR. The Medicare Contractor requests that these issues be dismissed.

[3] Medicare Contractor's September 14, 2018 Jurisdictional Challenge at 2-3.

The Medicare Contractor maintains the remaining issue in this case is the portion of Issue 1 related to SSI realignment, which is why the RNPR was issued. The Medicare Contractor argues the RNPR incorporates Western's realigned SSI percentage as calculated by CMS.[4]

Provider's Position

On October 12, 2018, Western filed a Jurisdictional Response in which it contends that the Board has jurisdiction over the DSH SSI Percentage issue including both the Provider Specific and SSI realignment sub-issues and the DSH Medicaid Eligible Days issue. Western maintains each of the appealed SSI Percentage issues are separate and distinct issues. Western asserts Issues 1 and 2 represent different aspects/components of the SSI Percentage issue. As such, the Board should find jurisdiction over both Issues 1 and 2. Western contends that Issue 2, the SSI Percentage (Systemic Errors) issue, addresses the various errors discussed in *Baystate Medical Center v. Leavitt*, 545 F. Supp.2d 20 (D.D.C. 2008) in CMS' calculation of the disproportionate payment percentage. Western maintains that Issue 1, the SSI Percentage (Provider Specific) including SSI realignment issue, addresses the various errors of omission and commission that do not fit into the systemic errors category.

Western argues that it has analyzed Medicare Part A records and has been able to identify patients believed to be entitled to both Medicare Part A and SSI. Western contends that it has reason to believe that the SSI percentage determined by CMS is incorrect due to the understated days in the SSI ratio. Western maintains that it is entitled to appeal an item with which it is dissatisfied; the DSH SSI percentage was adjusted on its cost report; it is dissatisfied with the amount of DSH payments that it received for fiscal year 2012. Thus, the Board should find jurisdiction over the DSH SSI Percentage (Provider Specific) issue.[5]

Western notes that the Medicare Contractor made an adjustment to DSH with Audit Adjustment No. 6. Western argues such an adjustment was enough to warrant Board jurisdiction over the Medicaid Eligible Days issue. Western maintains such an adjustment is not required, as DSH is not an item that has to be adjusted or claimed on a cost report. Accordingly, the presentment requirement does not apply. Western contends the issuance of a RNPR and timely appeal properly triggers the Board's jurisdiction over the Medicaid Eligible Days issue.[6]

Western asserts should the Board determine that the protesting/presentment requirement is valid, Western maintains that it does not apply in this situation as DSH is not an item that must be adjusted or even claimed on a cost report. Western argues because of CMS Ruling 1727-R, the Board should assert jurisdiction over the DSH Medicaid Eligible Days issue. Western argues it appealed a cost reporting period that ends on or after December 31, 2008, and begins before January 1, 2016, and its appeal was pending or initiated on or after April 23, 2018, the effective date of this Ruling. In addition, it had a good faith belief that claiming reimbursement for the

[4] *Id.* at 4-5.
[5] Provider's October 12, 2018 Jurisdictional Response at 1-2.
[6] *Id.* at 3.

additional DSH Medicaid Eligible Days in the cost report would be futile because it was subject to a regulation or other payment policy that bound the Medicare Contractor and left the Medicare Contractor with no authority or discretion to make payment in the manner sought by it. Specifically, although it was aware that it could support the additional Medicaid Eligible Days when the State matching data was issued, it was prohibited from claiming the additional Medicaid Eligible Days in the cost report because the State matching data had not been issued as of the deadline for filing the cost report.[7]

Western maintains the self-disallowance requirement in 42 C.F.R. § 405.1811(a)(1)(ii) does not apply to its appeal because, it has a good faith belief that claiming reimbursement for such item in the cost report would be futile because the item was subject to a regulation or other payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by it. Western argues the Board is prohibited from denying jurisdiction because its appeal comes within CMS' Ruling. Western requests the Board deny the Medicare Contractor's Jurisdictional Challenge and assert jurisdiction over its appeal based on CMS Ruling 1727-R.[8]

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is $10,000 or more (or $50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), which 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) of this subpart) 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. . . .

Additionally, 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] *Id.* at 8-9.
[8] *Id.* at 10.

> 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.

Finally, 42 C.F.R. § 405.1835(a)(1) provides:

> If a final contractor determination is reopened under §405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination (§§405.1887(d), 405.1889(b), and the "Exception" in §405.1873(c)(2)(i)).

The Board finds that it does *not* have jurisdiction over this appeal because the Provider appealed from a RNPR that did not adjust any of the issues under appeal.

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are *specifically* revised[.]"[9] The reopening in this case was a result of the Provider's request to realign its SSI percentage from the Federal Fiscal Year End to its individual cost reporting fiscal year end pursuant to the process permitted under 42 C.F.R. § 412.106(b)(3). The audit adjustments associated with the RNPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's fiscal year and did not adjust any of the monthly data underlying the SSI percentages (*i.e.*, there is no change in or revision dual eligible days since the underlying monthly data remains the same).[10] Since the matters specially revised in the revised NPRs were adjustments related to

[9] 42 C.F.R. § 405.1889(b)(1) (emphasis added).

[10] CMS does not utilize a new or different data match process when it issues a realigned SSI percentage. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010) (describing the data match process CMS uses). Further, as noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data on a month-by-month basis. As a result, the month-by-month data underlying the relevant published SSI percentages remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. For example, if a provider has a fiscal year ending ("FYE") December 31st and requested that the SSI percentage for its FYE 12/31/2012 be realigned from FFY 2012 (*i.e.*, October 1, 2011 through September 30, 2012) to the provider's FYE 12/31/2012 (*i.e.*, January 2012 through December 2012), CMS would use the month-by-month data for January 2012 through December 2012 that underlie the relevant published FFY SSI percentages which, in this example, would be the SSI percentages for FFY 2012 and FFY 2013 since the provider's fiscal year spans those FFYs (*i.e.*, the new SSI percentage realigned to the provider's FYE 12/31/2012 would be based on: a) the monthly data for January 2012 through September 2012 which was used in the published

recording the latest RNPR payment and realigning the SSI percentage from the federal fiscal year to the provider fiscal year, the Board finds that it does not have jurisdiction over the issues in the subject appeal pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b). The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[11]

In summary, the Board concludes that it does not have jurisdiction over any of the following issues because, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b), they do not have the right to appeal the RNPRs at issue:

- Issue 1, the DSH SSI Percentage (Provider Specific) (all three parts including SSI realignment issue[12]),
- Issue 2 the DSH SSI Percentage (Systemic Errors) issue;[13] and
- Issue 3, the DSH Medicaid Eligible Days issue.[14]

Accordingly, the Board dismisses these issues from the appeal. In addition, the Board denies the transfer of Issue 2, the DSH SSI Percentage (Systemic Errors) issue, from Case No. 18-1422 to Case No. 19-1196GC, CHS CY 2012 DSH SSI Percentage CIRP Group. The Board closes the case as no other issues remain in the appeal.

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.

FFY 2012 SSI percentage; and b) the monthly data for October 2012 through December 2012 which was used in the published FFY 2013 SSI percentage). *See* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction *using SSI and Medicare data* ***derived from*** the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period. (emphasis added)); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[11] *See also St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

[12] The Board recognizes that, in its appeal request, the Provider "preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period." However, not only is this not an appealable issue (since preservation of a right is not a determination), the Provider already obtained a realignment when the MAC issued the RNPR at issue. As such, the request to preserve its right to request realignment is now moot.

[13] *See supra* note 10 (discussing how CMS has not changed its data match process and how the realignment process does not change any of the monthly data underlying the SSI percentages).

[14] The issue pertains to the Medicaid fraction and there was no adjustment to the Medicaid fraction.

Board Members participating:

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

FOR THE BOARD

9/24/2020

X Clayton J. Nix

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Decision***
Cleveland Clinic Fdn. CY 2006 DSH SSI Fraction Dual Eligible Days CIRP Group
Case No. 20-1371GC

Dear Ms. Goron and Ms. Cummings,

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

Pertinent Facts

On March 6, 2020, the Providers filed this group appeal with the Provider Reimbursement Review Board ("Board"). The group issue statement as submitted:

> Whether patient days associated with Medicare Part A and Title XIX eligible patients should be included in the Medicaid percentage of the Medicare Disproportionate Share Hospital ("DSH") calculation. Further, whether the MACs' should have excluded from the SSI or Medicare fraction of the DSH calculation patient days applicable to patients who were eligible for both Medicare and Medicaid where Medicare Part A did not make a payment.

Statement of the Legal Basis

The Providers contend that the Lead MAC did not allow patient days associated with certain Medicare Part A and Title XIX dual eligible patients to be included in the numerator of either the SSI percentage or the Medicaid Percentage of the Medicare DSH calculation. These patients were eligible for Medicare Part A benefits, however, no payments were made by Medicare Part A for these patients. The MAC did not allow the days to be included in the Medicaid Proxy and CMS did not include the days in the calculation of the SSI percentage. In some instances, such days were included in the denominator of the SSI percentage.

> CMS has represented to several Federal courts that the Medicare/SSI fraction only counts Medicare paid days. See, e.g., Legacy Emanuel Hospital & Health Center v. Shalala, 97 F.3d 1261, 1265 (9th Cir. 1996).
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> While CMS has stated that the SSI fraction would only include patient days paid by Medicare Part A, intermediaries have refused to recognize these dual eligible patient days, which lack Medicare Part A payments, in the Medicaid percentage of the Medicare DSH payment calculation. Since CMS has stated that only "paid" days will be used in the SSI percentage, the Provider contends that the terms **paid** and **entitled** must be consistent with one another due to the usage of the two terms in 42 C.F.R. § 412.106(b) and CMS testimony. The numerator of the SSI percentage requires SSI payments to have been made, thus the denominator should also require Part A payment.
>
> It is the Providers contention that these days must be excluded from both the numerator and the denominator of the SSI percentage factor in the Medicare DSH formula.[1]

There are *only* two participants in this group appeal and they appealed from Revised Notices of Program Reimbursement ("RNPRs").

A. Background on Participant #1 – Fairview Hospital

On November 14, 2016, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Fairview Hospital. This reopening notice states that the cost report was reopened solely for the following issue:

> To update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42CFR 412.106(b)(3) and the provider's request received 11/09/2016.[2]

Fairview Hospital received its RNPR on September 4, 2019. The RNPR included adjustments "to update the SSI% and payment factor in accordance with CMS' SSI realignment calculation."[3]

B. Background on Participant #2 – Lutheran Hospital

On November 14, 2016, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Lutheran Hospital. This reopening notice states that the cost report was reopened solely for the following issue:

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[1] Group Appeal Issue Statement (March 6, 2020) (emphasis added)
[2] Fairview's Notice of Intent to Reopen Cost Report included in Group Appeal Request (March 6, 2020).
[3] Fairview's Audit Adjustment Report included in Group Appeal Request (March 6, 2020).

> To update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42CFR 412.106(b)(3) and the provider's request received 11/09/2016.[4]

Lutheran Hospital received its RNPR on September 4, 2019. The RNPR included adjustments "to update the SSI% and payment factor in accordance with CMS' SSI realignment calculation."[5]

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is $10,000 or more (or $50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

Relevant Regulations – Revised NPRs

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), which 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) of this subpart) 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. . . .

Additionally, 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.

[4] Lutheran's Notice of Intent to Reopen Cost Report included in Group Appeal Request (March 6, 2020).
[5] Lutheran's Audit Adjustment Report included in Group Appeal Request (March 6, 2020).

> (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.

Finally, 42 C.F.R. § 405.1835(a)(1) provides:

> If a final contractor determination is reopened under §405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination (§§405.1887(d), 405.1889(b), and the "Exception" in §405.1873(c)(2)(i)).

The Board finds that it does not have jurisdiction over the participants in this appeal because they appealed from a RNPR that did not adjust the DSH SSI Fraction for Dual Eligible Days.

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[6] The reopenings in this case were a result of the Provider's request to realign its SSI percentage from the Federal Fiscal Year End to its individual cost reporting fiscal year end. The audit adjustments associated with the RNPRs under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year and did not adjust any of the monthly data underlying the SSI percentage (*i.e.*, there is no change in or revision dual eligible days since the underlying monthly data remains the same).[7] The audit adjustment report explicitly stated that the adjustments were "To update the SSI% and payment factor in accordance with CMS' SSI realignment calculation." The Notices of Reopening explicitly stated that the purpose of the reopening was "to update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the provider's request ..." In other words, the determinations were only being reopened to include realigned SSI percentage. Since the only matters specifically revised in the RNPRs was adjustments related to realigning SSI

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[6] 42 C.F.R. § 405.1889(b)(1).

[7] CMS does not utilize a new or different data match process when it issues a realigned SSI percentage. 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). All of the underlying data which is gathered on a month-by-month basis remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital **must accept** the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

percentages from federal fiscal year to provider fiscal year, the Board does not have jurisdiction over the participants in the subject group appeal pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b). The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[8]

In conclusion, the participants are dismissed from the appeal because, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b), they do not have the right to appeal the RNPRs at issue. As there are no participants remaining, the Board hereby closes Case No. 20-1371GC and removes it from the Board's docket.

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

Board Members Participating:

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

FOR THE BOARD:

9/24/2020

X Clayton J. Nix

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

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

[8] *See also St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Jurisdictional Decision***
Cleveland Clinic Fdn. CY 2007 DSH Medicaid Fraction Medicare Managed Care Part C Days CIRP Group
Case No. 20-1517GC

Dear Ms. Goron and Ms. Cummings,

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

Pertinent Facts

On April 1, 2020, the Providers filed this group appeal with the Board. The group issue statement as submitted is:

> 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.

Statement of the Legal Basis

The Providers contend that the Lead MACs' treatment of the MA days is not in accordance with the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). The MAC failed to include patient days applicable to MA patients who were also eligible for Medicaid in the Medicaid fraction of the Medicare DSH payment adjustment, and instead included those days in the SSI or Medicare fraction. The key legal issue to be determined is whether dual eligible MA patients are "entitled to benefits under Part A." If these patients are not entitled to benefits under Part A, the hospital days associated with these patients should be included in the Medicaid fraction.

> It is clear from the statute that MA patients are not "entitled to benefits under Part A." Under the Medicare statute, "entitlement of an individual to [Medicare part A] benefits for a month shall consist of entitlement to have payment made under, and subject to the limitations in, [Medicare] part A . . . on his behalf for [certain] services." *See* 42 U.S.C § 426(c)(1). A person may only enroll in a MA plan if he is entitled to benefits under Medicare Part A. *See* 42 U.S.C. § 1395w-21(a)(3)(A). However, upon enrollment in a MA plan, an individual is no longer "entitle[d] to have payments made under, and subject to the limitations in, [Medicare] part A." Rather, "payments under a contract with a Medicare+Choice organization…with respect to an individual electing a Medicare+Choice plan offered by the organization shall be ***instead*** of the amounts which (in the absence of the contract) would otherwise be payable under [Medicare] parts A and B." *See* 42 U.S.C. § 1395w-21(i)(1) (emphasis added). *See also* 42 U.S.C. § 1395w-21(a)(1) ("Each [MA] eligible individual . . . is entitled to receive benefits . . . (A) through the original Medicare fee-for-service program under parts A and B . . . , **or** (B) through enrollment in a Medicare+Choice plan under [MA]." (Emphasis added)).[1]

There are *only* three participants in this group appeal and all appealed from Revised Notice of Program Reimbursement ("RNPR").

A. Background on Participant #1 – South Pointe Hospital

On August 14, 2019, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for South Pointe Hospital. South Pointe Hospital received its RNPR on October 2, 2019. The RNPR included adjustments "to update the SSI% and payment factor in accordance with CMS' SSI realignment calculation."[2]

B. Background on Participant #2 – Euclid Hospital

On October 16, 2015, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Euclid Hospital. This reopening notice states that the cost report was reopened solely for the following issue:

> To update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42CFR 412.106(b)(3) and the provider's request received 10/16/2015.[3]

Euclid Hospital received its RNPR on October 2, 2019. The RNPR included adjustments "to update the SSI% and payment factor in accordance with CMS' SSI realignment calculation."[4]

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[1] Group Appeal Issue Statement (April 1, 2020).
[2] South Pointe's Audit Adjustment Report included in Group Appeal Request (April 1, 2020).
[3] Euclid's Notice of Intent to Reopen Cost Report included in Direct Add Request (April 2, 2020).
[4] Euclid's Audit Adjustment Report included in Direct Add Request (April 2, 2020).

C. Background on Participant #3 – Cleveland Clinic

On October 16, 2015, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Cleveland Clinic. This reopening notice states that the cost report was reopened solely for the following issue:

> To update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42CFR 412.106(b)(3) and the provider's request received 10/16/2015[5]

Cleveland Clinic received its RNPR on October 2, 2019. The RNPR included adjustments "to update the SSI% and payment factor in accordance with CMS' SSI realignment calculation."[6]

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is $10,000 or more (or $50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

Relevant Regulations – Revised NPRs

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), which 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) of this subpart) 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. . . .

Additionally, 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.

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[5] Cleveland's Notice of Intent to Reopen Cost Report included in Direct Add Request (April 6, 2020).
[6] Cleveland's Audit Adjustment Report included in Direct Add Request (April 6, 2020).

> (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.

Finally, 42 C.F.R. § 405.1835(a)(1) provides:

> If a final contractor determination is reopened under §405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination (§§405.1887(d), 405.1889(b), and the "Exception" in §405.1873(c)(2)(i)).

The Board finds that it does not have jurisdiction over the participants in this appeal because they appealed from a RNPR that did not adjust the DSH Medicaid Fraction Medicare Managed Care Part C Days.

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[7] The reopenings in this case were a result of the Providers' request to realign its SSI percentage from the Federal Fiscal Year End to its individual cost reporting fiscal year end. The audit adjustments associated with the RNPRs under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year and did not adjust any of the monthly data underlying the SSI percentage (*i.e.*, there is no change in or revision dual eligible days since the underlying monthly data remains the same).[8] The audit adjustment reports explicitly stated

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[7] 42 C.F.R. § 405.1889(b)(1).

[8] CMS does not utilize a new or different data match process when it issues a realigned SSI percentage. 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). All of the underlying data which is gathered on a month-by-month basis remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital **must accept** the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

that the adjustments were "To update the SSI% and payment factor in accordance with CMS' SSI realignment calculation." The Notices of Reopening for Euclid Hospital and Cleveland Clinic explicitly stated that the purpose of the reopening was "to update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the provider's request ..." In other words, the determinations were only being reopened to include realigned SSI percentage. Since the only matters specifically revised in the RNPRs were adjustments related to realigning SSI percentages from federal fiscal year to provider fiscal year, the Board does not have jurisdiction over the participants in the subject group appeal pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b). The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[9]

In conclusion, all participants are dismissed from the appeal because, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b), they do not have the right to appeal the RNPRs at issue. As there are no participants remaining, the Board hereby closes Case No. 20-1517GC and removes it from the Board's docket.

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

Board Members Participating:

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

FOR THE BOARD:

9/24/2020

X Clayton J. Nix

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

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

[9] *See also St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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Judith Cummings
CGS Audit & Reimbursement
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RE: ***Jurisdictional Decision***
Cleveland Clinic Fdn. CY 2008 DSH Medicaid Fraction Dual Eligible Days CIRP Group
Case No. 20-1546GC

Dear Ms. Goron and Ms. Cummings,

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

Pertinent Facts

On April 6, 2020, the Providers filed this group appeal with the Provider Reimbursement Review Board ("Board"). The group issue statement as submitted:

> Whether patient days associated with Medicare Part A and Title XIX eligible patients should be included in the Medicaid percentage of the Medicare Disproportionate Share Hospital ("DSH") calculation. Further, whether the MAC should have included in the Medicaid fraction of the DSH calculation patient days applicable to patients who were eligible for both Medicare and Medicaid where Medicare Part A did not make a payment.

Statement of the Legal Basis

The Providers contend that the Lead MAC did not allow patient days associated with certain Medicare Part A and Title XIX dual eligible patients to be included in the numerator of either the SSI percentage or the Medicaid Percentage of the Medicare DSH calculation. These patients were eligible for Medicare Part A benefits, however, no payments were made by Medicare Part A for these patients. The MAC did not allow the days to be included in the Medicaid Proxy and CMS did not include the days in the calculation of the SSI percentage. In some instances, such days were included in the denominator of the SSI percentage.

> CMS has represented to several Federal courts that the Medicare/SSI fraction only counts Medicare paid days. See, e.g., Legacy Emanuel Hospital & Health Center v. Shalala, 97 F.3d 1261, 1265 (9th Cir. 1996).
>
> While CMS has stated that the SSI fraction would only include patient days paid by Medicare Part A, intermediaries have refused to recognize these dual eligible patient days, which lack Medicare Part A payments, in the Medicaid percentage of the Medicare DSH payment calculation. Since CMS has stated that only "paid" days will be used in the SSI percentage, the Provider contends that the terms **paid** and **entitled** must be consistent with one another due to the usage of the two terms in 42 C.F.R. § 412.106(b) and CMS testimony. The numerator of the SSI percentage requires SSI payments to have been made, thus the denominator should also require Part A payment.
>
> It is the Providers' contention that these days must be included in the Medicaid percentage.[1]

There is *only* one participant in this group appeal and it appealed from a Revised Notice of Program Reimbursement ("RNPR").

A. Background on Participant #1 – Fairview Hospital

On March 3, 2016, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Fairview Hospital. This reopening notice states that the cost report was reopened solely for the following issue:

> To update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the provider's request received 3/2/2016.[2]

Fairview Hospital received its RNPR on October 2, 2019. The RNPR included adjustments "to update the SSI% and payment factor in accordance with CMS' SSI realignment calculation."[3]

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is $10,000 or more (or $50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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[1] Group Appeal Issue Statement (April 6, 2020) (emphasis added).
[2] Fairview's Notice of Intent to Reopen Cost Report included in Group Appeal Request (April 6, 2020).
[3] Fairview's Audit Adjustment Report included in Group Appeal Request (April 6, 2020).

Relevant Regulations – Revised NPRs

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), which 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) of this subpart) 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. . . .

Additionally, 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.

Finally, 42 C.F.R. § 405.1835(a)(1) provides:

> If a final contractor determination is reopened under §405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination (§§405.1887(d), 405.1889(b), and the "Exception" in §405.1873(c)(2)(i)).

The Board finds that it does not have jurisdiction over the participant in this appeal because it appealed from a RNPR that did not adjust the DSH Medicaid Fraction for Dual Eligible Days.

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[4] The reopening in this case was a result of the Provider's request to realign its SSI percentage from the Federal Fiscal Year End to its individual cost reporting fiscal year end. The audit adjustments associated with the RNPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year and did not adjust any of the monthly data underlying the SSI percentage (*i.e.*, there is no change in or revision dual eligible days since the underlying monthly data remains the same).[5] The Notice of Reopening for Fairview Hospital explicitly stated that the purpose of the reopening was "to update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the provider's request ..." In other words, the determination was only being reopened to include realigned SSI percentage. Since the only matters specifically revised in the RNPR was adjustments related to realigning SSI percentages from federal fiscal year to provider fiscal year, the Board does not have jurisdiction over Fairview Hospital in the subject group appeal pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b). The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[6]

In conclusion, Fairview Hospital is dismissed from the appeal because, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b), it does not have the right to appeal the RNPR at issue. As there are no participants remaining, the Board hereby closes Case No. 20-1546GC 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.

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[4] 42 C.F.R. § 405.1889(b)(1).

[5] CMS does not utilize a new or different data match process when it issues a realigned SSI percentage. 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). All of the underlying data which is gathered on a month-by-month basis remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[6] *See also St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

Board Members Participating:

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

FOR THE BOARD:

9/24/2020

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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Via Electronic Delivery

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

RE: ***Jurisdictional Decision***
Cleveland Clinic Fdn. CY 2008 DSH/SSI Percentage CIRP Group
Case No. 20-1539GC

Dear Ms. Goron and Ms. Cummings,

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

Pertinent Facts

On April 6, 2020, the Providers filed this group appeal with the Board. The group issue statement as submitted is:

> Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?

Statement of the Legal Basis

The Providers contend that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww (d)(S)(F)(vi)(I). The Providers further contend that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.

The Providers challenge their SSI percentages based on the following reasons:

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.[1]

There is *only* one participant in this group appeal and it appealed from a Revised Notice of Program Reimbursement ("RNPR").

A. Background on Participant #1 – Fairview Hospital

On March 3, 2016, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Fairview Hospital. This reopening notice states that the cost report was reopened solely for the following issue:

> To update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42CFR 412.106(b)(3) and the provider's request received 3/2/2016.[2]

Fairview Hospital received its RNPR on October 2, 2019. The RNPR included adjustments "to update the SSI% and payment factor in accordance with CMS' SSI realignment calculation."[3]

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is $10,000 or more (or $50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

Relevant Regulations – Revised NPRs

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), which provides in relevant part:

---

[1] Group Appeal Issue Statement (April 6, 2020).
[2] Fairview's Notice of Intent to Reopen Cost Report included in Group Appeal Request (April 6, 2020).
[3] Fairview's Audit Adjustment Report included in Group Appeal Request (April 6, 2020).

> (a) General. (1) A Secretary determination, a contractor determination, or a decision by a reviewing entity (as described in § 405.1801(a) of this subpart) 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. . . .

Additionally, 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.

Finally, 42 C.F.R. § 405.1835(a)(1) provides:

> If a final contractor determination is reopened under §405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination (§§405.1887(d), 405.1889(b), and the "Exception" in §405.1873(c)(2)(i)).

The Board finds that it does not have jurisdiction over the participant in this appeal because it appealed from a RNPR that did not adjust the DSH/SSI Percentage for paid/unpaid and covered/uncovered days.

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[4] The reopening in this case was a result of the Provider's request to realign its SSI percentage from the Federal Fiscal Year End to its individual cost reporting fiscal year end. The audit adjustments associated with the RNPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year and did not adjust any of the monthly

[4] 42 C.F.R. § 405.1889(b)(1).

data underlying the SSI percentages (*i.e.*, CMS did not reapply its data matching methodology as the monthly data underlying the SSI percentages remains the same).[5] The audit adjustment report explicitly stated that the adjustments were "To update the SSI% and payment factor in accordance with CMS' SSI realignment calculation." The Notice of Reopening for Fairview Hospital explicitly stated that the purpose of the reopening was "to update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the provider's request ..." In other words, the determination was only being reopened to include realigned SSI percentage. Since the only matters specifically revised in the RNPR was adjustments related to realigning the SSI percentage from the federal fiscal year to the provider fiscal year, the Board does not have jurisdiction over Fairview Hospital in the subject group appeal pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b). The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[6]

In conclusion, Fairview Hospital is dismissed from the appeal because, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b), it does not have the right to appeal the RNPR at issue. As there are no participants remaining, the Board hereby closes Case No. 20-1539GC 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.

---

[5] CMS does not utilize a new or different data match process when it issues a realigned SSI percentage. 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). All of the underlying data which is gathered on a month-by-month basis remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[6] *See St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

Board Members Participating:

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

FOR THE BOARD:

9/25/2020

X Clayton J. Nix

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

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

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

RE: ***Jurisdictional Decision***
Cleveland Clinic Fdn. CY 2008 DSH SSI Fraction Dual Eligible Days CIRP Group
Case No. 20-1544GC

Dear Ms. Goron and Ms. Cummings,

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

Pertinent Facts

On April 6, 2020, the Providers filed this group appeal with the Board. The group issue statement as submitted is:

> Whether patient days associated with Medicare Part A and Title XIX eligible patients should be included in the Medicaid percentage of the Medicare Disproportionate Share Hospital ("DSH") calculation. Further, whether the MAC should have included in the Medicaid fraction of the DSH calculation patient days applicable to patients who were eligible for both Medicare and Medicaid where Medicare Part A did not make a payment.

Statement of the Legal Basis

The Providers contend that the Lead MAC did not allow patient days associated with certain Medicare Part A and Title XIX dual eligible patients to be included in the numerator of either the SSI percentage or the Medicaid Percentage of the Medicare DSH calculation. These patients were eligible for Medicare Part A benefits, however, no payments were made by Medicare Part A for these patients. The MAC did not allow the days to be included in the Medicaid Proxy and CMS did not include the days in the calculation of the SSI percentage. In some instances, such days were included in the denominator of the SSI percentage.

> CMS has represented to several Federal courts that the Medicare/SSI fraction only counts Medicare paid days. See, e.g., Legacy Emanuel Hospital & Health Center v. Shalala, 97 F.3d 1261, 1265 (9th Cir. 1996).
>
> While CMS has stated that the SSI fraction would only include patient days paid by Medicare Part A, intermediaries have refused to recognize these dual eligible patient days, which lack Medicare Part A payments, in the Medicaid percentage of the Medicare DSH payment calculation. Since CMS has stated that only "paid" days will be used in the SSI percentage, the Provider contends that the terms **paid** and **entitled** must be consistent with one another due to the usage of the two terms in 42 C.F.R. § 412.106(b) and CMS testimony. The numerator of the SSI percentage requires SSI payments to have been made, thus the denominator should also require Part A payment.
>
> It is the Providers' contention that these days must be included in the Medicaid percentage.[1]

There is *only* one participant in this group appeal and it appealed from a Revised Notice of Program Reimbursement ("RNPR").

A. Background on Participant #1 – Fairview Hospital

On March 3, 2016, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Fairview Hospital. This reopening notice states that the cost report was reopened solely for the following issue:

> To update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42CFR 412.106(b)(3) and the provider's request received 3/2/2016.[2]

Fairview Hospital received its RNPR on October 2, 2019. The RNPR included adjustments "to update the SSI% and payment factor in accordance with CMS' SSI realignment calculation."[3]

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is $10,000 or more (or $50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

---

[1] Group Appeal Issue Statement (April 6, 2020) (emphasis added)
[2] Fairview's Notice of Intent to Reopen Cost Report included in Group Appeal Request (April 6, 2020).
[3] Fairview's Audit Adjustment Report included in Group Appeal Request (April 6, 2020).

Relevant Regulations – Revised NPRs

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), which 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) of this subpart) 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. . . .

Additionally, 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.

Finally, 42 C.F.R. § 405.1835(a)(1) provides:

> If a final contractor determination is reopened under §405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination (§§405.1887(d), 405.1889(b), and the "Exception" in §405.1873(c)(2)(i)).

The Board finds that it does not have jurisdiction over the participant in this appeal because it appealed from a RNPR that did not adjust the DSH SSI Fraction for Dual Eligible Days.

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[4] The reopening in this case was a result of the Provider's request to realign its SSI percentage from the Federal Fiscal Year End to its individual cost reporting fiscal year end. The audit adjustments associated with the RNPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year and did not adjust any of the monthly data underlying the SSI percentages (*i.e.*, there is no change in or revision dual eligible days since the underlying monthly data remains the same).[5] The audit adjustment report explicitly stated that the adjustments were "To update the SSI% and payment factor in accordance with CMS' SSI realignment calculation." The Notice of Reopening for Fairview Hospital explicitly stated that the purpose of the reopening was "to update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the provider's request ..." In other words, the determination was only being reopened to include realigned SSI percentage. Since the only matters specifically revised in the RNPR was adjustments related to realigning the SSI percentage from the federal fiscal year to the provider fiscal year, the Board does not have jurisdiction over Fairview Hospital in the subject group appeal pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b). The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[6]

In conclusion, Fairview Hospital is dismissed from the appeal because, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b), it does not have the right to appeal the RNPR at issue. As there are no participants remaining, the Board hereby closes Case No. 20-1544GC and removes it from the Board's docket.

---

[4] 42 C.F.R. § 405.1889(b)(1).

[5] CMS does not utilize a new or different data match process when it issues a realigned SSI percentage. 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). All of the underlying data which is gathered on a month-by-month basis remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[6] *See St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

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:

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

FOR THE BOARD:

9/25/2020

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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Via Electronic Delivery

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Ms. Danene Hartley
Appeals Lead
National Government Services, Inc.
MP: INA101-AF42
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Indianapolis, IN 46206-6474

RE: ***Jurisdiction Determination re: Timely Filing of Appeal***
Council for Jewish Elderly (Prov. No. 14-5931)
FYE 06/30/2018
Case No. 20-1981

Dear Mr. Geraghty and Ms. Hartley:

The Provider Reimbursement Review Board ("Board") is in receipt of the Provider's request for an individual appeal, to which the Board assigned case number 20-1981. The pertinent facts and the Board's determination regarding jurisdiction over the appeal are set forth below.

BACKGROUND:

The subject appeal was electronically filed through the Board's OH CDMS system and was submitted by the Provider on August 17, 2020 (as verified by the date on the Board's Confirmation of Correspondence). The appeal is based on the Notice of Program Reimbursement ("NPR") dated May 23, 2019 for the Provider's fiscal year ended June 30, 2018.

FACTS:

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.

42 C.F.R. § 405.1837(a) specifies that "the Board may extend the [180-day] time limit upon a *good cause showing* by the provider."[1] Further, § 405.1837(b) specifies that "[t]he 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

[1] (Emphasis added.)

other catastrophe, fire, or strike), and the provider's written request for an extension is received by the Board within a reasonable time (as determined by the Board under the circumstances) after the expiration of the applicable 180-day limit specified in § 405.1835(a)(3) or § 405.1835(c)(2)."[2]

Board Rule 4.3.1 states, in part:

> The date of receipt of a contractor final determination is presumed to be 5 days after the date of issuance. This presumption, which is otherwise conclusive, may be overcome if it is established by a preponderance of the evidence that such materials were actually received on a later date. *See* 42 C.F.R. § 405.1801(a)(1)(iii).
>
> The appeal period begins on the date of receipt of the contractor final determination as defined above and ends 180 days from that date.

Board Rule 4.5.A states, in part:

> Timely filing is determined based on the date of receipt by the Board. The date of receipt is presumed to be:
>
> A. The date submitted to OH CDMS as evidenced by the Confirmation of Correspondence generated by the system.

The final determination in dispute is an NPR dated May 23, 2019. The Provider is presumed to have received the NPR five days later, on May 28, 2019. Pursuant to the Board rules and regulations cited above, the appeal deadline is calculated to be 180 days from May 28, 2019, which was Sunday, November 24, 2019. Because the deadline fell on a weekend, the deadline becomes the next business day, Monday, November 25, 2019.

The subject appeal was filed electronically through the OH CDMS system with August 17, 2020. The appeal request was filed 448 days after the date of receipt of the NPR.

PROVIDER ARGUMENT:

The Provider advises that it did not receive the cost report settlement information from the Medicare contractor for its FYE 6/30/2018 cost report until July 6, 2020.

The Provider states that it learned that the cost report settlement data had been uploaded to a former employee's Connex[3] account. The Provider stated that the former employee has not worked at the Council for Jewish Elderly since November of 2016 and that all cost reports since his departure have been signed by Thomas M Lockwood, the Council's CFO (Chief Financial

[2] (Emphasis added.)
[3] NGS Connex is a web application used by the Medicare Contractor, National Government Services, to transmit and receive information regarding the Medicare claims, cost reports, and other transactions.

Officer). The Provider stated that the cost report upload procedure changed in fiscal year 2018 and did not use the Connex system.

BOARD DETERMINATION:

The representative is responsible for ensuring his or her contact information is current with the Board and the Medicare Contractor, including a current email address and phone number. The case representative is also responsible for meeting the Board's deadlines and for timely responding to correspondence or requests from the Board or the opposing party. As stated in Board Rule 5.2, "[f]ailure of a representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines" and "[w]ithdrawal of a case representative or the recent appointment of a new representative will also not be considered cause for delay of any deadlines or proceedings."[4] Moreover, it is unclear why it took the Provider so long (presumably at least more than 1 year) to discover this administrative error.

42 C.F.R. § 405.1837 makes clear that an extension to the 180-day time limit can only be granted if the provider makes "a good cause showing" which "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)." Here, its clear that the Provider has not established that it could not reasonably be expected to file timely due to "extraordinary circumstances beyond its control." Rather, the Provider has only demonstrated administrative error on its part as it failed to inform the Medicare Contractor that a change was required regarding the contact information of the employee responsible for receiving NPR documentation.

Based on the above cited regulations and the Board Rules, the Board has determined that the appeal request was not timely filed because it was filed 448 days after the presumed date of receipt of the NPR and that good cause under 42 C.F.R. § 405.1837 does not exist regarding the untimely filing of the subject appeal request. Therefore, the Board hereby denies jurisdiction and dismisses the subject appeal for not being filed on a timely basis.

Board Members Participating:

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

For the Board:

9/25/2020

X Clayton J. Nix

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

cc: Wilson C. Leong, Federal Specialized Services

[4] *See also* Board Rule 5.5.1 (stating: "Withdrawal of a designated case representative, or the recent appointment of a new representative, generally will not be considered cause for delay of any deadlines or proceedings.").

DEPARTMENT OF HEALTH & HUMAN SERVICES

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WPS Government Health Administrators
Byron Lamprecht
Supervisor – Cost Report Appeals
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RE: ***Jurisdictional Decision***
IHA 2007-2008 DSH SSI Medicare Advantage Days Group
Case No. 10-0282G

Dear Ms. Griffin and Mr. Lamprecht,

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

Pertinent Facts:

The Provider Representative filed the request for an optional group appeal on December 18, 2009. The final determination being appealed is the publication of the FY 2007 SSI rates on the CMS website dated June 24, 2009. There were seven participants used to form the group. The Board acknowledged the group appeal and assigned Case No. 10-0282G. On June 10, 2019 the Provider Representative withdrew participants 1 through 5. Therefore, the only participants remaining in the group appeal are Participant # 6, Memorial Hospital of South Bend, and Participant #7, Union Hospital.

Background

This appeal involves multiple Providers' appeals for the issue of the inclusion of Medicare Advantage days in the calculation of the 2007 Supplemental Security Income ("SSI") Ratios. The Providers filed this appeal on December 18, 2009.[1] The Providers in the group based the appeal of the issue on the publication on June 24, 2009 of the SSI ratios *on the website* of the Centers for Medicare & Medicaid Services. The Providers did not appeal within 180 days of the one-year anniversary of the submission of the cost report or Notices of Program Reimbursement ("NPRs").[2]

[1] The Hearing Request was received on December 21, 2009.
[2] Those determinations were not under appeal in this case. It is unclear if the Providers appealed from other final determinations, in other appeals.

The Providers in the group contend that Medicare Part C days should not be included in either the numerator or denominator of the SSI fraction, which is part of the DSH calculation. In accordance with 42 U.S.C. § 1395ww(d)5)(F)(vi)(I), hospital inpatients who are "entitled to benefits under [P]art A" are to be included in the SSI fraction. The denominator includes all Part A days, whereas the numerator includes only Part A days for patients who are also entitled to SSI under Title XVI. The Providers maintain that patients who have enrolled in Medicare HMOs [health maintenance organizations] under Medicare Part C are entitled to benefits under Part C but not Part A.

The Providers assert that CMS has improperly included Part C days in the SSI percentages that were released on June 24, 2009 to be used to calculate the DSH SSI fraction for hospital cost reporting years beginning in Federal Fiscal Year (FFY) 2007 (the 2007 SSI data) resulting in an improper reduction in the DSH percentage for the Providers. The Providers' contend that all Part C days should be removed from the SSI fraction.

This improper treatment resulted in an underpayment to the Providers and is not consistent with congressional intent to reimburse hospitals for treatment of indigent patients pursuant to 42 U.S.C. 1395ww(d)(5)(F), 42 C.F.R. 412.106, Medicare Intermediary Manual 3610.15 or any other applicable statues, regulations, program guidelines, or case law.

Decision of the Board

A prerequisite for Board jurisdiction under 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 is that the provider appeal from a "final contractor or Secretary determination" as that term is used in 42 C.F.R. § 405.1835(a) and defined in § 405.1801. As discussed below, the Board finds that the June 24, 2009 publication of the 2007 SSI ratios *on the CMS website* is not a "final contractor or Secretary determination" that the Providers could appeal to the Board.

On July 24, 2009, CMS issued Transmittal 1744[3] (Change Request 6530) which provided updates for the DSH adjustment for the FY 2007 final determinations. This transmittal notified the providers and the intermediaries of the updated SSI/Medicare Beneficiary data for hospitals. However, *only 7 days later*, on July 31, 2009, CMS reversed its prior notice and instructed intermediaries that they were ***not*** to issue final settlements for the fiscal year 2007 using the 2007 SSI ratios.[4] Then, in the May 4, 2010 Federal Register the Secretary issued the Proposed Changes to the Inpatient Prospective Payment Systems (IPPS).[5] In this proposed rule, the Secretary announced that, as a result of the litigation in *Baystate Medical Center v. Leavitt*, 545 F. Supp.2d 20, as amended 587 F.Supp.2d 37 and 44 (D.D.C. 2008) the calculation of the SSI percentages were being changed based on new data matches. The Secretary also noted the CMS Administrator had prepared a Ruling[6] which provided for qualifying appeals and for cost reports not yet finally settled to be revised or settled using the new data match adopted in the forthcoming FY 2011 IPPS final rule for cost report periods prior to October 1, 2010 (Federal

[3] CMS Pub. 100-04 Claims Processing (July 24, 2009).
[4] *See* https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1774CP.pdf.
[5] 75 Fed. Reg. 23852 (May 4, 2010).
[6] Centers for Medicare and Medicare Ruling CMS-1498-R issued April 28, 2010.

fiscal year 2011).[7] Because the cost reports for South Bend and Union had not been settled when Ruling CMS-1498 was issued, they were subject to this ruling providing for a recalculation of the DSH adjustment.

On March16, 2012, CMS posted revised SSI percentages on the website. *See* http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html Presumably, the Participants received (or will receive) their final settled cost reports using updated SSI rates.

In summary, it is clear that the June 24, 2009 publication of the SSI percentage cannot be considered a final determination as CMS immediately rescinded those percentages and the action to rescind occurred well before this appeal being filed. To this end, there is no evidence that those SSI percentages were ever used in calculating the Participants' DSH adjustment for the year at issue. Moreover, the Transmittal 1744 made clear that it was only "provid[ing] updated ***data*** for determining the disproportionate share adjustment for IPPS hospitals and the low income patient adjustment for IRFs" and, as such, was not itself a final determination.

Based on the above, the Board hereby dismisses the remaining two participants from the appeal. As there are no participants remaining, the Board hereby closes Case No. 10-0282G and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Clayton J. Nix, Esq.
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Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

9/29/2020

X Clayton J. Nix

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

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

[7] 75 Fed. Reg. at 24006.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Decision***
14-0580GC Allina Health 2009 SSI Realignment CIRP
15-0817GC Allina Health 2011 SSI Realignment CIRP Group
16-0338GC Allina Health 2012 SSI Realignment CIRP Group
17-1618GC Allina Health 2014 SSI Realignment CIRP Group
17-1909GC Allina Health 2013 SSI Realignment CIRP Group
18-0196GC Allina Health 2010 SSI Realignment CIRP Group
19-0884GC Allina Health CY 2015 DSH SSI Income Realignment CIRP

Dear Ms. Webster and Ms. Hartley:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeals on its own motion. The Board's decision is set forth below.

Background:

Allina Health System has filed numerous group appeals relating to the SSI Realignment issue. Many of these groups have a related appeal of the SSI Accuracy Ratio issue for the same Providers and fiscal year ends ("FYEs"). There are seven (7) Group Appeals for the SSI Realignment issue which are the subject of the Board's decision.

All seven group cases were filed with a matching SSI Accuracy appeal that was filed at the same time as the SSI Realignment appeals:

14-0580GC Allina Health 2009 SSI Realignment CIRP
14-0576GC Allina Health 2009 DSH Post 1409-R Medicare Part A/SSI Fraction CIRP

19-0884GC Allina Health CY 2015 DSH SSI Income Realignment CIRP Group
19-0881GC Allina Health CY 2015 DSH Post 1498-R Medicare Part A/SSI Fraction CIRP Group

18-0196GC Allina Health 2010 SSI Realignment CIRP Group
16-0670GC Allina Health 2010 DSH Post 1498R Medicare Part A/SSI Fraction CIRP Group

17-1909GC Allina Health 2013 SSI Realignment CIRP Group
16-0964GC Allina Health 2013 DSH Post 1498R Medicare Part A/SSI Fraction CIRP Group

17-1618GC Allina Health 2014 SSI Realignment CIRP Group
17-1621GC Allina Health 2014 DSH Post 1498R Medicare Part A/SSI Fraction CIRP Group

16-0338GC Allina Health 2012 SSI Realignment CIRP Group
16-0341GC Allina Health 2012 DSH Post 1498R Medicare Part A/SSI Fraction CIRP Group

15-0817GC Allina Health 2011 SSI Realignment CIRP Group
15-0818GC Allina Health 2011 Post 1498R Medicare Part A/SSI Fraction CIRP Group

Although not identical, the issue statements for each of the SSI Realignment CIRP groups make similar arguments. Several of the issue statements include:

14-0580GC (SSI Realignment Appeal):

> Under CMS' regulations, Medicare Disproportionate Share Hospitals ("DSH") are entitled to request that their SSI fractions be recalculated based upon the hospital's cost reporting period (as opposed to the federal fiscal year). *See* 42 CFR § 412.106(b)(3). Normally, to assess whether a recalculation of the SSI fraction is advisable, hospitals request the pertinent data from CMS. *See* 65 Fed. Reg. 50548 (Aug. 18, 2000) (providing for the disclosure of data to hospitals for the purpose of "verify[ing] or challeng[ing CMS'] determination of the hospital's SSI ratio"). That data, commonly referred to as the "routine use data," show the patient days used by CMS to calculate the SSI fraction.
>
> In violation of Section 951 of the Medicare Modernization Act, s*ee* Pub. L. No. 108-173, and the routine use permitting hospitals access to this data, *see* 65 Fed. Reg. 50548, CMS is withholding and/or belatedly releasing this data to hospitals. Because CMS' withholding of this data impacts the final amounts paid to the hospitals for their cost reporting periods ending December 21, 2008, the Hospitals are appealing this common issue to the PRRB. The Hospitals are not requesting recalculations of their SSI fractions; rather, they are contesting the withholding of data that prevents them from obtaining the additional DSH reimbursement to which they may be entitled.

19-0884GC (SSI Realignment Appeal):

> Under CMS' regulations, Medicare Disproportionate Share Hospitals ("DSH") are entitled to request that their SSI fractions be recalculated based upon the hospital's cost reporting period (as opposed to the federal fiscal year). *See* 42 CFR § 412.106(b)(3).

Normally, to assess whether a recalculation of the SSI fraction is advisable, hospitals request the pertinent data from CMS. *See* 65 Fed. Reg. 50548 (Aug. 18, 2000) (providing for the disclosure of data to hospitals for the purpose of "verify[ing] or challeng[ing CMS'] determination of the hospital's SSI ratio").

That data, commonly referred to as the "routine use data," show the patient days used by CMS to calculate the SSI fraction. *See* 70 Fed. Reg. 47,278, 47,439 (Aug. 12, 2005) (stating that "a hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year. The data set made available to hospitals will be the same data set CMS uses to calculate the Medicare fractions for the Federal fiscal year."). Because the Providers' cost reporting periods cross Federal fiscal years [2015 and 2016], the routine use data for both years is necessary in order to determine whether a recalculation of the SSI fractions based on cost reporting period would be beneficial.

The Providers have appealed the MAC's treatment of several categories of days in the SSI fraction (*e.g.*, part C days and non-covered days), as well as whether errors and omissions by the agency in the calculation of the SSI fraction numerator understated that fraction. The final outcome of these related appeals could affect whether it is beneficial for the Providers to request a recalculation of the SSI fraction.

Accordingly, the Provider are filing this appeal to preserve their right to request recalculation of the SSI fraction based upon their cost reporting period, pending the final outcome of the providers' other DSH appeals challenging the calculation of the SSI fraction.

16-0338GC (SSI Realignment Appeal):

Under CMS' regulations, Medicare Disproportionate Share Hospitals ("DSH") are entitled to request that their SSI fractions be recalculated based upon the hospital's cost reporting period (as opposed to the federal fiscal year). *See* 42 CFR § 412.106(b)(3). Normally, to assess whether a recalculation of the SSI fraction is advisable, hospitals request the pertinent data from CMS. *See* 65 Fed. Reg. 50548 (Aug. 18, 2000) (providing for the disclosure of data to hospitals for the purpose of "verify[ing] or challeng[ing CMS'] determination of the hospital's SSI ratio"). That data, commonly referred to as the "routine use data," shows the patient days used by CMS to calculate the SSI fraction.

> The Providers have requested the routine use data for Federal fiscal year 2013, which is necessary to calculate their SSI fractions based on their cost reporting period, but at this time CMS has not provided the Providers this information. Accordingly, the Providers are filing this appeal in order to preserve their right to request realignment of the SSI fraction.

15-0817GC (SSI Realignment Appeal):

> Under CMS' regulations, Medicare Disproportionate Share Hospitals ("DSH") are entitled to request that their SSI fractions be recalculated based upon the hospital's cost reporting period (as opposed to the federal fiscal year). *See* 42 CFR § 412.106(b)(3). Normally, to assess whether a recalculation of the SSI fraction is advisable, hospitals request the pertinent data from CMS. *See* 65 Fed. Reg. 50548 (Aug. 18, 2000) (providing for the disclosure of data to hospitals for the purpose of "verify[ing] or challeng[ing CMS'] determination of the hospital's SSI ratio"). That data, commonly referred to as the "routine use data," show the patient days used by CMS to calculate the SSI fraction.
>
> In violation of Section 951 of the Medicare Modernization Act, s*ee* Pub. L. No. 108-173, and the routine use permitting hospitals access to this data, *see* 65 Fed. Reg. 50548, CMS is withholding and/or belatedly releasing this data to hospitals. Because CMS' withholding of this data impacts the final amounts paid to the hospitals for their cost reporting periods ending December 21, 2008, the Hospitals are appealing this common issue to the PRRB. The Hospitals are not requesting recalculations of their SSI fractions; rather, they are contesting the withholding of data that prevents them from obtaining the additional DSH reimbursement to which they may be entitled. The Provider protested this issue in its cost report, and the MAC made an audit adjustment disallowing the protested item.

The corresponding SSI Accuracy Group appeals all used the same appeal language:

> This appeal concerns the determination of the Providers' Medicare disproportionate share adjustment ("DSH") payments under the prospective payment system ("PPS") for inpatient hospital services. The issue is whether the Centers for Medicare & Medicaid Services ("CMS") has correctly determined the number of patient days counted in the numerator of the "SSI fraction" used in calculating the Providers' disproportionate patient percentage for purposed of the DSH adjustment. The Providers contend that the SSI fraction is understated to the extent that CMS has not corrected systemic flaws in the data and match process used by

> CMS in determining the SSI fractions. Further, CMS has failed to discharge its statutory obligation to arrange to furnish the Providers with access to the information needed to perform their own calculation of the proper SSI fraction and to fully and adequately vet CMS's calculation.

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 dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $50,000 or more, and the request for a hearing is filed within 180 days of the receipt of the final determination.

The Board finds that it does not have jurisdiction over the SSI Realignment issue in case numbers 14-0580GC, 19-0884GC, 18-0196GC, 17-1909GC, 17-1618GC, 16-0338GC, and 15-0817GC because there is no final determination from which the Providers are appealing and the issue is duplicative of the issue being pursued in the SSI Accuracy groups. Under 42 C.F.R. § 412.106(b)(3) a hospital can, if it prefers, use its cost reporting period (fiscal year end) data instead of the federal fiscal year end data in determining the DSH Medicare fraction. The decision to use its own cost reporting period is the hospitals alone, which then must submit a written request to the Medicare Contractor. Without these requests it is not possible for the Medicare Contractor to have issued a final determination from which any of the Providers could appeal. Furthermore, even if a Provider had requested a realignment from the Federal Fiscal Year to its cost reporting year, 42 C.F.R. § 412.106(b)(3) makes clear that the Provider must use the data from its cost reporting year; there is no appeal right that stems from a realignment request.

Additionally, the Board finds that the SSI Realignment is duplicative of the SSI Accuracy Group appeal.[1] This violates Board Rules which provide, "A Provider may not appeal an issue from a final determination in more than one appeal."[2]

Further, all seven of the SSI Realignment groups and the SSI Accuracy groups raise the issue that the SSI percentage as generated by the SSA and put forth by CMS is understated. Therefore, having two group appeals that make the same argument related to the SSI ratio is duplicative in violation of PRRB Rule 4.5 (Mar. 1, 2013 and July 1, 2015) and PRRB Rule 4.6 (Aug. 29, 2018). The Provider is ultimately seeking the same remedy from the two types of appeals – they want access to the underlying data so that they can determine that their ratios are understated and can therefore receive a new SSI ratio.

The Board notes that some of the SSI Realignment Group issue statements reference MMA § 951.[3] With respect to the Providers' argument that CMS has failed to provide "routine use"

[1] For example, the main thrust of the SSI Realignment appeals is the alleged lack of access to data and this a tenant of the SSI Accuracy appeals.
[2] PRRB Rule 4.5 (March 1, 2013 and July 1, 2015 Versions); PRRB Rule 4.6 (August 29, 2018).
[3] PRRB Case Nos. 14-0580GC and 15-0817GC.

data as required by the Medicare Modernization Act § 951, the Board does not have the authority to order CMS to comply with the MMA.

Conclusion

The Board finds that it does not have jurisdiction over the group issue in the SSI Realignment Groups because there is no final determination from which the Providers can appeal and the issue is duplicative of those issues in the SSI Accuracy Groups. PRRB Case Nos. 14-0580GC, 19-0884GC, 18-0196GC, 17-1909GC, 17-1618GC, 16-0338GC, and 15-0817GC are hereby closed and removed from the Board's docket.

Board Members Participating:

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

For the Board:

9/30/2020

X Clayton J. Nix

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cc: Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Decision***
Cleveland Clinic Fdn. CY 2006 DSH SSI Fractn Medicare Mngd Care Part C Days CIRP
Case No. 20-1370GC

Dear Ms. Goron and Ms. Cummings,

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

Pertinent Facts

On March 6, 2020, the Providers filed this group appeal with the Provider Reimbursement Review Board ("Board"). The group issue statement as submitted:

> "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.

Statement of the Legal Basis

The Providers contend that the Lead MACs' treatment of the MA days is not in accordance with the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). The MAC failed to include patient days applicable to MA patients who were also eligible for Medicaid in the Medicaid fraction of the Medicare DSH payment adjustment, and instead included those days in the SSI or Medicare fraction. The key legal issue to be determined is whether dual eligible MA patients are "entitled to benefits under Part A." If these patients are not entitled to benefits under Part A, the hospital days associated with these patients should be included in the Medicaid fraction.

> It is clear from the statute that MA patients are not "entitled to benefits under Part A." Under the Medicare statute, "entitlement of an individual to [Medicare part A] benefits for a month shall consist of entitlement to have payment made under, and subject to the limitations in, [Medicare] part A . . . on his behalf for [certain] services." *See* 42 U.S.C § 426(c)(1). A person may only enroll in a MA plan if he is entitled to benefits under Medicare Part A. *See* 42 U.S.C. § 1395w-21(a)(3)(A). However, upon enrollment in a MA plan, an individual is no longer "entitle[d] to have payments made under, and subject to the limitations in, [Medicare] part A." Rather, "payments under a contract with a Medicare+Choice organization…with respect to an individual electing a Medicare+Choice plan offered by the organization shall be ***instead*** of the amounts which (in the absence of the contract) would otherwise be payable under [Medicare] parts A and B." *See* 42 U.S.C. § 1395w-21(i)(1) (emphasis added). *See also* 42 U.S.C. § 1395w-21(a)(1) ("Each [MA] eligible individual . . . is entitled to receive benefits . . . (A) through the original Medicare fee-for-service program under parts A and B . . . , **or** (B) through enrollment in a Medicare+Choice plan under [MA]." (Emphasis added)).")[1]

There are *only* two participants in this group appeal and all appealed from Revised Notices of Program Reimbursement ("RNPRs").

A. Background on Participant #1 – Fairview Hospital

On November 14, 2016, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Fairview Hospital. This reopening notice states that the cost report was reopened solely for the following issue:

> To update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42CFR 412.106(b)(3) and the provider's request received 11/09/2016.[2]

Fairview Hospital received its RNPR on September 4, 2019. The RNPR included adjustments "to update the SSI% and payment factor in accordance with CMS' SSI realignment calculation."[3]

B. Background on Participant #2 – Lutheran Hospital

On November 14, 2016, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Lutheran Hospital. This reopening notice states that the cost report was reopened solely for the following issue:

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[1] Group Appeal Issue Statement (March 6, 2020).
[2] Fairview's Notice of Intent to Reopen Cost Report included in Group Appeal Request (March 6, 2020).
[3] Fairview's Audit Adjustment Report included in Group Appeal Request (March 6, 2020).

> To update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42CFR 412.106(b)(3) and the provider's request received 11/09/2016.[4]

Lutheran Hospital received its RNPR on September 4, 2019. The RNPR included adjustments "to update the SSI% and payment factor in accordance with CMS' SSI realignment calculation."[5]

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is $10,000 or more (or $50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

Relevant Regulations – Revised NPRs

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), which 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) of this subpart) 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. . . .

Additionally, 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.

[4] Lutheran's Notice of Intent to Reopen Cost Report included in Group Appeal Request (March 6, 2020).
[5] Lutheran's Audit Adjustment Report included in Group Appeal Request (March 6, 2020).

> (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.

Finally, 42 C.F.R. § 405.1835(a)(1) provides:

> If a final contractor determination is reopened under §405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination (§§405.1887(d), 405.1889(b), and the "Exception" in §405.1873(c)(2)(i)).

The Board finds that it does not have jurisdiction over the participants in this appeal because they appealed from a RNPR that did not adjust the DSH SSI Fraction Medicare Managed Care Part C Days.

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[6] The reopenings in this case were a result of the Providers' request to realign its SSI percentage from the Federal Fiscal Year End to its individual cost reporting fiscal year end. The audit adjustments associated with the RNPRs under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year and did not adjust any of the monthly data underlying the SSI percentages (*i.e.*, there is no change in or revision to Part C days since the underlying monthly data remains the same).[7] The audit adjustment reports explicitly stated that the adjustments were "To update the SSI% and payment factor in accordance with CMS' SSI realignment calculation." The Notices of Reopening explicitly stated that the purpose of the reopening was "to update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the provider's request ..." In other words, the determinations were only being reopened to include realigned SSI percentage. Since

[6] 42 C.F.R. § 405.1889(b)(1).

[7] CMS does not utilize a new or different data match process when it issues a realigned SSI percentage. 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). All of the underlying data which is gathered on a month-by-month basis remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital **must accept** the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

the only matters specifically revised in the RNPRs were adjustments related to realigning the SSI percentage from the federal fiscal year to the provider fiscal year, the Board does not have jurisdiction over the participants in the subject group appeal pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b). The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[8]

In conclusion, all participants are dismissed from the appeal because, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b), they do not have the right to appeal the RNPRs at issue. As there are no participants remaining, the Board hereby closes Case No. 20-1370GC and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Clayton J. Nix, Esq.
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

9/30/2020

X Clayton J. Nix

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

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

[8] *See St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

Healthcare Reimbursement Services, Inc.
Corinna Goron
C/O Appeals Department
17101 Preston Rd., Ste. 220
Dallas, TX 75248-1372

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

RE: ***Jurisdictional Decision***
Cleveland Clinic Fdn. CY 2006 DSH Medicaid Fraction Medicare Managed Care Part C Days CIRP Group
Case No. 20-1372GC

Dear Ms. Goron and Ms. Cummings,

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

Pertinent Facts

On March 6, 2020, the Providers filed this group appeal with the Provider Reimbursement Review Board ("Board"). The group issue statement as submitted:

> 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.

Statement of the Legal Basis

The Providers contend that the Lead MACs' treatment of the MA days is not in accordance with the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). The MAC failed to include patient days applicable to MA patients who were also eligible for Medicaid in the Medicaid fraction of the Medicare DSH payment adjustment, and instead included those days in the SSI or Medicare fraction. The key legal issue to be determined is whether dual eligible MA patients are "entitled to benefits under Part A." If these patients are not entitled to benefits under Part A, the hospital days associated with these patients should be included in the Medicaid fraction.

> It is clear from the statute that MA patients are not "entitled to benefits under Part A." Under the Medicare statute, "entitlement of an individual to [Medicare part A] benefits for a month shall consist of entitlement to have payment made under, and subject to the limitations in, [Medicare] part A . . . on his behalf for [certain] services." *See* 42 U.S.C § 426(c)(1). A person may only enroll in a MA plan if he is entitled to benefits under Medicare Part A. *See* 42 U.S.C. § 1395w-21(a)(3)(A). However, upon enrollment in a MA plan, an individual is no longer "entitle[d] to have payments made under, and subject to the limitations in, [Medicare] part A." Rather, "payments under a contract with a Medicare+Choice organization…with respect to an individual electing a Medicare+Choice plan offered by the organization shall be ***instead*** of the amounts which (in the absence of the contract) would otherwise be payable under [Medicare] parts A and B." *See* 42 U.S.C. § 1395w-21(i)(1) (emphasis added). *See also* 42 U.S.C. § 1395w-21(a)(1) ("Each [MA] eligible individual . . . is entitled to receive benefits . . . (A) through the original Medicare fee-for-service program under parts A and B . . . , **or** (B) through enrollment in a Medicare+Choice plan under [MA]." (Emphasis added)).[1]

There are three participants in this group appeal and all appealed from Revised Notice of Program Reimbursement ("RNPR").

A. Background on Participant #1 – Fairview Hospital

On November 14, 2016, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Fairview Hospital. This reopening notice states that the cost report was reopened solely for the following issue:

> To update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42CFR 412.106(b)(3) and the provider's request received 11/09/2016.[2]

Fairview Hospital received its RNPR on September 4, 2019. The RNPR included adjustments "to update the SSI% and payment factor in accordance with CMS' SSI realignment calculation."[3]

B. Background on Participant #2 – Lutheran Hospital

On November 14, 2016, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Lutheran Hospital. This reopening notice states that the cost report was reopened solely for the following issue:

> To update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42CFR 412.106(b)(3) and the provider's request received 11/09/2016.[4]

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[1] Group Appeal Issue Statement (March 6, 2020).
[2] Fairview's Notice of Intent to Reopen Cost Report included in Group Appeal Request (March 6, 2020).
[3] Fairview's Audit Adjustment Report included in Group Appeal Request (March 6, 2020).
[4] Lutheran's Notice of Intent to Reopen Cost Report included in Group Appeal Request (March 6, 2020).

Lutheran Hospital received its RNPR on September 4, 2019. The RNPR included adjustments "to update the SSI% and payment factor in accordance with CMS' SSI realignment calculation."[5]

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is $10,000 or more (or $50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

Relevant Regulations – Revised NPRs

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), which 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) of this subpart) 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. . . .

Additionally, 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.

Finally, 42 C.F.R. § 405.1835(a)(1) provides:

[5] Lutheran's Audit Adjustment Report included in Group Appeal Request (March 6, 2020).

> If a final contractor determination is reopened under §405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination (§§405.1887(d), 405.1889(b), and the "Exception" in §405.1873(c)(2)(i)).

The Board finds that it does not have jurisdiction over the participants in this appeal because they appealed from a RNPR that did not adjust the DSH Medicaid Fraction Medicare Managed Care Part C Days.

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[6] The reopenings in this case were a result of the Providers' request to realign its SSI percentage from the Federal Fiscal Year End to its individual cost reporting fiscal year end. The audit adjustments associated with the RNPRs under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year and did not adjust any of the monthly data underlying the SSI percentages (*i.e.*, there is no change in or revision to Part C days since the underlying monthly data remains the same).[7] The audit adjustment reports explicitly stated that the adjustments were "To update the SSI% and payment factor in accordance with CMS' SSI realignment calculation." The Notices of Reopening for Euclid Hospital and Cleveland Clinic explicitly stated that the purpose of the reopening was "to update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the provider's request ..." In other words, the determinations were only being reopened to include realigned SSI percentage. Since the only matters specifically revised in the RNPRs were adjustments related to realigning the SSI percentage from the federal fiscal year to the provider fiscal year, the Board does not have jurisdiction over the participants in the subject group appeal pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b). The Board notes that Courts have

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[6] 42 C.F.R. § 405.1889(b)(1).

[7] CMS does not utilize a new or different data match process when it issues a realigned SSI percentage. 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). All of the underlying data which is gathered on a month-by-month basis remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital **must accept** the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[8]

In conclusion, all participants are dismissed from the appeal because, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b), they do not have the right to appeal the RNPRs at issue. As there are no participants remaining, the Board hereby closes Case No. 20-1372GC and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Clayton J. Nix, Esq.
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

9/30/2020

X Clayton J. Nix

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

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

[8] *See St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Decision***
Rochester Regional Health CY 2013 DSH Part C Days – Pre 10/1/2013 CIRP Group
Case No. 20-1527GC

Dear Ms. Webster and Ms. VanArsdale,

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

Pertinent Facts

On April 3, 2020, the Providers filed this group appeal with the Provider Reimbursement Review Board ("Board"). The group issue statement as submitted:

> "The issue in this appeal is the proper treatment in the Medicare disproportionate share hospital ("DSH") calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days"). In a 2004 final rule, CMS first announced a policy change to begin counting part C days in the Medicare Part A/SSI fraction and to exclude those days from the numerator of the Medicaid fraction. *See* 69 Fed. Reg. 48,916, 49,099 (Aug. 11, 2004). That rule was vacated in *Allina Health Servs. v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014) ("*Allina I*"). The Supreme Court also held that the Secretary's continued application of the same policy from the 2004 rule after the D.C. Circuit's vacatur of that rule in *Allina I* was procedurally invalid because the Medicare Act required the Secretary to engage in notice and comment rulemaking. *Azar v. Allina Health Servs.*, 139 S. Ct. 1804, 1810-15 (2019) *aff'g*, 863 F.3d 937, 942-45 (D.C. Cir. 2017) ("*Allina II*").
>
> The Providers thus contend that all Medicaid eligible part C days must be counted in the numerator of the Medicaid fraction, and that part C days must be excluded from the Medicare part A/SSI fraction, for the cost years at issue. *See Allina I,*

> 746 F.3d at 1108 (holding that "the [Medicare Act] unambiguously requires that Part C days be counted in one fraction or the other.").
>
> The continued application of the part C days policy reflected in the vacated rule to these cost years violates the notice and comment requirements of the Medicare Act, as the Supreme Court and D.C. Circuit held in the *Allina II* decisions. *See* 42 U.S.C. §§ 1395hh(a)(2), 1395hh(a)(4); *Allina II*, 139 S. Ct. at 1810-15; *Allina II*, 863 F.3d at 942-45 (finding that the Secretary violated the rulemaking provisions of the Medicare Act under sections 1395hh(a)(2) and (a)(4)). Furthermore, the continued application of the 2004 policy also violates the notice and comment rulemaking provisions of the Administrative Procedure Act. 5 U.S.C. §§ 551(5), 553(b).
>
> To the extent that CMS's erroneous calculation of the DSH adjustment "flows through" to impact capital DSH reimbursement, the Providers also appeal that aspect of the DSH calculation for these cost years. *See* 42 C.F.R. §§ 412.320, 412.312; Provider Reimbursement Manual ("PRM") (Part II), CMS Pub. 15-2, §§ 3660 and 4064; PRM (Part I), CMS Pub. 15-1, § 2807.2.[1]

There are two participants in this group appeal and all appealed from Revised Notices of Program Reimbursement ("RNPRs").

A. Background on Participant #1 – Newark Wayne Community Hospital

On April 8, 2019, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Newark Wayne Community Hospital. This reopening notice states that the cost report was reopened solely for the following issue:

> To review the DSH payment calculation for the realigned SSI based on the cost report period.[2]

Newark Wayne Community Hospital received its RNPR on October 10, 2019. The RNPR included adjustments "to adjust the SSI% and Medicare DSH% to audited amounts …"[3]

B. Background on Participant #2 – Rochester General Hospital

On May 7, 2019, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Rochester General Hospital. This reopening notice states that the cost report was reopened solely for the following issue:

> To review the DSH payment calculation for the realigned SSI based on the cost report period.[4]

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[1] Group Appeal Issue Statement (April 3, 2020).
[2] Newark's Notice of Intent to Reopen Cost Report included in Group Appeal Request (April 3, 2020).
[3] Newark's Audit Adjustment Report included in Group Appeal Request (April 3, 2020).
[4] Rochester's Notice of Intent to Reopen Cost Report Directly Added (April 23, 2020).

Rochester General Hospital received its RNPR on October 28, 2019. The RNPR included adjustments "to adjust the SSI% and Medicare DSH% to audited amounts … "[5]

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is $10,000 or more (or $50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

Relevant Regulations – Revised NPRs

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), which 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) of this subpart) 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. . . .

Additionally, 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.

Finally, 42 C.F.R. § 405.1835(a)(1) provides:

[5] Rochester's Audit Adjustment Report Directly Added (April 23, 2020).

> If a final contractor determination is reopened under §405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination (§§405.1887(d), 405.1889(b), and the "Exception" in §405.1873(c)(2)(i)).

The Board finds that it does not have jurisdiction over the participants in this appeal because they appealed from a RNPR that did not adjust the DSH Part C – Pre-10/1/2013 Days.

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[6] The reopenings in this case were a result of the Providers' request to realign its SSI percentage from the Federal Fiscal Year End to its individual cost reporting fiscal year end. The audit adjustments associated with the RNPRs under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year and did not adjust any of the monthly data underlying the SSI percentages (*i.e.*, there is no change in or revision to Part C days since the underlying monthly data remains the same).[7] The Notices of Reopening explicitly stated that the purpose of the reopenings was "to review the DSH payment calculation for the realigned SSI based on the cost report period." In other words, the determination was only being reopened to include realigned SSI percentage. Since the only matters specifically revised in the RNPRs was adjustments related to realigning the SSI percentage from the federal fiscal year to the provider fiscal year, the Board does not have jurisdiction over the participants in the subject group appeal pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b). The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[8]

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[6] 42 C.F.R. § 405.1889(b)(1).

[7] CMS does not utilize a new or different data match process when it issues a realigned SSI percentage. 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). All of the underlying data which is gathered on a month-by-month basis remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[8] *See St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

In conclusion, all participants are dismissed from the appeal because, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b), they do not have the right to appeal the RNPRs at issue. As there are no participants remaining, the Board hereby closes Case No. 20-1527GC and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Clayton J. Nix, Esq.
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

9/30/2020

X Clayton J. Nix

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

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