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

Refer toRefer to: 09-1600GC

SEP 08 2016

CERTIFIED MAIL

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President
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Noridian Healthcare Solutions, LLC
Evaline Alcantara
Appeals Coordinator Jurisdiction E
P.O. Box 6782
Fargo, ND 58108-6782

RE: Bifurcation Decision
CHW 2007 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 09-1600GC

Dear Mr. Knight and Ms. Alcantara:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the CHW 2007 [Disproportionate Share Hospital ("DSH")] Dual Eligible Days [Common Issue Related Party] ("CIRP") Group's Request for Bifurcation for four Providers. The Board hereby denies the request for bifurcation of the dual eligible Part A non-covered and HMO/Part C[1] days issues for the four Providers at issue. The decision of the Board is set forth below.

BACKGROUND

The Providers' representative, Toyon Associates, Inc., has requested that the Board grant bifurcation of the dual eligible Part A and Part C issues for four Providers in this group appeal: Chandler Regional Medical Center (provider number 03-0036); French Hospital (provider number 05-0232); Marian Medical Center (provider number 05-0107); and Mercy Hospital Bakersfield (provider number 05-0295). Toyon has requested that the Part C issue be transferred to case number 10-0029GC (CHW 2007 DSH Part C Days CIRP Group). According to Toyon, the Part C days group was not yet formed when the above-mentioned Providers filed their transfer requests.

This dual eligible group appeal was filed with the Board on April 28, 2009, with the following issue statement:

> Whether the Medicaid Ratio used to calculate Medicare Disproportionate Share Payments (DSH) accurately reflects the number of patient days furnished to

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

patients eligible for Medicaid in situations where the patient is also enrolled in the Medicare Part A Program but is not entitled to Medicare Part A benefits.

We contend that the number of Medicaid eligible patient days used to calculate the Medicaid ratio are understated due to exclusion of various categories of Medicaid eligible patients who are enrolled in Medicare Part A but are not entitled to Medicare Part A benefits. The applicable regulation governing this issue is 42 CFR 412.106.

The Part C group, case number 10-0029GC was established on October 13, 2009.

BOARD'S DECISION

The Board hereby denies bifurcation of the issues for all four Providers included in the bifurcation request: Chandler Regional Medical Center (provider number 03-0036); French Hospital (provider number 05-0232); Marian Medical Center (provider number 05-0107); and Mercy Hospital Bakersfield (provider number 05-0295).

On May 23, 2008, the Secretary published updated regulatory provisions concerning PRRB appeals.[2] The May 23, 2008 Final Rule states that the new regulations were effective beginning August 21, 2008, and applicable to all appeals filed on or after this date.[3] Under these new regulations, a provider's request for hearing must contain an issue statement that describes each contested item with a certain degree of specificity. Specifically, a provider's hearing request must include "[a]n explanation (for each specific item at issue . . .) of the provider's dissatisfaction with the contractor's or Secretary's determination under appeal . . ."[4]

The Board also updated its rules to coincide with the publication of the May 23, 2008 Final Rule. Board Rule 8 concerns provider issues involving multiple components and states that in order "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible . . ."[5]

The Board notes that the group appeal request and all of the Providers' individual appeals and transfer requests were filed after the August 21, 2008 effective date of the Secretary's Final Rule. As such, the newly effective regulations mandate that, within its request for hearing, each Provider and group appeal request must include, for each specific item at issue, an explanation of the provider's dissatisfaction with the contractor's or Secretary's determination under appeal. Board Rule 8 further requires a Provider to appeal each contested component of a multiple-component issue as a separate issue and to describe each issue as narrowly as possible.

In the instant appeal, the Board finds that Chandler Regional Medical Center and Mercy Hospital Bakersfield both filed individual appeal requests with issue statements that did not identify dual

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[2] Provider Reimbursement Determinations and Appeals, 73 Fed. Reg. 30190 (May 23, 2008) ("May 23, 2008 Final Rule").
[3] *Id.*
[4] 42 C.F.R. § 405.1835(b)(2).
[5] PRRB Rules at 6-7 (Aug. 21, 2008).

eligible Part C days with the requisite specific to allow the Board to assume jurisdiction over this issue. Accordingly, the Board denies Toyon's request for bifurcation for Chandler Regional Medical Center and Mercy Hospital Bakersfield.

The Board acknowledges that both French Hospital Medical Center and Marian Medical Center in this group filed individual appeal requests which clearly identified both the HMO/Part C and Part A exhausted days. Their individual appeal requests both characterized the exhausted and Medicare HMO days as "dual eligible." The Providers' transfer requests and the CIRP group appeal request, did not, however, raise the Medicare HMO/Part C days issue. Therefore, the Board has determined that the Part C days issue remains in the Providers' individual appeals, PRRB Case Nos. 09-1046 and 09-1047.

The Board hereby reopens the Providers' individual appeals, PRRB Case Nos. 09-1046 and 09-1047 and transfers the Part C days issue to PRRB Case No. 10-0029GC, CHW 2007 DSH Part C Days CIRP Group. The Providers' representative is to notify the Board within 60 days of today's date if the CIRP group 10-0029GC is complete.

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

Board Members Participating
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

FOR THE BOARD

Charlotte Benson

Board Member

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

cc: Wilson Leong, Federal Specialized Services

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SEP 15 2016

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President
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Aracadia, CA 91006

Bill Tisdale
Novitas Solutions, Inc.
Director JH, Provider Audit Reimbursement
Union Trust Building
501 Grant Street, Suite 600
Pittsburgh, PA 15219

RE: Thibodaux Regional Medical Center
Provider No.: 19-0004
FYE: 09/30/2009
PRRB Case No.: 14-0250

Dear Mr. Ravindran and Mr. Tisdale,

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

Background

The Provider submitted a request for hearing on October 22, 2013, based on a Notice of Program Reimbursement ("NPR") dated August 30, 2013. The hearing request included ten issues, six of which were subsequently transferred to group appeals and two of which were withdrawn. Two issues remain in this appeal: Issue No. 1 – DSH/SSI (Provider Specific) and Issue No. 3 – DSH Payment – Medicaid Eligible Days. The Provider also submitted a response to an Alert 10 on July 21, 2014.

Board's Decision

Although the Medicare Contractor did not challenge either issue that remains in the appeal, upon review the Board finds that it does not have jurisdiction over either the DSH/SSI (Provider Specific) issue or the Medicaid Eligible Days issue.

Issue No. 1 – DSH/SSI (Provider Specific)

The Board finds that it does not have jurisdiction over the DSH SSI Ratio Realignment issue as it is duplicative and there is no final determination. 42 C.F.R. § 405.1835 (2013) states in relevant part:

> A provider . . . has a right to a Board hearing . . . for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination only if . . . [t]he provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue. . .

In this case, the Provider does not appear to have requested a realignment of the SSI calculation and the Medicare Contractor has not made a final determination regarding the DSH/SSI (Provider Specific) issue. Under 42 C.F.R. § 412.106(b)(3) a hospital can, if it prefers, use its cost reporting period data instead of the federal fiscal year data in determining the DSH Medicare fraction. The decision to use its own cost reporting period is the hospitals alone; it 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 the Provider 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.

In addition, the majority of the DSH/SSI (Provider Specific) issue is duplicative of the already transferred DSH/SSI (Systemic Errors) issue. The Provider contends in the DSH/SSI (Provider Specific) issue statement that it is dissatisfied with "the Medicare Contractor's calculation of the computation of the DSH percentage in accordance with the Statutory Instructions." This explanation of the DSH/SSI (Provider Specific) issue is duplicative of the DSH/SSI (Systemic Errors) issue statement which also contends that "the SSI percentages calculated by the Centers for Medicare and Medicaid and used by the Medicare Contractor to settle their cost report does not address all the deficiencies...and incorporates ne methodology inconsistent with the Medicare statute." The SSI Systemic Errors issue was transferred to a group and no longer remains pending in this appeal.

Accordingly, because the DSH/SSI (Provider Specific) issue is duplicative of the Systemic Errors issue and the Medicare Contractor has not made a determination regarding SSI realignment from which the Provider could be dissatisfied, the Board finds that it lacks jurisdiction over the issue in this appeal and dismisses the issue from case number 14-0250.

Issue No. 3 – DSH Payment – Medicaid Eligible Days Issue

The Board finds that it does not have jurisdiction over the DSH – Medicaid Eligible Days Issue because the appeal does not comply with the Statutory Requirements set out at 42 C.F.R. § 405.1835(a)(1)(i) (2013) or 42 C.F.R. § 405.1835(a)(1)(ii) (2013).

Effective with cost report periods that end on or after December 31, 2008, CMS amended the regulations governing cost report appeals to incorporate Provider Reimbursement Manual (PRM) 15-2 § 115 *et seq.* into the regulations at 42 C.F.R. § 405.1835(a)(1)(ii) (2009) by specifying that where a provider seeks payments that it believes may not be allowable or may not be in accordance with Medicare policy, the provider must claim the items as self-disallowed costs "by following the applicable procedures for filing a cost report under protest."

Here, the Provider's cost report was for FYE 09/30/2009; therefore, any self-disallowed items are required to be protested. The Provider failed to include a reimbursement claim for additional Medicaid days or file those days under protest. Therefore, the Provider failed to preserve its rights and lacks any legal basis to appeal the item to the Board under 42 C.F.R. § 405.1835(a)(1)(ii) for self-disallowed costs.

The Provider cites adjustments 5, 7, 11, 22, 23, 24, 30 and S-D in the appeal request related to Medicaid Eligible days, however, upon review of those adjustment numbers form the attached adjustment report;

none of these items adjust Medicaid Eligible Days on W/S S-3. Two of the adjustment remove protested amounts, (adjustment 7 removes protested amounts on W/S E Part A and adjustment 11 removes protested amounts on W/S E Part B (not applicable to DSH)). However, the Provider failed to submit the documentation filed with cost report that identifies what makes up that protested amount, and filed a statement with the appeal request simply asserting that the Medicaid eligible days in dispute were not available at the time of filing and therefore were self-disallowed.

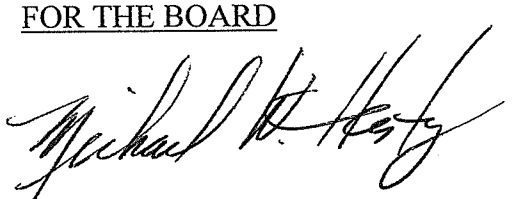
The Provider claims that it self-disallowed because it did not have all the data at the time of the cost report filing; however, under the 2008 regulation the Provider is still required to file a claim under protest if it believes there are additional costs to which it should be reimbursed. As this appeal is for FYE 09/30/2009, 42 C.F.R. § 405.1835(a)(1)(i) (2013) applies and the Provider is required to report a claim for reimbursement as a protested item. The Board is bound by this regulation that requires a claim and finds that the Provider failed to meet it.

The Board finds that it lacks jurisdiction over the last two issues in this appeal: Issue No. 1 – DSH/SSI (Provider Specific) and Issue No. 3 – the DSH Payment – Medicaid Eligible Days. Case No. 14-0250 is dismissed and removed from the Boards docket, as all other issues have been transferred to group appeals or withdrawn.

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

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

FOR THE BOARD



Michael W. Harty
Chairman

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

cc: Federal Specialized Services
Wilson C. Leong, Esq., CPA
PRRB Appeals
1701 S. Racine Avenue
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Refer to: 14-3696

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SEP 19 2016

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President
c/o Appeals Department
17101 Preston Road, Suite 220
Dallas, TX 75248-1372

Bill Tisdale
Novitas Solutions, Inc.
Director JH, Provider Audit and Reimbursement
Union Trust Building
501 Grant Street, Suite 600
Pittsburgh, PA 15219

RE: Medical Center of Louisiana – New Orleans
Provider No.: 19-0005
FYE: 06/30/2010
PRRB Case No.: 14-3696

Dear Ms. Sherman and Mr. Tisdale,

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

Background

On December 23, 2013, the Provider, Medical Center of Louisiana at New Orleans, was issued its Revised Notice of Program Reimbursement ("NPR"). The Provider's Individual Appeal Request was filed with the Board on June 23, 2014, appealing the issues of Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") (Provider Specific) and DSH Payment – Medicaid Eligible Days. The Medicare Contractor filed a jurisdictional challenge to the SSI (Provider Specific) issue stating that the SSI Percentage had not been adjusted. The Provider then filed a jurisdictional response stating that the Board has jurisdiction over the SSI (Provider Specific) issue. On February 11, 2015, the Provider filed its Preliminary Position Paper and a request to withdraw the DSH Payment – Medicaid Eligible Days issue.

Medicare Contractor's Position

The Medicare Contractor filed a jurisdictional challenge on October 15, 2014, on the basis that the SSI percentage was not adjusted during the reopening of the cost report under appeal. The Medicare Contractor contends that the Board lacks jurisdiction where the provider appeals its own classification of certain costs and statistics. Because the Medicare Contractor contends that this issue was not part of the final determination and it did not make any changes to the SSI percentage on the cost report, the Board does not have jurisdiction.

Provider's Position

The Provider contends that the Board does have jurisdiction over the DSH/SSI (Provider Specific) Issue. The revised NPR included adjustments to the Provider's DSH calculation in Adjustment No. 5. The Provider is dissatisfied with the amount of the DSH reimbursement and contends that it was incorrectly calculated because the SSI percentage contained errors. Upon release of the MEDPAR data, the Provider believes that that it can specifically identify patients entitled to both Medicare Part A and SSI who were not included in the SSI percentage. Once these patients are identified, the Provider contends that it will be entitled to a correction. The Provider argues that the Board has jurisdiction over the SSI percentage because the DSH was adjusted in the audit adjustment report for the appeal from the revised NPR.

Board's Decision

The last remaining issue in this appeal is the DSH/SSI (Provider Specific) issue. The Board finds that it does not have jurisdiction over the DSH/SSI percentage issue in the Revised NPR because it was not specifically adjusted and the SSI Realignment portion of the issue because a final determination has not been issued.

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

The Code of Federal Regulations provides for an opportunity for a revised NPR.
42 C.F.R. § 405.1885 (2013) provides in relevant part:

> A Secretary determination, an intermediary determination…may be reopened for findings on matters at issue in a determination or decision, by CMS, by the intermediary or by the reviewing entity that made the decision.

In accordance with 42 C.F.R. § 405.1889 (2013), a revised NPR is considered a separate and distinct determination from which the provider may appeal. The regulation provides:

> (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…the revision must be considered a separate and distinct determination or decision.
>
> (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
>
> (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.

Here, Medical Center of Louisiana at New Orleans referenced Adjustment No. 5 in its revised NPR appeal of the DSH/SSI percentage issue. Adjustment No.5 was to include additional Medicaid Eligible days on Worksheet S-3 of the cost report. There are no work papers, reopening notice or other documents provided to the Board to establish that the Medicare Contractor adjusted the SSI percentage as part of the reopening, which is reported on Worksheet E Part A of the cost report. As Medical Center of Louisiana at New Orleans's appeal of the DSH/SSI percentage issue from its revised NPR does not satisfy the requirements of 42 C.F.R. §§ 405.1885, 405.1889, the Board finds that it does not have jurisdiction over the issue.

In addition, the last sentence of the SSI (Provider Specific) issue statement reads: "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." In this case, the Provider does not appear to have requested a realignment of the SSI calculation and the Medicare Contractor has not made a final determination regarding the SSI realignment issue. Under 42 C.F.R. § 412.106(b)(3) a hospital can, if it prefers, use its cost reporting period data instead of the federal fiscal year data in determining the DSH Medicare fraction. The decision to use its own cost reporting period is the hospital's 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. Because no final determination has been issued, the Board also lacks jurisdiction over this issue.

As the SSI Provider Specific issue is the last remaining issue in the appeal, and the Board finds that it lacks jurisdiction as it was not adjusted in the Revised NPR and was premature, case number 14-3696 is hereby dismissed.

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

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

FOR THE BOARD

Michael W. Harty
Chairman

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

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

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SEP 21 2016

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P.O. Box 6722
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RE: University of Washington Medical Center as a participant in QRS University of Washington Medicine 2005-2006 SSI CIRP Group.
Provider No.: 50-0008
FYE: 06/30/2006
PRRB Case No.: 09-1763GC

Dear Mr. Nord and Mr. Ward,

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced appeal. The Board grants the reconsideration request and therefore reinstates University of Washington Medical Center (Provider No.: 50-0008, FYE 06/30/2006) as a participant in this group. The Board's decision is set forth below.

Background

The Medicare Contractor issued a Notice of Program Reimbursement (NPR) for FYE 06/30/2006 on November 12, 2008. The Provider, University of Washington Medical Center, filed an appeal request with the Board in which it appealed several issue including the SSI Percentage issue.

On June 14, 2010, the Board received the Provider's Request to Transfer the SSI Percentage issue to this Common Issue Related Party ("CIRP") Group Appeal, Case No.: 09-1763GC. The Board dismissed the 06/30/2006 cost reporting period from the CIRP group based on the finding that the Provider failed to properly add the SSI Percentage issue within the time period allowed. The remaining Providers were then remanded pursuant to CMS ruling 1498-R and Case No.: 09-1763GC was closed.

The Board, on April 1, 2016 received the Provider's Request for correction of the Board's Decision on the basis that University of Washington Medical Center (06/30/2006) timely added the issue. The request also included additional information not originally submitted with the schedule of providers.

Board's Decision

The Board grants the Reconsideration Request and reinstates the University of Washington

Medical Center's 06/30/2006 cost reporting period in CIRP group 09-1763GC because the Provider timely added the issue to the appeal based on the additional information submitted with the reinstatement request.

Pursuant to 42 C.F.R. § 405.1835(e)(2008), a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board only if—

> (1) The request to add issues complies with the requirements of paragraphs (a) and (b), or paragraphs (c) and (d), of this section as to each new specific item at issue.
>
> (2) The specific items raised in the initial hearing request and the specific items identified in subsequent requests to add issues, when combined, satisfy the amount in controversy requirements of paragraph (a)(2) or paragraph (c)(3) of this section.
>
> (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2), of this section.

Participant 1, University of Washington Medical Center, was issued its Notice of Program Reimbursement on November 12, 2008. The Provider then had 180 days plus a five day mailing presumption to file its individual appeal request with the Board, or by May 18, 2009. The Provider in this case timely filed its initial appeal request on January 13, 2009. The Provider then had another 60 days to add any additional issues to this appeal, totaling 240 days from November 12, 2008. The last day for the Board to timely receive this add request would have been July 10, 2009.

The Provider filed its request to add issues to the appeal on June 15, 2009 and included FedEx Confirmation that it was received June 16, 2009. The Provider timely filed it's add request within the timeframe allowed by the regulation and therefore the request for reconsideration is granted.

Accordingly, Case No.: 09-1763GC is reinstated and another remand will be issued to include University of Washington Medical Center, which will be addressed under separate cover.

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:
Michael W. Harty
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

FOR THE BOARD

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
cc: Wilson Leong, FSS

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SEP 22 2016

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Russell Kramer
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Wisconsin Physicians Service
Byron Lamprecht, Cost Report Appeals
P. O. Box 8696
Madison, WI 53708

RE: Covenant Medical Center
Juris. Challenge DSH – SSI (Provider Specific)
PN: 16-0067
FYE: 6/30/2009
PRRB Case Number: 13-0357

Dear Mr. Kramer and Mr. Lamprecht,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal in response to the Medicare contractor's jurisdictional challenge concerning the subject provider.

Background

The Covenant Medical Center ("Covenant" or "Provider") filed a timely appeal on December 20, 2012 from its August 7, 2012 Notice of Program Reimbursement ("NPR"). The issues initially raised included:

(1) Disproportionate Share Hospital Payment ("DSH") – Supplemental Security Income ("SSI") (Provider Specific)
(2) DSH – SSI
(3) DSH – Medicaid Eligible Days
(4) DSH – Medicare Managed Care Days
(5) DSH – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)
(6) Outlier Payments – Fixed Loss Threshold, Operating Cost to Charge Ratio and Outlier Reconciliation Adjustments.

The Provider submitted transfer request for issues #'s 2, 4, 5 and 6 above and only briefed issue #1, DSH-SSI-Provider Specific in its Final Position Paper.[1]

The Medicare Contractor filed a jurisdictional challenge on July 8, 2013 regarding Issue #1, DSH – SSI (Provider Specific) and the Provider filed a jurisdictional response on July 25, 2013.

[1] *See* Provider's and Medicare Contractor's Final Position Papers.

Medicare Contractor's Position

The Medicare Contractor contends that the Provider did not request recalculation of the SSI percentage based on the Provider's cost reporting period, thus it did not exhaust its available remedy and cannot demonstrate that dissatisfaction exists. The Medicare Contractor concedes that the Provider is entitled to a recalculation based on 42 C.F.R. § 412.106 (b)(3), if the Provider adheres to the requirements for making such a request, but the Provider is not entitled to appeal an action before it has been taken and asserts the appeal of this issue is premature.

Provider's Position

The Provider contends that the Board has jurisdiction over the SSI Provider Specific issue. The Provider further contends that the published SSI percentage was incorrectly computed because CMS did not include patients that were entitled to the SSI benefits based on the Provider's fiscal year end. The Provider also clarifies that it has not reconciled its own records of patients with Medicare Part A and SSI against CMS, based on the federal fiscal year since the complete MEDPAR data has not been released. [2]

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 - 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the 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 notice of the final determination.

Issue #1, DSH – SSI (Provider Specific), was raised as "Whether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation." The Provider contended that the SSI percentage was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits so both the SSI percentage and the subsequent audit adjustment were flawed. The Provider stated that it was seeking data from CMS in order to reconcile its records and identify the data that CMS failed to include. It went on to indicate that the Provider "preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period."[3]

The Board finds that it has jurisdiction over the portion DSH – SSI (Provider) Specific issue as it relates to the "errors of omission and commission" as there was an adjustment to the SSI percentage (Adj. 32), and the appeal meets the amount in controversy and timely filing requirements. However, the Board also finds that this issue is duplicative of the SSI Systemic Errors issue (Issue #2), that was transferred to Case No. 13-3224GC.[4] The "systemic" arguments and the "provider specific" arguments put forth in the appeal request are categories of the same argument (not separate issues) related to the accuracy of the SSI fraction within the DSH

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[2] See Providers Final Position Paper and the Jurisdiction Response dated July 25, 2013.
[3] See Provider's Individual Appeal Request, Tab 3.
[4] Refer to Medicare Contractor Position Paper.

adjustment.

The Board finds that it does not have jurisdiction over the portion DSH – SSI Provider Specific issue as it relates to the realignment of the SSI percentage to the Provider's fiscal year end. The issue of realignment was not actually raised in the appeal request because the Provider only mentioned that it "preserves its right to request under separate cover that CMS recalculate the SSI percentage" but did not actually raise an issue of dissatisfaction specific to the realignment process.

Accordingly, the Board dismisses Issue #1, DSH – SSI (Provider Specific) issue from this appeal, and finds that the Issue # 3, DSH Medicaid Eligible Days was abandoned, by the Provider in case No. 13-0357 as the issue was not briefed in its final position paper. The Board hereby closes case No. 13-0357, as no issues remain in the appeal.

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

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

FOR THE BOARD

Michael W. Harty
Chairman

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

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to: 13-0358

CERTIFIED MAIL

SEP 22 2016

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

Wisconsin Physicians Service
Byron Lamprecht, Cost Report Appeals
P. O. Box 8696
Madison, WI 53708

RE: Covenant Medical Center
Juris. Challenge DSH – SSI (Provider Specific)
PN: 16-0067
FYE: 6/30/2009
PRRB Case Number: 13-0358

Dear Mr. Kramer and Mr. Lamprecht,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal in response to the Medicare contractor's jurisdictional challenge concerning the subject provider.

Background

The Covenant Medical Center ("Covenant" or "Provider") filed a timely appeal on December 20, 2012 from its September 12, 2012 Notice of Program Reimbursement ("NPR").[1] The issues initially raised included:

(1) Disproportionate Share Hospital Payment ("DSH") – Supplemental Security Income ("SSI") (Provider Specific)
(2) DSH – SSI
(3) DSH – Medicaid Eligible Days
(4) DSH – Medicare Managed Care Days
(5) DSH – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)
(6) Outlier Payments – Fixed Loss Threshold, Operating Cost to Charge Ratio and Outlier Reconciliation Adjustments.

The Provider submitted transfer request for issues #'s 2, 4, 5 and 6 above and only briefed issue #1, DSH-SSI-Provider Specific in its Final Position Paper.[2]

The Medicare Contractor filed a jurisdictional challenge on July 8, 2013 regarding Issue #1, DSH – SSI (Provider Specific) and the Provider filed a jurisdictional response on July 29, 2013.

[1] The Appeal Request notes the NPR date as September 12, 2012. However the NPR is not dated, upon PRRB's request the Provider submitted a letter dated September 19, 2012 that references that the Provider should have received an NPR before September 29, 2012.
[2] *See* Provider's and Medicare Contractor's Final Position Papers.

Medicare Contractor's Position

The Medicare Contractor contends that the Provider did not request recalculation of the SSI percentage based on the Provider's cost reporting period, thus it did not exhaust its available remedy and cannot demonstrate that dissatisfaction exists. The Medicare Contractor concedes that the Provider is entitled to a recalculation based on 42 C.F.R. § 412.106 (b)(3), if the Provider adheres to the requirements for making such a request, but the Provider is not entitled to appeal an action before it has been taken and asserts the appeal of this issue is premature.

Provider's Position

The Provider contends that the Board has jurisdiction over the SSI Provider Specific issue. The Provider further contends that the published SSI percentage was incorrectly computed because CMS did not include patients that were entitled to the SSI benefits based on the Provider's fiscal year end. The Provider also clarifies that it has not reconciled its own records of patients with Medicare Part A and SSI against CMS, based on the federal fiscal year since the complete MEDPAR data has not been released. [3]

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 - 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the 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 notice of the final determination.

Issue #1, DSH – SSI (Provider Specific), was raised as "Whether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation." The Provider contended that the SSI percentage was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits so both the SSI percentage and the subsequent audit adjustment were flawed. The Provider stated that it was seeking data from CMS in order to reconcile its records and identify the data that CMS failed to include. It went on to indicate that the Provider "preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period."[4]

The Board finds that it has jurisdiction over the portion DSH – SSI (Provider) Specific issue as it relates to the "errors of omission and commission" as there was an adjustment to the SSI percentage (Adj. 49), and the appeal meets the amount in controversy and timely filing requirements. However, the Board also finds that this issue is duplicative of the SSI Systemic Errors issue (Issue #2), that was transferred to Case No. 13-3267GC.[5] The "systemic" arguments and the "provider specific" arguments put forth in the appeal request are categories of the same

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[3] See Providers Final Position Paper and the Jurisdiction Response dated July 25, 2013.
[4] See Provider's Individual Appeal Request, Tab 3.
[5] Refer to Medicare Contractor Position Paper.

argument (not separate issues) related to the accuracy of the SSI fraction within the DSH adjustment.

The Board finds that it does not have jurisdiction over the portion DSH – SSI Provider Specific issue as it relates to the realignment of the SSI percentage to the Provider's fiscal year end. The issue of realignment was not actually raised in the appeal request because the Provider only mentioned that it "preserves its right to request under separate cover that CMS recalculate the SSI percentage" but did not actually raise an issue of dissatisfaction specific to the realignment process.

Accordingly, the Board dismisses Issue #1, DSH – SSI (Provider Specific) issue from this appeal, and finds that the Issue # 3, DSH Medicaid Eligible Days was abandoned, by the Provider in case No. 13-0358 as the issue was not briefed in its final position paper. The Board hereby closes case No. 13-0358, as no issues remain in the appeal.

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

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

FOR THE BOARD

Michael W. Harty
Chairman

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

cc: Wilson C. Leong, Federal Specialized Services

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Refer to:

CERTIFIED MAIL

SEP 22 2016

Maureen O'Brien Griffin
Hall, Render, Killian, Heath & Lyman
500 North Meridian Street, Suite 400
Indianapolis, IN 46204

RE: Franciscan Alliance 2008 SSI Fraction Medicare Advantage CIRP Group
Case No. 13-2056GC

Franciscan Alliance 2008 Medicaid Fraction Medicare Advantage Days CIRP Group
Case No. 13-2051GC

Dear Ms. O'Brien Griffin:

The Provider Reimbursement Review Board (the Board) has reviewed your August 1, 2016 request seeking to consolidate the above-referenced group appeals which involve the inclusion/exclusion of Medicare Advantage Days in the Medicare and Medicaid fractions of the disproportionate share hospital (DSH) adjustment. Your correspondence also requests the bifurcation of the Inpatient Rehabilitation (Rehab) Units from the existing groups into a newly created Rehab group.

Bifurcation of Rehab Units

In accordance with your request, the Board has bifurcated Franciscan St. James Health (14-T172) and St. Francis Hospital – Beech Grove (15-T033) from the subject DSH group appeals, case numbers 13-2056GC & 13-2051GC and established a new optional group as follows:

Case No.	Group Name
16-2196G	Hall Render 2008 Rehab LIP Medicare/Medicaid Part C Days Group[1]

Enclosed please find a Group Acknowledgement and Critical Due Dates letter for the new group.

[1] An optional group was formed since the Providers did not meet the $50K minimum amount in controversy requirement.

Participants in Rehab Group

The Board notes that the Schedule of Providers included with the request for bifurcated group included St. Franciscan Saint Anthony Health – Michigan City (15-T015) as a participant to be transferred from case numbers 13-2056GC and 13-2051GC. Upon review of the documentation in the initial group appeal requests, however, the Board finds that there is not enough evidence to support an adjustment to the LIP/IRF in either of the initial group appeals. Therefore, St. Franciscan Saint Anthony Health – Michigan City (15-T015) is not included as a participant in the group appeal.

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

Consolidation of Medicare & Medicaid Fraction Groups

As indicated in your correspondence, the Board has recently agreed with your position, that the issue of whether the Medicare Advantage Days should be counted in the Medicaid Fraction rather than the Medicare Fraction is one issue. Therefore, the Board is consolidating the Franciscan Alliance 2008 Medicaid Fraction Medicare Advantage Days CIRP Group, Case No. 13-2051GC into the Franciscan Alliance 2008 Medicare Fraction Medicare Advantage Days CIRP Group, Case No. 13-2056GC. Case No. 13-2051GC is hereby closed. The group name for case no. 13-2056GC has been modified to the Franciscan Alliance 2008 Medicare/Medicaid Fraction Medicare Advantage Days CIRP Group.

Please refer to only Case No. 13-2056GC in future correspondence with the Board.

Group Completion

Please advise the Board whether the newly consolidated group is complete within 30 days of the date of this letter. If the group is not fully formed, please identify the Providers for which you are awaiting NPRs, within the same 30 day period.

Board Members Participating:
Michael W. Harty
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

For the Board:

Michael W. Harty
Chairman

Enclosures: Group Acknowledgement and Critical Due Dates letter (16-2196G)
42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and .1877

cc: Byron Lamprecht, Wisconsin Physicians Service (J-8)(w/enclosure)
Wilson C. Leong, Esq., CPA, Federal Specialized Services (w/enclosure)

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Refer to: 15-1743

SEP 22 2016

CERTIFIED MAIL

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

Byron Lamprecht
Wisconsin Physicians Service
Cost Report Appeals
P.O. Box 8696
Madison, WI 53708-1834

RE: Jurisdictional Decision – Avoyelles Hospital
Provider No.: 19-0099
FYE: 12/31/2011
PRRB Case No.: 15-1743

Dear Mr. Ravindran and Mr. Lamprecht,

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced appeal. Though the Board finds that this appeal was timely filed, the Board also finds that it does not have jurisdiction over the DSH SSI (Provider Specific) issue as it is duplicative of the Systemic Errors issue and no final determination has been issued. In addition, the Board finds that it does not have jurisdiction over the DSH – Medicaid Eligible Days issue as it does not comply with statutory requirements. The Board's decision is set forth below.

Background

The Medicare Contractor issued a Notice of Program Reimbursement (NPR) for FYE 12/31/2011 on September 3, 2014. The Provider, Avoyelles Hospital, filed an appeal request with the Board in which it appealed the following issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH Payments/SSI Percentage (Systemic Errors)
3. DSH – SSI Fraction/Medicare Managed Care Part C Days
4. DSH – SSI Fraction/Dual Eligible Days
5. DSH – Medicaid Eligible Days
6. DSH – Medicaid Fraction/Medicare Managed Care Part C Days
7. DSH – Medicaid Fraction/Dual Eligible Days
8. Outlier Payments – Fixed Loss Threshold.

On March 30, 2015, the Board received the Medicare Contractor's Jurisdictional Challenge over the SSI Realignment Issue. On April 24, 2015 The Board received the Provider's Jurisdictional Response.

Six of the eight issues have since been transferred to group appeals. The only issues that remain pending in case number 15-1743 are the DSH SSI (Provider Specific) Issue and the DSH – Medicaid Eligible Days issue.

Medicare Contractor's Contentions

The Medicare Contractor is challenging the Board's jurisdiction to hear this case in its entirety because of its contention that the Provider's appeal request was not timely filed. Pursuant to 42 C.F.R. § 405.1841, "the request for a Board hearing must be filed in writing with the Board within 180 days of the date the notice of the intermediary's determination was mailed to the provider." The Medicare Contractor contends that the NPR was sent on September 3, 2014 and the Provider filed its appeal request on March 6, 2015 which was received by the Board on March 9, 2015. The Medicare Contractor contends that the Provider has failed to meet the timeliness requirements.

The Medicare Contractor is also challenging the Board's jurisdiction to hear the SSI realignment[1] issue because of its contention that it is not an appealable issue and it is not timely filed. The Medicare Contractor contends that this issue may be suitable for a reopening but cannot be appealed because the decision to realign a provider's SSI percentage with its Fiscal Year End is through a provider's own election and not a Medicare Contractor's determination. The Hospital must make a formal request through its Medicare Contractor to CMS in order to receive a realigned SSI percentage.

The Provider's right to a PRRB hearing derives from a Medicare Contractor or CMS determination pursuant to 42 C.F.R. § 405.1801(a). The Medicare Contractor contends that it did not and cannot make a determination in terms of the Provider's SSI percentage. The Provider is the only party that can make the election regarding the fiscal year end for the SSI percentage and there is no Medicare Contractor determination the Provider can contest. The Provider did not pursue the available remedy and it is not appropriate to include this issue in the PRRB appeal. The Medicare Contractor concludes that pursuant to 42 C.F.R. § 405.1803, the PRRB does not have jurisdiction over this issue because the Provider wants to change its election of the fiscal year end for the SSI percentage of the DSH computation and should not be permitted to raise this issue for the first time before the Board.

Provider's Contentions

The Provider contends that the Board has jurisdiction over the DSH/SSI (Provider Specific) issue which includes the realignment issue. The Provider claims that it is not addressing a realignment of the SSI percentage but is addressing the various errors of omission and commission that do not fit into the "Systemic Errors" category. In addition, the Provider contends that this is an appealable issue because the Medicare Contractor specifically adjusted the Provider's SSI percentage and the Provider is dissatisfied with the amount of the DSH payment that it received

[1] The "SSI Realignment" issue refers to what the Provider identifies as the SSI Provider Specific Issue.
[2] The Provider did not respond to the Medicare Contractor's challenge to the timelines of the appeal request.

for fiscal year 2011 as a result of its understated SSI percentage. The Provider concludes that it is entitled to appeal an item with which it is dissatisfied.

Board's Decision

Timeliness

The Board finds that the Provider's Individual Appeal Request was timely filed. Pursuant to 42 C.F.R. § 405.1835(a)(3), the Board must receive the hearing request no later than 180 days after the provider is issued its final determination. For appeal requests filed after August 21, 2008, 42 C.F.R. § 405.1801 and PRRB Rule 21, states that the date of filing is the date of receipt by the Board, or the date of delivery by a nationally-recognized next-day courier. For mailing purposes, pursuant to 42 C.F.R. § 405.1801(a)(1)(iii) and PRRB Rule 4.3, the date of receipt of an NPR is presumed to be five days after the date of issuance. However, 42 C.F.R. § 405.1801(d)(3) states that "if the last day of the designated time period is a Saturday or a Sunday…the deadline becomes the next day that is not one of the aforementioned days."

The Provider's NPR was issued on September 3, 2014. Here, the 185th day fell on Saturday March 7, 2015. Because the last day of the designated time period fell on a Saturday, the deadline became the next business day. The request for a hearing was received by the Board on Monday March 9, 2015 which was the next business day following Saturday March 7, 2015 therefore the request was timely filed.

DSH – SSI Percentage (Provider Specific) Issue

The Board also finds that it does not have jurisdiction over the DSH SSI Ratio Realignment issue as it is duplicative and there is no final determination. 42 C.F.R. § 405.1835 (2014) states,

> A provider . . . has a right to a Board hearing . . . for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination only if . . . [t]he provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue. . .

In this case, the Provider does not appear to have requested a realignment of the SSI calculation and the Medicare Contractor has not made a final determination regarding the DSH SSI realignment issue. Under 42 C.F.R. § 412.106(b)(3) a hospital can, if it prefers, use its cost reporting period data instead of the federal fiscal year 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.

In addition, the majority of the DSH SSI Ratio Realignment issue is duplicative of the already transferred Systemic Errors issue. The Provider contends in the SSI (Provider Specific) issue

statement that it is dissatisfied with "the Medicare Contractor's calculation of the computation of the DSH percentage in accordance with the Statutory Instructions." The SSI Systemic Errors issue statement also contends that "the Medicare Contractor's determination of the Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare Statute...the SSI percentages calculated by the Centers for Medicare and Medicaid Services and used by the Medicare Contractor to settle their cost report does not address all the deficiencies...and incorporate a new methodology inconsistent with the Medicare Statute." The SSI Systemic Errors issue was transferred to a group and no longer remains pending in this appeal. Therefore, because the DSH SSI (Provider Specific) issue is duplicative of the Systemic Errors issue and the Medicare Contractor has not made a determination regarding SSI realignment from which Avoyelles Hospital could be dissatisfied, the Board finds that it lacks jurisdiction over the issue in this appeal and dismisses the issue from case number 15-1743

DSH – Medicaid Eligible Days Issue

The Board finds that it does not have jurisdiction over the DSH – Medicaid Eligible Days Issue because the appeal does not comply with the Statutory Requirements set out at 42 C.F.R. § 405.1835(a)(1)(i) (2009) or 42 C.F.R. § 405.1835(a)(1)(ii) (2014).

Effective with cost report periods that end on or after December 31, 2008, CMS amended the regulations governing cost report appeals to incorporate Provider Reimbursement Manual (PRM) 15-2 § 115 *et seq.* into the regulations at 42 C.F.R. § 405.1835(a)(1)(ii) (2009) by specifying that, where a provider seeks payments that it believes may not be allowable or may not be in accordance with Medicare policy, the provider must claim the items as self-disallowed costs "by following the applicable procedures for filing a cost report under protest." Here, the Provider's cost report was for FYE 12/31/11; therefore, any self-disallowed items are required to be protested. The Provider failed to include a reimbursement claim for additional Medicaid days or file those days under protest. Therefore, the Provider failed to preserve its rights and lacks any legal basis to appeal the item to the Board under 42 C.F.R. § 405.1835(a)(1)(ii) for self-disallowed costs.

The Provider cites adjustments 7, 32 and S-D in the appeal request related to Medicaid Eligible days, however, upon review of those adjustment numbers form the attached adjustment report; none of these items adjust Medicaid Eligible Days.[2] Adjustment 7 is a PS&R adjustment which adjusts Medicare days. Adjustment 32 revises the SSI% on W/S E Part A. Neither of those adjustments relates to Medicaid Eligible Days. The Provider also references S-D, or self-disallowance, but as this appeal is for FY 12/31/2011, 42 C.F.R. § 405.1835(a)(1)(i) (2014) applies, which requires a provider to report a claim for reimbursement as a protested item. The Board finds that it lacks jurisdiction over the last two issues in the appeal: DSH/SSI (Provider Specific) issue and the DSH – Medicaid Eligible Days issue. Case No. 15-1743 is dismissed and removed from the Boards 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:
Michael W. Harty
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA
Sue Anderson, Esq.

FOR THE BOARD

Michael W. Harty
Chairman

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

cc: Wilson Leong, FSS

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Refer to: 16-0203

CERTIFIED MAIL

SEP 22 2016

Sharon DiSunno
Vice President, Quality Management
Southampton Hospital
240 Meeting House Lane
Southampton, New York 11968

Pam VanArsdale
National Government Services, Inc.
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, Indiana 46206

RE: Jurisdictional Decision
Provider No.: 33-0340
PRRB Case No.: 16-0203
FYE: 12/31/2015

Dear Ms. DiSunno and Ms. VanArsdale:

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

Background

Southampton Hospital ("the Provider") received a two-percentage-point reduction of its annual payment update for calendar year 2015 due to the Provider's failure to fully meet the requirements of the Hospital Outpatient Quality Reporting ("HOQR") Program. Following the Provider's request for reconsideration of the reduction, in a decision dated May 1, 2015, the Centers for Medicare and Medicaid Services ("CMS") upheld the reduction.

On November 9, 2015, the Provider filed the above-referenced appeal of CMS' determination to uphold the reduction.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. § 405.1835, a provider has a right to a hearing before the Board with respect to a final contractor or Secretary determination for the provider's cost reporting period if: 1) it is dissatisfied with the final determination of the total amount of reimbursement due the provider; 2) the amount in controversy is $10,000 or more; and 3) the request for a hearing is received by the Board within 180 days of the date of receipt of the final determination.[1]

[1] 42 C.F.R. § 405.1835(a); *see also* 42 C.F.R. § 419.46(f)(3) (A provider "dissatisfied with a decision made by CMS on its reconsideration request [concerning the HOQR program] may file an appeal with the [] Board under part 405, subpart R, of this chapter.")

The Board does not have jurisdiction over this appeal because the Provider's appeal request was not timely filed. As stated above, the Provider's appeal request was due to be filed with the Board no later than 180 days after it received CMS' May 1, 2015, determination, i.e., on or before November 2, 2015. However, the Provider's appeal request was not received by the Board until November 9, 2015.

For mailing purposes, pursuant to 42 C.F.R. § 405.1801(a)(1)(iii) and Board Rule 4.3, the date of receipt of a final determination is presumed to be five days after the date of issuance of the determination unless a provider establishes by a preponderance of the evidence that the final determination was actually received on a later date. In this case, the Provider is presumed to have received CMS' final determination within five days of May 1, 2015, i.e., on or before May 6, 2015. The Provider did not present any evidence that the final determination was received later than May 6, 2015.

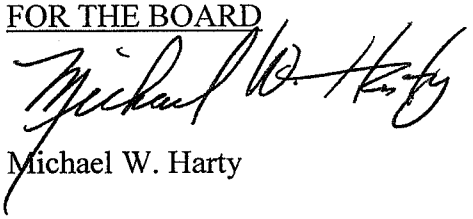
Furthermore, the date of receipt is the date stamped "received" by the Board where a nationally-recognized next-day courier is not used for delivery.[2] Here, the Provider's appeal was not delivered via nationally-recognized next-day courier, and was stamped "received" by the Board on November 9, 2015 - seven days after the November 2, 2015, filing deadline. Thus, the Provider filed its appeal 192 days after the presumed date of receipt of its final determination.

As set forth above, the Board finds that the appeal request was not received by the Board within 180 days of the date of receipt of the final determination as required by 42 C.F.R. § 405.1835, and as such, was not timely filed. Accordingly, the Board hereby dismisses the appeal, and case number 16-0203 is closed.

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
Michael W. Harty
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

FOR THE BOARD



Michael W. Harty

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

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

[2] 42 C.F.R. § 405.1801(a)(2).

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Refer to: 11-0540GC

CERTIFIED MAIL

SEP 22 2016

James C. Ravindran
President
Quality Reimbursement Services
150 N. Santa Anita Avenue, Suite 570A
Arcadia, California 91006

Barb Hinkle
Appeals Lead
Cahaba GBA
c/o National Government Services, Inc.
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, Indiana 46206

RE: Jurisdictional Determination – DCH Regional Medical Center, as a participant in QRS DCH Health 2002 - 2004 DSH/SSI CIRP Group
Provider No.: 01-0092
PRRB Case No.: 11-0540GC
FYE: 9/30/2005

Dear Mr. Ravindran and Ms. Hinkle:

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in this appeal. The decision of the Board with regard to jurisdiction of the above-mentioned group participant is set forth below.

Background

The above-referenced group appeal challenged the data-matching process used in calculating the Supplemental Security Income ("SSI") fraction of the Providers' Medicare payment determination. The providers filed a request for a common issue related party ("CIRP") group appeal on March 14, 2011. There are six participants in the group, including DCH Regional Medical Center, which is listed as Participant No. 6 on the Schedule of Providers ("SOP").

Board's Decision

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

Participant No. 6 appealed from a revised Notice of Program Reimbursement ("NPR") dated September 26, 2011. A revised NPR stems from the reopening and revision of "[a] ... [Medicare]

[1] 42 C.F.R. § 405.1835(a).

contractor determination ... with respect to specific findings on matters at issue in a determination ...."[2] As such, a revised NPR is "considered a separate and distinct determination" from which a provider may appeal.[3]

Since Participant No. 6's appeal is based on a revised NPR, "[o]nly those matters that are specifically revised in" the revised NPR "are within the scope of any appeal" of the revised NPR.[4] The United States District Court for the District of Columbia recently issued a decision upholding the Secretary of the Department of Health and Human Services' "issue-specific interpretation" of the above-quoted reopening regulations.[5] Based on the *Emanuel* decision, in order for the Board to have jurisdiction over Participant No. 6's appeal, the revised NPR upon which the appeal us based must have specifically adjusted the SSI percentage.

However, Participant No. 6 failed to demonstrate that the SSI percentage issue was specifically adjusted on the revised NPR upon which its appeal is based.[6] To the contrary, audit adjustment no. R3-003, identified in Participant No. 6's appeal request as the adjustment at issue, reflects a general Medicare Disproportionate Share Hospital adjustment – not a specific adjustment to the SSI percentage issue.[7]

Since Participant No. 6 failed to demonstrate that the SSI percentage issue was specifically adjusted on the revised NPR upon which its appeal is based, the Board finds that it does not have jurisdiction over Participant No. 6, DCH Regional Medical Center (provider no. 01-0092, FYE 9/30/2005), and hereby dismisses Participant No. 6 from case number 11-0540GC.

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

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

FOR THE BOARD

Michael W. Harty

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

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[2] 42 C.F.R. § 405.1885(a)(1).
[3] 42 C.F.R. § 405.1889(a)
[4] 42 C.F.R. § 405.1889(b)(1); *see also HCA Health Services of Oklahoma, Inc. v. Shalala*, 27 F.3d 614, 615 (D.C. Cir. 1994)(the Board's jurisdiction is limited to the "specific issues revisited on reopening" in an appeal of the reopening of the original determination).
[5] *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F. Supp. 3d 348, 356-57 (D.D.C. 2014).
[6] SOP Tabs 6-A - 6-D.
[7] SOP Tab 6-B ("Description of Issue" field); Tab 6-D, p. 1. (audit adjustment no. R3-003).

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

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

Refer to: 13-1119 & 14-2753

SEP 29 2016

Certified Mail

Robert Coughlin
Reimbursement Manager
H. Lee Moffitt Cancer Center
12902 Magnolia Drive
Tampa, FL 33612

Geoff Pike
Provider Audit and Reimbursement Dept.
First Coast Service Options, Inc.
532 Riverside Avenue
Jacksonville, FL 32231-0014

RE: **PRRB Own Motion Expedited Judicial Review Determination**
Provider Name: H. Lee Moffitt Cancer Center
Provider No.: 10-0271
FYEs: 6/30/2011 & 6/30/2012,
PRRB Case Nos.: 13-1119 & 14-2753

Dear Mr. Coughlin and Mr. Pike:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's July 1, 2016 comments regarding the suitability of these appeals for Expedited Judicial Review ("EJR") filed subsequent to the Board's June 6, 2016 notice that it was considering EJR on its own motion. The Board's decision regarding EJR on its own motion is set forth below.

Issue under Appeal

Does the implementation date of the Outpatient Prospective Payment System ("OPPS") Payment Adjustment for Certain Cancer Hospitals (required under Section 3138 of the Affordable Care Act) violate the Social Security Act?[1]

Statutory and Regulatory Background

Section 3138 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 ("ACA") amended the outpatient prospective payment statute, in subsection 1833(t) of the Act, by adding a new paragraph 18 requiring a payment adjustment for certain cancer hospitals "described in section 1886(d)(1)(B)(v) of the Social Security Act," which includes the Provider. As amended by the ACA, the statute required the Secretary to perform a study of the costs incurred by the 11 comprehensive cancer centers identified by statute to determine if their costs of services paid under the outpatient prospective payment exceed the costs incurred by other hospitals for those services.[2]

[1] The Provider has also appealed whether the Medicare Contractor properly calculated the cancer center's payment-to-cost ratio ("PCR") for both fiscal years ("FY") under appeal. This issue is addressed under separate cover.
[2] Social Security Act § 1833(t)(18)(A), 42 U.S.C. § 1395l(t)(18)(A).

The statute also mandated that the Secretary "shall provide for an appropriate adjustment" to the payments made to the 11 comprehensive cancer centers, including the Provider, if the Secretary were to determine that their costs exceed the costs incurred by other hospitals for outpatient services paid under prospective payment systems.[3] The statute stated that the Secretary "shall reflect those higher costs effective for services furnished on or after January 1, 2011.

In 2010, the Secretary performed a study and determined that the 11 comprehensive cancer centers' costs exceed the costs incurred by other hospitals; and that their payments, even including the hold harmless payments, amount to a lower percentage of their reasonable costs than other hospitals receive.[4] Accordingly, the Secretary proposed a payment adjustment that would raise the payments to the comprehensive cancer centers for outpatient services to a level equal to 91% of their reasonable costs, which the Secretary determined to be on par with the average payment-to-cost ratio for other hospitals that are paid under the prospective payment system.

The OPPS Final Rule for FY 2012 states, "because the many public comments we received identified a broad range of very important issues and concerns associated with the proposed cancer hospital payment adjustment, we determined that further study and deliberation was necessary and, therefore, we did not finalize the CY 2011 proposed payment adjustment for certain cancer hospitals."[5] The implementing regulation at issue here reflects the fact that the Secretary did not finalize the adjustment for CY 2011. 42 C.F.R. § 419.43(i)(1) states: "General Rule. CMS provides for a payment adjustment for covered hospital outpatient department services furnished **on or after January 1, 2012**, by a hospital described in section 1886(d)(1)(B)(v) of the Act."[6]

The Provider argues that the Secretary's one year delay in implementing the payment adjustment is contrary to law because the Affordable Care Act set a specific implementation date. The Provider further argues that the Secretary's determination not to implement the payment adjustment by January 1, 2011 is arbitrary, capricious and contrary to law.[7]

Parties' Positions

On June 6, 2016, the Board sent letters to the parties requesting comment on whether the issue of if the implementation date of the OPPS Payment Adjustment for Certain Cancer Hospitals (required under Section 3138 of the Affordable Care Act) violates the Social Security Act is appropriate for EJR pursuant to 42 C.F.R. § 405.1842(a). The Provider responded that the Board should not issue EJR now because it would like to consolidate the appeals with appeals from other comprehensive cancer centers as their final determinations are issued.

The Medicare Contractor did not submit comments.

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[3] § 1833(t)(B), 42 U.S.C. § 1395l(t)(18)(B).
[4] 78 Fed. Reg. 71800, 71885-71886 (Nov. 24, 2010).
[5] 76 Fed. Reg. 74121, 74202 (Nov. 30, 2011).
[6] Emphasis added.
[7] Provider Final Position Paper at 50.

Decision of the Board

The Board has reviewed the Provider's requests for hearing and comments regarding the Board's notice that it was considering EJR on its own motion. The regulation at 42 C.F.R. § 405.1842(a) permits the Board to consider whether it lacks the authority to decide a legal question relevant to the matter at issue once it has made a finding that it has jurisdiction to conduct a hearing under the provisions of 42 C.F.R. §§ 405.1840(a) and 405.1837(a). The Board concludes that the Provider timely filed both requests for hearing from the issuance of Notices of Program Reimbursement ("NPR") and the amount in controversy exceeds the $10,000 threshold necessary for each individual appeal.[8] Furthermore, on its as-filed cost reports, the Provider protested the failure to implement the cancer center adjustment by January 1, 2011; the Medicare Contractor made an adjustment to remove the protested amount.

Consequently, the Board has determined that it has jurisdiction over Provider's appeals. However, the Board finds that it lacks the authority to decide the legal question of whether the implementation date of the OPPS Payment Adjustment for Certain Cancer Hospitals (required under Section 3138 of the Affordable Care Act) violates the Social Security Act; therefore, EJR on the Board's own motion is appropriate for the issue under dispute in these cases.

The Board finds that:

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

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

3) it is bound by the applicable existing Medicare law and regulation (42 U.S.C. § 1395*l*(t)(18) and 42 C.F.R. § 419.43(i)(1)); and

4) it is without the authority to decide the legal question of whether the implementation date of the OPPS Payment Adjustment for Certain Cancer Hospitals (required under Section 3138 of the Affordable Care Act) violates the Social Security Act.

Accordingly, the Board finds on its own motion that the challenge to the implementation date of the OPPS payment adjustment as contrary to the Social Security Act properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants expedited judicial review on its own motion for the issue and the subject years. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review.

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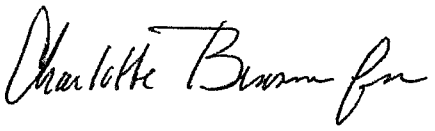
[8] *See* 42 C.F.R. § 405.1837(a)(3).

Review of the jurisdictional determination may available under the provisions of 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

Board Members

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

FOR THE BOARD:



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Edward Lau, Esq., Federal Specialized Services