DEPARTMENT OF HEALTH & HUMAN SERVICES

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

NOV 01 2017

Certified Mail

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

RE: Expedited Judicial Review Request
Hall Render Part C Days Groups
FYE: 2007 and 2012
PRRB Case Nos.: 13-1168G, 15-1148GC, 15-2419GC, 15-3024GC, and 15-3137GC

Dear Ms. Griffin:

On October 4, 2017, the Provider Reimbursement Review Board ("PRRB" or "Board") received a request for expedited judicial review ("EJR") for the above-referenced group appeal (dated October 2, 2017). The Board has reviewed the request and hereby grants EJR for the issue in this group appeal, as explained below.

The issue in this group appeal is:

> The improper inclusion by the [Medicare contractor] and the Centers for Medicare & Medicaid Services (CMS) of inpatient days attributable to Medicare Advantage patients in the numerator and d[en]ominator of the Medicare Proxy when calculating disproportionate share hospital (DSH) eligibility and payments.[1]

Statutory and Regulatory Background: Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system ("PPS").[2] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[3]

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[4] The instant cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[5]

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[1] October 2, 2017 EJR Request at 1-2.
[2] *See* 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.
[3] *Id.*
[4] *See* 42 U.S.C. § 1395ww(d)(5).
[5] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[6] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, then is used to determine the amount of the DSH payment due to the qualifying hospital.[7] The DPP is defined as the sum of two fractions expressed as percentages.[8] Those two fractions are the "Medicare" or "SSI"[9] fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), defines the Medicare/SSI fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . . (emphasis added)

The Medicare/SSI fraction is computed annually by CMS, and utilized by the Medicare contractors to compute a hospital's DSH eligibility and payment adjustment.[10]

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), defines the Medicaid fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period. (emphasis added)

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[11]

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[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] "SSI" stands for "Supplemental Security Income."
[10] 42 C.F.R. § 412.106(b)(2)-(3).
[11] 42 C.F.R. § 412.106(b)(4).

Medicare Advantage Program

The Medicare program permits its beneficiaries to receive services from managed care entities. The managed care statute implementing payments to health maintenance organizations ("HMOs") and competitive medical plans ("CMPs") is found at 42 U.S.C. § 1395mm. The statute at 42 U.S.C. § 1395mm(a)(5) provides for "payment to the eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter . . ." Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days.

In the September 4, 1990 Federal Register, the Secretary[12] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[13]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[14]

With the creation of Medicare Part C in 1997,[15] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C

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[12] of Health and Human Services
[13] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).
[14] *Id.*
[15] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.

days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal years 2001-2004.[16]

No further guidance regarding the treatment of Part C days in the DSH calculation was provided until the 2004 Inpatient Prospective Payment System ("IPPS") proposed rules were published in the Federal Register. In that notice the Secretary stated that:

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction* . . . (emphasis added)[17]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[18] In response to a comment regarding this change, the Secretary explained that:

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A.* We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[19] (emphasis added)

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[16] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).
[17] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).
[18] 69 Fed. Reg. at 49,099.
[19] *Id.*

Consequently, within the Secretary's response to the commenter, the Secretary announced that CMS would include Medicare Part C inpatient days in the Medicare fraction of the DSH calculation.

Although the change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 final rule was issued.[20] In that publication, the Secretary noted that no substantive regulatory change had in fact occurred but that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule.[21] As a result, the pertinent regulatory language was "technically corrected" to reflect that Part C days were required to be included in the Medicare fraction of the DPP as of October 1, 2004.

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius,*[22] vacated the FFY 2005 IPPS rule. However, as the providers point out, the Secretary has not acquiesced or taken action to implement the decision[23] and the decision is not binding in actions by other hospitals.

Providers' Request for EJR

The underlying issue in this EJR request involves the question of whether Medicare Part C patients are "entitled to benefits" under Part A, thereby requiring them to be counted in the Medicare Part A/SSI fraction and excluded from the Medicaid fraction numerator or vice versa.

Prior to 2004, the Secretary treated Part C patients as not entitled to benefits under Part A. From 1986-2004, the Secretary interpreted the term "entitled to benefits under Part A" to mean covered or paid by Medicare Part A. In the final rule for the FFY 2005, the Secretary reversed course and announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective October 1, 2004.[24]

In *Allina*, the Court affirmed the district court's decision "that the Secretary's final rule was not a logical outgrowth of the proposed rule."[25] The providers claim that because the Secretary has not acquiesced to the decision, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

In these cases, the providers contend that all Part C days should be excluded from the Part A/SSI fraction and the Medicaid-eligible Part C days should be included in the numerator of the Medicaid fraction. To obtain relief, the providers seek a ruling on the procedural and substantive

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[20] 72 Fed. Reg. 47,130, 47,384 (Aug. 22, 2007).
[21] *Id.*
[22] 746 F. 3d 1102 (D.C. Cir. 2014).
[23] October 2, EJR Request at 8.
[24] 69 Fed. Reg. at 49,099.
[25] *Allina* at 1109.

validity of the 2004 rule that the providers claim the Board lacks the authority to grant. The providers argue that since the Secretary has not acquiesced to the decision in *Allina*, the Board remains bound by the regulation and EJR is appropriate.

Decision of the Board

Board's Authority

Under the Medicare statute codified at 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1) (2016), the Board is required to grant a provider's EJR request if it determines that (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

Jurisdictional Requirements

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the providers requesting EJR. Pursuant to the pertinent regulations governing Board jurisdiction, 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 for an individual appeal or $50,000 or more for a group, and the request for hearing was timely filed.[26]

The providers included in this EJR request filed appeals of either original notices of program reimbursement ("NPRs") in which the Medicare contractor settled cost reporting periods ending in 2007 or 2012, or revised NPRS ("RNPRs") for cost reporting periods ending in 2007.

For providers with appeals of cost reporting periods ending before December 31, 2008, the providers may demonstrate dissatisfaction with the amount of Medicare reimbursement of the Part C days issue appealed from their respective original NPRs by claiming the issue as a "self-disallowed cost" pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen*.[27]

For appeals of original NPRs for cost reporting time periods ending on or after December 31, 2008, providers preserve their respective rights to claim dissatisfaction with the amount of Medicare

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[26] For appeals filed on or after August 21, 2008, a hearing request is considered timely if it is filed within 180 days of the date of receipt of the final determination. 42 C.F.R. § 405.1835(a) (2008).

[27] 485 U.S. at 399 (1988). Under the facts of *Bethesda*, the Board initially found that it was without jurisdiction to review the providers' challenge to the Secretary's regulation regarding apportionment of malpractice insurance costs because the providers had "self-disallowed" the costs in their respective cost reports filed with the Medicare contractor. The Supreme Court held that "[t]he Board may not decline to consider a provider's challenge to a regulation of the Secretary on the ground that the provider failed to contest the regulation's validity in the cost report submitted to [the Medicare Contractor]." The Court went on to state that "the submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations."

payment for a specific item at issue by either including a claim for the specific item on their cost reports for the period where the providers seek payment they believe to be in accordance with Medicare policy, or self-disallowing the specific item by following the applicable procedures for filing cost reports under protest.[28]

For participants filing appeals from RNPRs, the Board only has jurisdiction to hear a participant's appeal of matters that the Medicare contractor specifically revised within the RNPR.[29]

Jurisdictional Determination for Providers

The Board finds that all providers involved with the instant EJR request have had an adjustment to the SSI%[30] on their respective NPRs/RNPRs or have properly protested/self-disallowed the appealed issue such that the Board has jurisdiction to hear their respective appeals. In addition, the providers' documentation shows that the estimated amount in controversy for each group appeal exceeds $50,000 and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding Its Authority to Consider the Appealed Issue

The providers within this EJR request filed appeals covering cost reporting periods ending in 2007 or 2012, thus the cost reporting periods fall squarely within the time frame covered by the Secretary's final rule being challenged in this EJR request.[31] The Board recognizes that the D.C. Circuit vacated the regulation in *Allina* for the time period at issue in these requests, however, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only federal circuit to date that has vacated the regulation and, if the Board were to grant EJR, the providers would have the right to bring suit in federal court in either the D.C. Circuit *or* the federal circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). In addition, within its July 25, 2017 decision in *Allina Health Services v. Price*,[32] the D.C. Circuit Court agreed with the Board's decision to grant EJR for the identical issue involved in the instant EJR request.

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[28] 42 C.F.R. § 405.1835(a)(1) (2008).

[29] For RNPRs issued on or after August 21, 2008, the regulation at 42 C.F.R. § 405.1889(b)(1) (2008) states that 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.

[30] The terms "SSI fraction," "SSI%," and "Medicare fraction" are synonymous and used interchangeably within this decision

[31] As stated in the FY 2014 IPPS Final Rule, the Secretary "proposed to readopt the policy of counting the days of patients enrolled in MA plans in the Medicare fraction of the DPP[,]" thus "sought public comments from interested parties . . ." following publication of the FY 2014 IPPS Proposed Rule, 78 Fed. Reg. 27578 (May 10, 2013). Ultimately, the Secretary finalized this DSH policy for FFY 2014 and subsequent years on August 19, 2013, in the FY 2014 IPPS Final Rule. *See* 78 Fed. Reg. 50496, 50615 (Aug. 19, 2013). The provider appeals in the instant EJR request are all based upon FY 2013 cost reporting periods and earlier.

[32] *See* No. 16-5255, 2017 WL 3137996 (D.C. Cir. July 25, 2017).

Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.[33]

Board's Decision Regarding the EJR Request

The Board finds that:

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

2) based upon the providers' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;

3) it is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

4) it is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), are valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the providers' request for EJR for the issue and the subject years. The providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes these cases.

Board Members Participating:

L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A

FOR THE BOARD:

Board Member

Enclosures: 42 U.S.C. § 1395oo(f)
Schedules of Providers, List of Cases

cc: Byron Lamprecht, Wisconsin Physicians Service (Certified Mail w/Schedules of Providers)
Bill Tisdale, Novitas Solutions (Certified Mail w/Schedules of Providers)
Pam Van Arsdale, NGS (Certified Mail w/Schedules of Providers)
Judith E. Cummings, CGS Administrators (Certified Mail w/Schedules of Providers)
Wilson Leong, FSS (w/Schedules of Providers)

[33] On October 12, 2017, and October 17, 2017, one of the Medicare contractors, Wisconsin Physicians Service ("WPS"), filed objections to the EJR requests for PRRB Case Nos. 13-1168G and 15-3137GC. In its filings, WPS argues that the Board should deny the EJR requests because the Board has the authority to decide the issue under appeal since the Board is not bound by the Secretary's regulation that the federal district court vacated in *Allina*. The Board's explanation of its authority regarding this issue addresses the arguments set out in WPS' challenges.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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NOV 01 2017

VIA CERTIFIED MAIL

Sue C. Liu
Director of Reimbursement
Beaumont Health
16500 West 12 Mile Road
Southfield, MI 48076

RE: **Restructure and Closure of CIRP (Common Issue Related Party) Group**
Group Name: Beaumont Health 2013 Uncompensated Care Payments CIRP Group
PRRB Case No. 17-1146GC

Dear Ms. Liu:

On February 24, 2017, the Provider Reimbursement Review Board (Board) received a request to establish a Common Issue Related Party (CIRP) group appeal for Beaumont Health for fiscal year 2013. The Providers' issue statement for the group was "[w]hether the Medicare Administrative Contractor (the "MAC") properly determined the uncompensated care payment in the Medicare cost report." The Beaumont Health 2013 Uncompensated Care Payments CIRP Group was established and assigned PRRB Case No. 17-1146GC.

Wisconsin Physicians Service Insurance Corporation (WPS) was designated as the Lead Medicare Contractor for the group appeal. Pursuant to PRRB Rule 15.2, Advise Board if Group is Proper, WPS submitted a letter dated March 1, 2017 informing the Board that the group issue (uncompensated care payments) was a single common issue but was not suitable for a group appeal. PRRB Rule 13, Common Group Issue, states that "[t]he matter at issue must include a single common question of fact or interpretation of law, regulation or CMS policy or ruling. A group case is not appropriate if facts that must be proved are unique to the respective Providers or if the undisputed controlling facts are not common to all group members." *See also* 42 C.F.R. § 405.1837(a)(2). WPS found no other jurisdictional impediments.

In a letter dated April 14, 2017, Beaumont Health responded to the Medicare Contractor's evaluation of the group issue. Beaumont Health agreed that the issue may not be suitable for a group appeal due to the factual differences between the Providers and requested that the Board restructure the CIRP group into individual appeals.

The Board has reviewed the above-captioned appeal in response to the Medicare Contractor's March 1, 2017 letter and the Providers' April 14, 2017 reply. As the parties have agreed that the issue for PRRB Case No. 17-1146GC is not suitable for a group appeal and WPS found no other jurisdictional impediments, the Board grants Beaumont Health's request to restructure the Beaumont Health 2013 Uncompensated Care Payments CIRP Group into individual appeals.

The group appeal was established with two Beaumont Health Providers via the transfer of Wayne (Provider No. 23-0142) from PRRB Case No. 16-1983 and the direct add of Taylor (Provider No. 23-0270). Both Providers have met the $10,000 threshold for an individual appeal as required by Board Rule 6.3 and 42 C.F.R. §§ 405.1835 and 405.1839.

Beaumont Health had requested an individual appeal for Wayne for fiscal year 2013 by letter dated July 1, 2016. The appeal request was received on July 5, 2016 and assigned PRRB Case No. 16-1983. Issue 5 on the Statement of Issues was the Uncompensated Care Pool Share Understatement issue. On February 24, 2017, the Board received a letter from Beaumont requesting that the Uncompensated Care Payments issue be transferred to the subject group appeal and the remaining issues in the individual appeal were either transferred to a group appeal or withdrawn, closing PRRB Case No. 16-1983. In order to facilitate the restructuring of the group appeal, the individual appeal is being reinstated. As the individual appeal is being reinstated solely to preserve the Provider's rights to appeal the Uncompensated Care Payments issue, and more than 240 days have elapsed since the issuance of the Provider's Notice of Program Reimbursement (NPR), no other issues can be added to PRRB Case No. 16-1983.

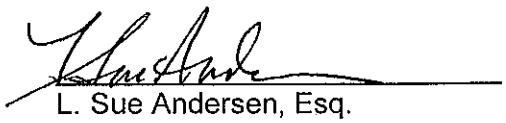
With respect to Taylor for FY 2013, Beaumont Health requested the establishment of an individual appeal through a letter dated July 20, 2017. The appeal request was received on July 24, 2017 and was assigned PRRB Case No. 17-1900. As the Uncompensated Care Payments issue was not included in the individual appeal, the group issue is hereby transferred from PRRB Case No. 17-1146GC to PRRB Case No. 17-1900.

As the Uncompensated Care Payments issue for the two Providers participating in the CIRP group appeal has been transferred to individual appeals, PRRB Case No. 17-1146GC is hereby dismissed from the Board's docket.

BOARD MEMBERS:

L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA, CHFP, FMFMA
Gregory H. Ziegler, CPA, CPC-A

FOR THE BOARD:



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NOV 02 2017

Refer to: 14-2823

CERTIFIED MAIL

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RE: Denver Health Medical Center
Jurisdictional Challenge
PN: 06-0011
FYE: 12/31/2009
CASE NO.: 14-2823

Dear Mr. Springston and Mr. Tisdale,

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

Background:

The Provider submitted a request for hearing on March 3, 2014, based on a Notice of Program Reimbursement ("NPR") dated September 6, 2013. The hearing request included three issues. The Provider added two issues on April 25, 2014. One issue was subsequently transferred to a group appeal on October 6, 2014. Another issue was withdrawn by the Provider via Provider's preliminary position paper dated October 31, 2014. Three issues remain in the appeal as follows: Issue No. 1 – Medicare Disproportionate Share Hospital (DSH) Payments – Additional Medicaid Eligible Days, Issue No.2 – Bad Debts and Issue No. 4 – Rural Floor Budget Neutrality. The Medicare Contractor submitted a jurisdictional challenges for Issue No. 1 on May 13, 2014 The Provider filed an Alert 10 response on July 21, 2014 for Issue No. 1.

Medicare Contractor's Position

Medicare DSH – Additional Medicaid Eligible Days

The Medicare Contractor contends that this issue does not meet the jurisdictional requirements, as an adjustment was not made to the additional Medicaid eligible patient days in question. The Medicare Contractor maintains that it accepted the Provider's as-filed Medicaid days. The

Provider cannot demonstrate dissatisfaction with the Medicare Contractor's final determination, as there was no Medicare Contractor final determination for the days in contention.[1]

The Medicare Contractor argues that in the case at issue it did not make an adjustment for the additional Medicaid eligible days in question. The Provider is not able to demonstrate that it meets the dissatisfaction requirement. The Provider did not preserve its right to claim dissatisfaction as it did not include a claim for the specific additional Medicaid eligible days now in question. The Medicare Contractor contends that the Provider has failed to preserve its right to claim dissatisfaction by properly filing the reimbursement impact of the additional Medicaid eligible days in question as a Protested Amount.[2]

Provider's Position

Medicare DSH – Additional Medicaid Eligible Days

The Provider filed an Alert 10 Response on July 21, 2014 stating that it performs an eligibility process to identify additional Medicaid eligible days. There are a number of practical impediments to identifying all additional Medicaid eligible days prior to filing its cost reports. Such as, retroactive determinations, Medicaid as secondary payor, etc.[3]

Board Determination:

Pursuant to 42 C.F.R. § 405.1835(a)(i) –(ii) (2009), "[a] provider . . . has a right to a Board hearing . . . only if— (1) [t]he provider has preserved its right to claim dissatisfaction . . . by . . . [i]ncluding a claim for specific item(s) on its cost report . . . or . . . self-disallowing the specific item(s) by . . . filing a cost report under protest . . . ." 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). Thus, when 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."[4]

The Provider is appealing from a 12/31/2009 cost report, which means that it either had to claim the cost at issue or it is subject to the protest requirement in order for the Board to have jurisdiction.

Medicare DSH – Additional Medicaid Eligible Days

The Board finds that it does not have jurisdiction over the DSH - Medicaid eligible days issue in this appeal. The Provider did not protest the Medicaid eligible days currently under appeal on its cost report notwithstanding the fact that it knew that the Colorado database would be updated

[1] Medicare Contractor's jurisdictional challenge at 3. (May 13, 2014)
[2] *Id.* at 3.
[3] Provider's Alert 10 Response at 5. (July 21, 2014)
[4] 42 C.F.R. § 405.1835(a)(1)(ii) (2009).

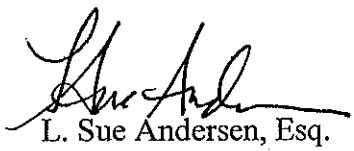
and the Provider would have additional days at a later point in time. Therefore, the Board could only have jurisdiction over those days if the Provider included a claim for the specific items on its cost report or if it filed the days it could not document as a protested amount as required by 42 C.F.R. § 405.1835(a)(1). The Board finds that the Provider did neither, and therefore, the Board concludes that Denver Health Medical Center has not met the dissatisfaction requirement of including a specific claim on the cost report, or protesting the specific Medicaid eligible days at issue. As the Board lacks jurisdiction over the issue, it hereby dismisses the issue from the appeal.

Case No. 14-2823 remains open for other issues that are still pending.

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
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A

FOR THE BOARD



L. Sue Andersen, Esq.
Chairperson

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

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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NOV 17 2017

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RE: Novant Presbyterian Hospital
Provider No.: 34-0053
FYE: 12/31/2001
PRRB Case No's: 06-1851, 06-1852

Dear Mr. Romano and Ms. Polson,

Novant Presbyterian Hospital ("Novant" or "Provider") filed timely appeals from the Notices of Program Reimbursement ("NPRs") for FYs 2001 and 2002 to specifically challenge the accuracy of the DSH payment.[1] The Board held a consolidated hearing on these appeals on September 25, 2015 for the parties to address the merits of the remaining issue. During the hearing, the Provider Reimbursement Review Board ("Board") also requested the parties address how Novant meets the Board's jurisdictional requirements for both years under appeal and had additional questions regarding the jurisdictional matter.

The Board finds that it does not have jurisdiction under 42 U.S.C. § 1395oo(a) over the Medicaid adolescent psychiatric days at issue for Novant's fiscal years ("FYs") 2001 and 2002. Further, the Board majority declines to exercise its discretion under 42 U.S.C. § 1395oo(d) to hear this issue as part of Novant's appeal of its NPR for FYs 2001 and 2002. The Board's decision is set forth below.[2]

BACKGROUND:

At hearing, Novant recognized that the Medicaid adolescent psychiatric days at issue were not included on the Novant's cost reports for FYs 2001 and 2002[3] and asserted that, prior to issuing the NPRs, the Medicare Contractor made no adjustment to any category of Medicaid eligible

[1] The appeal requests for FYs 2001 and 2002 included other issues. However, the only remaining issue in both appeals is the treatment of Medicaid adolescent psychiatric days in the DSH calculation. Refer to the original appeal filed on July 14, 2016 as well as the case file, Partial Administrative Resolution.
[2] 42. C.F.R § 405.1871 requires a Board hearing decision be issued if the Board finds jurisdiction over a specific matter at issue **and** it conducts a hearing on the matter. As the Board has found it lacks jurisdictions over the specific matter at issue, a hearing decision on the merits of the specific matter is not required.
[3] Tr. at 11.

days.[4] Although there is no discrepancy that an audit adjustment was not made for FY 2002, the Medicare Contractor has documented that the FY 2001 NPR issued in December 2005 includes an audit adjustment to increase Medicaid eligible days for FY 2001 by 1033 days.[5] Novant filed appeals with the Board, generically appealing Medicaid eligible days, stating that the Medicare Contractor failed to include Medicaid-eligible days attributable to patients eligible for Medicaid, as well as to patients eligible for general assistance."[6]

Subsequent to the filing of the appeals, Novant identified additional "Medicaid eligible days" (paid and unpaid) that it believed it was entitled to include in the DSH adjustment calculation for FYs 2001 and 2002. In an attempt to resolve the Medicaid eligible days issue in the pending appeals, Novant submitted new listings of Medicaid eligible days for FYs 2001 and 2002 to the Medicare Contractor for review in 2011 and again in 2015.[7] Specifically, the new listings included 1654 and 2,969 additional days for FYs 2001 and 2002 respectively.

The Medicare Contractor reviewed these listings and determined that some of the additional Medicaid days included in these listings were for Medicaid patients who were treated in Novant's adolescent psychiatric unit. The Medicare Contractor refused to include any of the additional Medicaid days associated with the adolescent psychiatric unit because it "contends those days occurred in an excluded unit and are thus not included in the calculation of the DSH payment based on [42 C.F.R. §] 412.106."[8]

Novant states that CMS promulgated regulations to implement the DSH statute through the interim final rule published on May 6, 1986 ("May 1986 Interim Final Rule")[9] and the final rule on September 3, 1986 ("September 1986 Final Rule"). Novant asserts that, at the outset of implementing the DSH adjustment, these final rules made clear that providers need not "formally apply" for a DSH adjustment because the information on which the Medicare Contractor decisions are based is readily available.[10] Specifically, the Medicare Contractor would base its decision to make a DSH adjustment on the published SSI information supplied by CMS and the Medicaid day's information supplied by a provider for cost reporting purposes. Similarly, Novant points to the Preamble to the May 1986 Interim Final Rule, where CMS stated that the Medicare Contractors' audit of the Medicaid patient days are a "determination" in and of itself and separate and distinct from the actual DSH adjustment.[11] Thus, Novant asserts that the Board has jurisdiction over these cases because Novant is *generally* dissatisfied with the Medicare Contractor's determination of its Medicaid eligible days.[12]

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[4] Tr. at 10-11.
[5] Medicare Contractor Final Position Paper, Case No. 06-1851, at 7; Medicare Contractor Exhibit I-7, Case No. 06-1851, at 6.
[6] *See* Medicare Contractor Exhibit I-2, Case Nos. 06-1851 and 06-1852, at 2.
[7] Medicare Contractor Final Position Paper, Case Nos. 06-1851 and 06-1852, at 9-10. The number of days requested in the 2015 listings is not separately identified.
[8] Provider Exhibit P-29 at 2 and 5.
[9] *See* 51 *Fed. Reg.* 16772 (May 6, 1986).
[10] *See* 51 Fed. Reg. 31454 (Sept. 3, 1986).
[11] *Id.* at 16777 (emphasis added).
[12] *See* Provider Post Hearing Brief at 8-9.

Novant recognizes, however, that the Board may require something more than general dissatisfaction. Specifically, Novant recognizes that the Board may require Novant to show that it had a practical impediment in identifying all of its Medicaid eligible days at the time of the filing of the cost reports.[13] In this regard, Novant contends for the cost years at issue that they faced multiple practical impediments in attempting to identify all Medicaid eligible days at the time of the filing of the cost reports. Some of these practical impediments are simply a result of the nature of Medicaid eligibility determinations while others are particular to North Carolina because CMS has never established a federal standard for how states must maintain their databases for eligibility verification.[14] Specifically, Novant has identified the following practical impediments and claims that they prevented it from identifying the Medicaid eligible adolescent psychiatric days at the time of filing its cost reports for FYs 2001 and 2002:

1. *Retroactive Eligibility Determinations Issued Subsequent to the Cost Report Filing.*—The most common circumstance in which the North Carolina Medicaid agency is unable to verify Medicaid eligible days is the retroactive eligibility situations where the determination of eligibility may occur months or even years after an application has been submitted but is effective back to the date of the application.[15]

2. *Inability to Exactly Match the North Carolina Medicaid Database.*—Novant further emphasizes that the North Carolina Medicaid agency may also fail to identify individuals who are eligible for Medicaid due to deficiencies in its methodology for matching Novant's list of inpatients with North Carolina's database of Medicaid recipients. In particular, where the social security number is used, the North Carolina Medicaid agency identifies a match only if the patient's social security number *and* name (or social security number *and* date of birth) exactly match with the hospital's records (*e.g.*, the name "John Doe" would not match "John Q. Doe").[16]

3. *Difficulty in identifying Medicaid eligibility when Medicaid is not primary.*—Novant contends that, when the state Medicaid program has made no payment for a hospital stay because there was another, primary payor, then it may be difficult for a hospital to identify the Medicaid eligible days for that stay. By statute, Medicaid is the secondary payor to all other payors. Hospitals generally are able to identify Medicaid paid days when they receive a remittance advice from the State Medicaid agency indicating payment by the State Medicaid plan. The Provider contends however, a more complex situation is presented when no payment is made by Medicaid, even though an individual is actually Medicaid-eligible. In these situations, hospitals may not be able to identify patients as Medicaid eligible because the State Medicaid plan makes no payment on behalf of that patient.[17]

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[13] *Id.* at 9.
[14] *See id.* at 14-15.
[15] *See* Provider's Post Hearing Brief at 15-16; Provider Exhibit P-26 at ¶ 4 (Decl. of Christine Butterfield).
[16] *See* Provider's Post Hearing Brief at 15-18; Provider Exhibit P-26 at ¶ 7 (Decl. of Christine Butterfield).
[17] *See* Provider's Post Hearing Brief at 18; Provider Exhibit P-27 at 1 (Decl. of Janahan Ramanathan).

4. *Uncooperative patients*.—Novant summarizes other common situations where the patient is uncooperative (*e.g.*, fails to notify a hospital of his or her eligibility or give incorrect identification information such as incorrect date of birth).[18]

Based on these practical impediments, Novant contends that it is not until well after the cost report has been filed that Novant is able to identify all of its North Carolina Medicaid eligible days by submitting updated requests for verification to the North Carolina Medicaid agency.[19]

BOARD'S DECISION:

The crux of this dispute centers around the gateway to Board jurisdiction under 42 U.S.C. § 1395oo(a). As explained more fully in *St. Vincent Hosp. & Health Ctr. V. Blue Cross Blue Shield Ass'n* ("*St. Vincent*"),[20] the Board has generally interpreted § 1395oo(a) as: (1) the gateway to establishing Board jurisdiction to hear an appeal; and (2) requiring that dissatisfaction be expressed with respect to the total reimbursement for "each claim" (as opposed to a general dissatisfaction to the total reimbursement on the NPR) because the Board has viewed the NPR as being comprised of many individual determinations on various items for which the provider has sought payment in the as-filed cost report. After jurisdiction is established under 42 U.S.C. § 1395oo(a), the Board has the discretionary power under 42 U.S.C. § 1395oo(d) to consider and make a determination over other matters covered by the cost report.

Novant in this case failed to claim the Medicaid adolescent psychiatric days at issue on its as-filed cost report for FYs 2001 and 2002. The Board majority considered whether it has jurisdiction under § 1395oo(a) over these days and, if not, whether it could and should exercise its discretionary powers under § 1395oo(d) to consider these days.

A. Board Jurisdiction under 42 U.S.C. § 1395oo(a)

At the outset, the Board majority rejects Novant's assertion that the Board has jurisdiction to hear appeals of Medicaid eligible days under 42 U.S.C. § 1395oo(a) whenever a provider is *generally* dissatisfied with the DSH reimbursement it received in the relevant NPR. As explained fully its decisions in *Norwalk Hosp. v. Blue Cross and Blue Shield Ass'n* ("*Norwalk*")[21] and *Danbury Hosp. v. Blue Cross and Blue Shield Ass'n* ("*Danbury*"),[22] the Board has determined that: (1) hospitals have an obligation to submit Medicaid eligible days information as part of the cost reporting process; (2) this obligation is separate and distinct from the DSH adjustment determination process; and (3) the hospitals have the burden of proof and can only report and claim on their cost report those Medicaid eligible days that have been verified with the relevant State.[23] The Board further determined that, pursuant to the concept of futility in *Bethesda*, it had jurisdiction under 42 U.S.C. § 1395oo(a) over a hospital's appeal of the number of Medicaid eligible days for the DSH adjustment if that hospital can establish a

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[18] *See* Provider's Post Hearing Brief at 19.
[19] *See* Provider Exhibit P-26 at ¶ 3 (Decl. of Christine Butterfield).
[20] PRRB Dec. No. 2013-D39 at 13-16 (Sept. 13, 2013).
[21] PRRB Dec. No. 2012-D14, (Mar. 19, 2012), *vacated*, CMS Adm'r Dec. (May 21, 2012).
[22] PRRB Dec. No.2014-D03 (Feb. 11, 2014), *declined review*, CMS Adm'r (Mar. 26, 2014).
[23] 42 CFR § 412.106(b)(4)(iii). *See also Danbury* PRRB Dec. No. 2014-D03 at 15.

"practical impediment" as to why it (through no fault of its own) could not claim these days at the time that it filed its cost report. In granting jurisdiction for these situations, the Board concluded that a "practical impediment" (*i.e.*, the fact that only Medicaid eligible days verified by the State can be claimed on the cost report and that the hospital, through no fault of its own, was unable verify the Medicaid eligible days at issue from States' records prior to filing its cost report due to lack of availability or access to the relevant State records) was analogous to the "legal impediment" which the Supreme Court found sufficient for Board jurisdiction under 42 U.S.C. § 1395oo in *Bethesda* because both are grounded in the following *Bethesda* concept of the futility – "[p]roviders know that . . . the intermediary is without power to award reimbursement except as the regulations provide, and any attempt to persuade the intermediary to otherwise would be futile."[24]

In the current appeals, Novant acknowledges that the Medicaid adolescent psychiatric days at issue had never previously been submitted to the Medicare Contractor (either on the as-filed cost report or as part of the desk review of the as-filed cost report prior to the issuance of the relevant NPR). While Novant did identify forty nine (49) Medicaid adolescent psychiatric days that were included in the NPR for FY 2001, these days were not adjusted off and are not at issue. Rather, Novant is seeking to add an additional 990 Medicaid adolescent psychiatric days to the numerator of the DSH Medicaid fraction for FY 2001. Similarly, for FY 2002, Novant is seeking to add an additional 709 Medicaid adolescent psychiatric days to the numerator of the DSH Medicaid fraction for FY 2002. However, the FY 2002 NPR did not include any psych Medicaid days in the numerator of the DPP of the DSH adjustment.

Novant essentially takes the position that, once it identifies a practical impediment that affected it in general, then it can claim any Medicaid-eligible days whenever it identifies them. Significantly, while Novant identified these practical impediments, the Board cannot put them in the proper context because Novant has failed to furnish the Board with an adequate description of the process that it used to identify and report Medicaid days for the cost reports filed for the fiscal years at issue. In this regard, the Board majority disagrees with Novant's assertion that the testimony from its consultant provides an adequate description of the process it used to identify and report Medicaid eligible days on its as-filed cost reports for FYs 2001 and 2002.[25] The record is clear that Novant's consultant was not involved with FYs 2001 and 2002 until after these appeals were filed and, as such, has no direct knowledge of the process that Novant used for FYs 2001 and 2002. Moreover, even if her description were accurate, it would not be adequate because: (1) Novant admits that it billed services furnished in the adolescent psychiatric unit using its Medicare excluded unit billing number;[26] and (2) Novant's consultant readily recognized that Novant would cull out those Medicaid days that did not qualify to be counted for Medicare DSH purposes such as days attributable to Medicare excluded units but could not explain how the Medicaid adolescent psychiatric days at issue were treated under this

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[24] *Bethesda*, 485 U.S. at 404. *See also Danbury* PRRB Dec. No. 2014-D03 at 15-18.

[25] *See* Provider's Post Hearing Brief at 20.

[26] Tr. at 110 (Novant witness stating: "The Medicare MAC auditors tested adolescent claims and discovered that they were billed using the Medicare-exempt unit Provider/[N]PI [*sic*] number, rather that the hospital general acute number"); Tr. at 310-11 (Novant witness stating: "When we started reviewing the days, it [*i.e.*, the Medicare-exempt unit billing number] was on the UB92s for the patients").

process.[27] As a result, it is unclear and Novant's consultant could not confirm whether Novant's process identified some or all of the Medicaid adolescent psychiatric days at issue but that Novant misidentified them as Medicare excluded unit days and excluded them from its listing for the FY 2001 and 2002 as-filed cost report or, in the alternative, whether Novant's process did not identify the days at all notwithstanding its queries to the state system and its own internal billing and patient records.[28]

Indeed, it is the cloud surrounding Novant's alleged misrepresentation of its adolescent psychiatric unit as a Medicare excluded unit that distinguishes this appeal from the Board's decision in *Barberton Citizens Hosp. v. CGS Adm'rs*[29] where the Board was dealing with Medicaid eligible days for care furnished in hospital units where there was no such similar type of cloud. In this regard, there is nothing in the record to suggest that the alleged practical impediments impacted or relate to the Medicaid adolescent psychiatric days at issue. Rather, the record suggests that Novant simply failed to claim the Medicaid adolescent psychiatric days at issue due to error, inadvertence, negligence or a generally deficient process for identifying Medicaid-eligible days. In particular, Novant acknowledges that it made the following misrepresentations or inconsistencies about the adolescent psychiatric unit:

(1) Novant alleges that, over the course of 20 plus years, it had a history of submitting ***in error*** attestation letters to the State survey office that its 20-bed adolescent psychiatric unit was an excluded Medicare unit.[30] As a result, Novant claims there has been a history of incorrectly attesting that its IPPS exempt beds totaled 60 (*i.e.*, the 40 bed adult psychiatric unit plus the 20-bed adolescent psychiatric unit).[31]

(2) Novant admits that it used its Medicare exempt unit/NPI billing number whenever it billed the Medicaid program for services furnished in the adolescent psychiatric unit but insists that it used that billing number not because the unit was an excluded Medicare unit but because private payors required Novant to use one billing number for all of its psychiatric units (*i.e.*, use one billing number for both the exempt and non-exempt psychiatric units).[32] Novant's use of the Medicare exempt unit NPI/billing number for adolescent psychiatric services is borne out in the sample of 8 adolescent psychiatric claims (153 days in the aggregate with Medicaid listed as either primary or secondary) that the Medicare Contractor submitted for the record.[33]

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[27] Tr. at 467-468. *See also* Tr. at 461-463 (Novant witness stating: "I didn't work with the original audit, so I don't know ...what psych days they had included in there."); Tr. at 446 (Novant witness stating: "I'm going based on the Provider here. That the Provider has their listing at the time of the cost report, but there's a period there where they did revise before they settled...were audited and settled."); Tr. at 447 (Novant witness stating: "on those listings one of the years has some 7D psych days in it ...and one of them, I don't think that there were 7D psych days.").

[28] *See* Tr. at 444-447 (Novant witness stating: "And so I don't know what happened to that period"). *See also* Tr. at 119-120 (Novant witness confirming there was no adjustment for these cost years, on the issue of adolescent psych days.)

[29] PRRB Dec. No. 2015-D05 (Mar. 19, 2015), *declined review*, CMS Adm'r (Apr. 22, 2015).

[30] *See* Provider Exhibit P-5 at 1.

[31] *See* Provider Exhibit P-5, Tab B.

[32] *See* Provider Exhibit P-5 at 1.

[33] *See* Medicare Contractor Exhibit I-10, Case No. 06-1851 (sample of 4 Novant claims with discharges in 2001 comprised of lengths of stay of 10 days, 9 days, 52 days and 30 days); Medicare Contractor Exhibit I-10, Case No.

Once the extent of Novant's self-professed internal confusion and inconsistencies are appreciated, it is not surprising then that Novant failed to report 95 and 100 percent of the universe of Medicaid adolescent psychiatric days during the cost reporting process for FYs 2001 and 2002 respectively. In this same vein, it stretches credulity to believe that, prior to filing the as-filed cost reports for FYs 2001 and 2002, Novant had not received payment and remittance advices from North Carolina Medicaid on virtually *any* of the universe of Medicaid adolescent psychiatric days for FYs 2001 and 2002,[34] and that Novant essentially had no internal records on the Medicaid eligibility for the universe of Medicaid adolescent psychiatric days for FYs 2001 and 2002.

In summary, based on the record before it, the Board must conclude that, due to choice, error, and/or inadvertence, Novant failed to identify and include the days at issue on the as-filed cost reports or the new listings submitted during the desk review process. Accordingly without evidence to the contrary, the Board must find that the Medicaid adolescent psychiatric days at issue are unclaimed costs for which it lacks jurisdiction under 42 U.S.C. § 1395oo(a) to hear.

B. Board Discretionary Powers under 42 U.S.C. § 1395oo(d)

In each of the two cases before the Board, the original appeal request filed with Board included other issues for which the Board had jurisdiction under 42 U.S.C. § 1395oo(a). As such, the Board has jurisdiction over Novant's appeal and must decide whether to exercise discretion under 42 U.S.C. § 1395oo(d) to hear the adolescent psychiatric days issue notwithstanding the lack of jurisdiction under § 1395oo(a) over the adolescent psychiatric Medicaid days at issue. As discussed in *St. Vincent*,[35] the Board has consistently declined to exercise discretion under 42 U.S.C. § 1395oo(d) to hear appeal of other issues involving unclaimed costs when reimbursement of those was not precluded by a specific law, regulation, CMS Ruling or manual instruction and has dismissed those appeals when the sole issue(s) in the case involves unclaimed costs. Accordingly, based on its finding that Novant failed to claim the adolescent psychiatric Medicaid days at issue due to error or inadvertence rather than futility, the Board declines to exercise its discretion under § 1395oo(d) to hear the adolescent psychiatric Medicaid days issue.

CONCLUSION:

The Board finds that it does not have jurisdiction under 42 U.S.C. § 1395oo(a) over the Medicaid adolescent psychiatric days at issue for FYs 2001 and 2002. Further, the Board declines to exercise its discretion under 42 U.S.C. § 1395oo(d) to consider this issue as part of Novant's appeal of its NPR for FYs 2001 and 2002. These appeals are now closed.

06-1852 (sample of 4 Novant claims with discharges in 2002 comprised of lengths of stay of 5 days, 30 days, 15 days and 2 days). Medicaid was primary for 3 of 4 of the claims for FY 2001 and 2 of 4 claims for FY 2002.

[34] The 52 Medicaid adolescent psychiatric days that were included on the FY 2001 as filed cost report may very well relate to a single patient stay as stays in this unit can be lengthy as highlighted by the fact that the Medicare Contractor's 4-claim sample from FY 2001 includes a Medicaid primary payor claim with *same* number of days (*i.e.*, 52 days). Medicare Contractor Exhibit I-2, Case No. 06-1851, at 3.

[35] PRRB Dec. No. 2013-D39 at 15.

BOARD MEMBERS PARTICIPATING:

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Gregory H. Ziegler, C.P.A., CPC-A

FOR THE BOARD:

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CERTIFIED MAIL NOV 17 2017

James C. Ravindran, President
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
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RE: Parkview Medical Center, Provider No. 06-0020, FYE 06/30/2007
PRRB Case No. 13-1452

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeal prior to scheduling a hearing date. The pertinent facts in the case and the Board's determination are set forth below.

Pertinent Facts:

On October 5, 2012 the Medicare Administrative Contractor (MAC) issued the revised Notice of Program Reimbursement (RNPR) for Parkview Medical Center's (Parkview) 6/30/2007 cost year.

Quality Reimbursement Services (QRS) filed an appeal on behalf of Parkview on April 4, 2013. The appeal included two issues:

1. Medicare SSI, Provider Specific Data/Realignment
2. Medicare SSI Accuracy

On November 7, 2013 QRS requested the transfer of the SSI Accuracy issue to Case No. 13-2679G (the QRS 2007 DSH SSI Percentage Group (2)).

Board Determination:

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

In this case, the Provider filed its appeal from a RNPR. The Code of Federal Regulations at 42 C.F.R. § 405.1885 (2008) provides for an opportunity for a RNPR, stating 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).

Further, in accordance with 42 C.F.R. § 405.1889 (2008), a RNPR 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 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.

With regard to the DSH/SSI Provider Specific issue, the Board finds that it has jurisdiction over the portion of this issue (Issue 1) challenging the data used to calculate the SSI percentage as the RNPR did have an adjustment to the SSI percentage (Adj. 4), and the appeal meets the amount in controversy and timely filing requirements. However, the Board also finds that the inaccurate data portion of Issue 1 is duplicative of the DSH/SSI Systemic Errors issue (Issue 2) that was transferred to Case No. 13-2679G. The basis of both issues is that the SSI percentage is improperly calculated, and the Provider does not have the underlying data to determine if the SSI percentage is accurate. The portion of Issue 1 challenging the accuracy of the SSI ratio data now resides in Case No. 13-2679G.

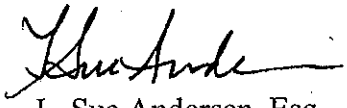
Regarding the portion of Issue 1 addressing realignment of the DSH calculation to the Provider's fiscal year end, the Board finds that realignment using the Provider's fiscal year end is a Provider election, and there is no evidence in the record that the Medicare Contractor has made a final determination regarding this issue. Therefore, the Board does not have jurisdiction over the sub-issue of Issue 1 related to the DSH/SSI Percentage Realignment, and it is dismissed from the appeal.

After the noted transfer of the SSI Systemic issue and the dismissal of the SSI Provider Specific issue, there are no remaining issues in the case. Therefore, Case No. 13-1452 is hereby closed.

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

Board Members Participating:
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A

For the Board:



L. Sue Andersen, Esq.
Chairperson

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

cc: Bill Tisdale, Novitas Solutions, Inc. (J-H)
Wilson C. Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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CERTIFIED MAIL

NOV 17 2017

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

RE: Floyd Medical Center, Provider No. 11-0054, FYE: 06/30/2007
PRRB Case No.13-1635

Dear Mr. Ravindran:

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

Pertinent Facts:

The Provider filed a request for hearing on April 17, 2013, based on a revised Notice of Program Reimbursement ("RNPR") dated October 16, 2012. The hearing request included the following issues:

- SSI Provider Specific
- SSI Systemic Errors (*Including Medicare Part A Days - exclusion of Medicare fraction & inclusion in Medicaid fraction*)
- DSH Managed Care Part C Days (*The issue description included the inclusion in the Medicaid percentage & the exclusion from the SSI Percentage.*)

QRS filed a preliminary positon paper on November 14, 2013.

On November 26 2013, QRS transferred the following issues to groups:

Issue	Group
SSI Systemic Errors	13-2679G
Managed Care Part C (SSI Fraction)	14-1173G
Managed Care Part C (Medicaid Fraction)	13-2676G
Dual Eligible Days (SSI Fraction)	14-1174G
Dual Eligible Days (Medicaid Fraction)	13-2678G

Board Determination:

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

The Board finds that it has jurisdiction over the portion of the SSI -Provider Specific that challenges the data used to calculate the SSI percentage as:

1.) the cost report was reopened to revise the SSI fraction to "ensure the accurate inclusion of Medicare Advantage data submitted by providers, which will be included in the revised SSI ratios . . . ",[1]
2.) there was an adjustment to the SSI percentage on the RNPR (Adj. R1-001), and
3.) the appeal meets the amount in controversy and timely filing requirements.

However, the Board also finds that the inaccurate data portion of the SSI -Provider Specific is duplicative of the SSI - Systemic Errors issue that was transferred to Case No. 13-2679G. The basis of both Issues is that the SSI percentage is improperly calculated, and the Provider does not have the underlying data to determine if the SSI percentage is accurate. The portion of the SSI -Provider Specific issue challenging the accuracy of the SSI ratio data now resides in Case No. 13-2679G.

Regarding the portion of the SSI -Provider Specific issue addressing realignment of the DSH calculation to the Provider's fiscal year end, 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 hospital's alone, which then must submit a written request to the Medicare Contractor. Without this request, 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.

Because the DSH SSI (Provider Specific) issue is duplicative of the Systemic Errors issue which is pending in a group appeal (Case No. 13-2679G) and the Medicare Contractor has not made a final determination with regard to the realignment, the Board finds that it lacks jurisdiction over the DSH/SSI percentage (Provider Specific) issue and dismisses it from Case No. 13-1635. Since there are no issues remaining in the appeal, the Board closes the case.

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

Board Members Participating:
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A

For the Board:

L. Sue Andersen, Esq.
Chairperson

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

cc: Barb Hinkle, Cahaba GBA c/o National Government Services, Inc. (J-J)
Wilson C. Leong, Esq., CPA, Federal Specialized Services

[1] Medicare Contractor's April 6, 2011 Notice of Reopening.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

CERTIFIED MAIL

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

RE: Centegra Health FFY 2011 DSH SSI Fraction Medicare Advantage Days CIRP Group
Case No. 14-3972GC

Centegra Health FFY 2011 DSH Medicaid Fraction Medicare Advantage Days CIRP Group, Case No. 14-3973GC

Beaumont Health 2011 Rehab LIP Part C Days CIRP Group
Case No. 16-1364GC

Medisys Health Network 2011 SSI Fraction Part C Days CIRP Group
Case No. 15-0508GC

Medisys Health Network 2011 Medicaid Fraction Part C Days CIRP Group
Case No. 15-0509GC

Dear Ms. O'Brien Griffin:

The Provider Reimbursement Review Board (the Board) has reviewed your October 26, 2017 request seeking to consolidate the Medicare and Medicaid Fraction Part C Days groups, as well as bifurcating the Rehabilitation facilities (Rehabs) from these cases[1] in order to transfer them to a new optional group. The actions taken by the Board are detailed below.

LIP Bifurcation

In the August 7, 2001 issue of the Federal Register (66 FR 41316), CMS published a final rule effective January 1, 2002, which established a prospective payment system (PPS) for Medicare payment of inpatient hospital services provided by a rehabilitation hospital or rehabilitation unit of a hospital. Section 1886(j)(3)(A)(v) of the Act conferred broad discretion on the Secretary to adjust prospective payments "by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities."[2] One such factor was an adjustment for low-

[1] Bifurcation of rehab was not requested from the Centegra Health FFY 2011 DSH Medicaid Fraction Part C CIRP, Case No. 14-3973GC.
[2] 66 Fed. Reg. 41356.

income patients, referred to as the LIP adjustment.[3] The measure used to compute the rehabilitation facility's percentage of low-income patients in the LIP adjustment is the same measure used to determine low-income patients in acute care hospitals within the disproportionate share hospital (DSH) adjustment.[4]

Because the LIP calculation applies only to rehabilitation facilities it is not a common legal issue to the DSH Medicare Part C Days issue. Your correspondence requests the bifurcation and transfer of the following providers:

Provider No.	Provider Name	From Group
14-T116	Northern Illinois Medical Center	14-3972GC
23-T151	Beaumont Hospital – Farmington Hills	16-1364GC
33-T014	Jamaica Hospital Medical Center	15-0508GC
33-T014	Jamaica Hospital Medical Center	15-0509GC

According to your correspondence each of these participants is the only Rehab in their respective chain appealing this issue. Therefore, in accordance with your request, the Board agrees to transfer the subject providers to a newly formed optional group - the Hall Render 2011 Rehab LIP Medicare/Medicaid Part C Days Group III, to which we have assigned Case No. 18-0137G. Enclosed please find a copy of the Board's Acknowledgement letter for this optional group.

Consolidation of Medicare & Medicaid Fraction Groups

Further, 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 Centegra Health FFY 2011 DSH Medicaid Fraction Medicare Advantage Days CIRP Group, Case No. 14-3973GC, into the Centegra Health FFY 2011 DSH SSI Fraction Medicare Advantage Days CIRP Group, Case No. 14-3972GC and
- the Medisys Health Network 2011 Medicaid Fraction Part C Days CIRP Group, Case No. 15-0509GC, into the Medisys Health Network 2011 SSI Fraction Part C Days CIRP Group, Case No. 15-0508GC.

Case Nos. 14-3973GC and 15-0509GC are hereby closed. In addition, the Board has modified the names of both surviving groups by substituting "Medicare/Medicaid" in the group names.[5] Please refer to only Case Nos. 14-3972GC and 15-0508GC, respectively, in future correspondence with the Board.

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[3] 66 Fed. Reg. 41360.
[4] Id.
[5] Case No. 14-3972GC will be referred to as the Centegra Health FFY 2011 Medicare/Medicaid Fraction Medicare Advantage Days CIRP Group and Case No. 15-0508GC will be referred to as the Medisys Health Network 2011 Medicare/Medicaid Part C Days CIRP Group.

Group Completion

Your October 25, 2017 correspondence also advises that, after the bifurcation/transfer of the rehabs and the consolidation of the Medicare and Medicaid Fraction Part C groups, the surviving groups (Case Nos. 14-3972GC & 15-0508GC) are complete. Therefore, the Board is setting the preliminary position paper due dates. Enclosed, please find a Critical Due Dates letter for each consolidated group.

Closure of Case No. 16-1364GC

Since Beaumont Hospital – Farmington Hills (23-T151) was the only participant in the subject CIRP group and has now been transferred to the newly formed optional group, Case No. 18-0137G, there are no remaining participants to adjudicate. Therefore, the Board hereby closes Case No. 16-1364GC.

For the Board:

L. Sue Andersen, Esq.
Chairperson

cc: Pam VanArsdale, NGS (J-K) (MAC for 15-0508GC & 15-0509GC)
Danene Hartley, NGS (J-6) (MAC for 14-3972GC & 14-3973GC)
Byron Lamprecht, WPS (J-8) (MAC for 16-1364GC)
Wilson C. Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

CERTIFIED MAIL

NOV 17 2017

Corinna Goron, President
Healthcare Reimbursement Services, Inc.
c/o Appeals Department
17101 Preston Road, Suite 220
Dallas, TX 75248 1372

RE: St. Vincent Charity Medical Center
Provider No. 36-0037
FYE 9/30/2007
Case No.: 13-1598

Dear Ms. Goron:

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

Pertinent Facts:

Healthcare Reimbursement Services, Inc. (HRS) filed a request for hearing on behalf of the Provider on April 17, 2013, based on a Notice of Program Reimbursement ("NPR") dated October 19, 2012. The hearing request included the following issues:

SSI Systemic Errors
SSI Provider Specific
Medicaid Eligible Days
DSH Managed Care Part C Days*
DSH Dual Eligible Part A Days*

(*The issue description included the inclusion in the Medicaid percentage & the exclusion from the SSI Percentage.)

On November 26 2013, HRS transferred the following issues to common issue related party (CIRP) groups:

Issue	Group Case
SSI Systemic Errors	14-1057GC
Managed Care Part C (SSI Fraction)	14-1065GC
Managed Care Part C (Medicaid Fraction)	14-1066GC
Dual Eligible Days (SSI Fraction)	14-1059GC
Dual Eligible Days (Medicaid Fraction)	14-1061GC

HRS filed the Provider's preliminary positon paper on November 29, 2013 and advised that the only issue briefed was the SSI – Provider Specific because all other issues had been transferred

to groups. The Medicaid Eligible Days issue was not transferred to a group, and according to the cover letter, was not addressed in the preliminary position paper.

Board Determination:

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

The Board finds that it has jurisdiction over the portion of the SSI - Provider Specific issue that challenges the data used to calculate the SSI percentage as there was an adjustment to the SSI percentage (Adj. 31), and the appeal meets the amount in controversy and timely filing requirements. However, the Board also finds that the inaccurate data portion of the SSI - Provider Specific issue is duplicative of the SSI - Systemic Errors issue that was transferred to Case No. 14-1057GC. The basis of both issues is that the SSI percentage is improperly calculated, and the Provider does not have the underlying data to determine if the SSI percentage is accurate. The portion of the SSI -Provider Specific issue challenging the accuracy of the SSI ratio data now resides in Case No. 14-1057GC.

Regarding the portion of the SSI percentage (Provider Specific) addressing realignment of the DSH calculation to the Provider's fiscal year end, the Board finds that the realignment issue is premature. 42 C.F.R. § 405.1835 (2007) states, "The provider . . . has a right to a hearing before the Board about any matter . . . if an intermediary determination has been made with respect to the provider . . .".

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. In fact, the Provider's cost report year end under appeal is 9/30/2007, which is the Federal fiscal year end. 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 this request, 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.

Because the DSH SSI (Provider Specific) issue is duplicative of the Systemic Errors issue which is pending in a group appeal (Case No. 14-1057GC) and the Medicare Contractor has not made a final determination with regard to the realignment, the Board finds that it lacks jurisdiction over the DSH/SSI percentage (Provider Specific) issue and dismisses it from Case No. 13-1598.

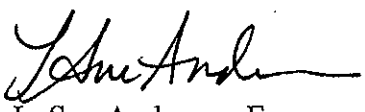
With regard to the Medicaid Eligible Days issue, the Board considers the issue to have been abandoned as it was not addressed in the preliminary position paper according to the

Representative's cover letter. Since there are no issues remaining in the appeal, the Board closes the case.

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

Board Members Participating:
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A

For the Board:



L. Sue Andersen, Esq.
Chairperson

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

cc: Judith E. Cummings, CGS Administrators (J-15)
Wilson C. Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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NOV 17 2017

CERTIFIED MAIL

Daniel J. Hettich
King & Spalding, LLP
1700 Pennsylvania Avenue, NW
Suite 200
Washington, DC 20006-4706

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

RE: Laredo Medical Center
Provider No.: 45-0029
FYE: 9/30/08
PRRB Case No.: 13-1249

Dear Mr. Hettich and Mr. Lamprecht,

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

Background

The Provider submitted a request for hearing on March 20, 2013, based on a Notice of Program Reimbursement ("NPR") dated October 22, 2012. The hearing request included one issue: Traditional Medicare Bad Debts.

The Medicare Contractor submitted a jurisdictional challenge on this issue on February 18, 2014. The Provider submitted a responsive brief on March 18, 2014.

Medicare Contractor's Position

The Medicare Contractor contends that it made no adjustment for the issue under appeal. Therefore, the Medicare Contractor has not made a determination with respect to the provider for the issue appealed.[1]

The Medicare Contractor argues that the bad debts being appealed are not associated with bad debts adjusted with the Notice of Amount of Program Reimbursement. The Provider's Preliminary Position Paper stated "...the Provider did not include the bad debt placed with SARMA in the 2008 cost report. Now that it is clear that SARMA terminated collection of the debt in 2008, the Provider has appealed to include Medicare bad debts in the 2008 cost report..."[2]

[1] Medicare Contractor's jurisdictional challenge at 1-2.
[2] Medicare Contractor's jurisdictional challenge at 2.

Provider's Position

The Provider explains that this appeal involves Medicare bad debt that had been placed with a collection agency with whom the Provider later terminated its collection contract on April 10, 2008 during the Provider's fiscal year ending September 30, 2008. Although the terms of the agreement required the collection agency to continue collection efforts for one year after termination, unknown to the Provider at the time, the collection agency ceased collection efforts. Mindful of the Medicare Contractor's 2006 change in bad debt policy that accounts cannot be claimed until they are returned from a collection agency, the Provider did not claim these debts in its 2008 cost report. However, after the Provider learned that the agency ceased collection efforts after termination of the contract, it initiated this appeal to have these accounts reimbursed in the cost-reporting period in which the agency states that it ceased collection efforts.[3]

The Provider contends that Section 1878(a) of the Social Security Act grants the Provider the right to a hearing before the Board if three prerequisites are satisfied: (i) the Provider is dissatisfied with the Medicare Contractor's final determination as to the amount of program reimbursement due to the Provider for the period covered by such cost report; (ii) the amount in controversy is at least $10,000 for an individual appeal, or $50,000 for a group appeal; and (iii) the Provider files a request for hearing within 180 days after notice of the Medicare Contractor's determination.[4]

A Medicare Contractor determination is defined in the regulations as:

> (1) With respect to a provider of services that has filed a cost report under §§413.20 and 413.24(f) of this chapter, the term means a determination of the amount of total reimbursement due the provider, pursuant to §405.1803 following the close of the provider's cost reporting period, for items and services furnished to beneficiaries for which reimbursement may be made on a reasonable cost basis under Medicare for the period covered by the cost report.
>
> (2) With respect to a hospital that receives payments for inpatient hospital services under the prospective payment system (part 412 of this chapter), the term means a determination of the total amount of payment due the hospital, pursuant to §405.1803 following the close of the hospital's cost reporting period, under that system for the period covered by the determination.
>
> (3) For purposes of appeal to the Provider Reimbursement Review Board, the term is synonymous with the phrases "Medicare Contractor's final determination" and "final determination of the Secretary," as this phrases are used in section 1878(a) of the Act.[5]

This definition, read in conjunction with Section 405.1803, makes clear that the "Medicare Contractor determination" is reflected in a NPR. CMS' 2008 amendment to the regulations

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[3] Provider's responsive brief at 1.
[4] 42 U.S.C. §§ 1395oo(a); 42 C.F.R. § 405.1835.
[5] 42 C.F.R. § 405.1801.

making the dissatisfaction requirement more stringent are inapplicable here because that portion of the amendment is only effective for cost reporting periods on or after December 31, 2008.[6]

The Provider contends that its appeal meets the three requirements for Board jurisdiction. The Provider argues that there is no dispute that the Provider met the second and third requirements. The Medicare Contractor's challenge relates to the first requirement, and its belief that the Provider cannot be "dissatisfied with the Medicare Contractor's final determination as to the amount of program reimbursement due" because the Provider did not claim, and the Medicare Contractor did not specifically issue an audit adjustment with respect to the Medicare bad debts at issue.[7]

The Provider contends that the basis for the Medicare Contractor's challenge is faulty, most fundamentally because the Supreme Court and multiple other courts have clearly determined that a provider need not list every item on their cost report but instead must only be dissatisfied with the total amount of Medicare reimbursement. Just as the *Bethesda* Court was directly addressing instances where it was a legal impossibility for a cost to have been included on the cost report because of an adverse agency policy, here it was logistically challenging to include the costs on the cost report.[8]

The Provider explains that the Provider and SARMA entered into an agreement for collection services effective April 12, 2006. On April 10, 2008, the Provider terminated the Agreement and informed SARMA that:

> ...we want to emphasize that we are not removing any existing inventory from our account basis your business organization is currently working with us. We are requesting that your staff proceed with your collection processes on these accounts and we will remit payment for any fees incurred for future collections.[9]

Further, the Agreement provided that SARMA would continue collection efforts for debts placed with the agency within the last 18 months even where a party terminates the contract. In particular, the Agreement sets forth in relevant part that:

> [i]n the event of termination of this Agreement, Client shall allow Collector to retain for collection accounts previously placed within 18 months and any account...In any event, Collector will return all accounts where no payments are being made monthly or where client has not authorized legal action twelve (12) months from termination date.

Despite the Agreement, the Provider's close and return policy, and the Provider's instruction in the termination letter, SRAMA discontinued collection efforts once it received the Provider's termination letter and did not return any debts that it ceased collecting.[10]

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[6] Provider's responsive brief at 6.
[7] Provider's responsive brief at 13.
[8] Provider's responsive brief at 13-14.
[9] Provider's responsive brief at 11-12.
[10] Provider's responsive brief at 12.

The Provider argues that it is seeking reimbursement in the appropriate fiscal year as determined and directed by the Medicare Contractor's bad debt guidance after learning of the SARMA issue. The Provider is simply seeking to have that allowable Medicare Bad Debt reimbursed in the period deemed acceptable to the Medicare Contractor, i.e. the period in which the accounts were actually returned as uncollectible by the collection agency. In line with the Medicare Contractor's prior position, upon filing the September 30, 2008 cost report, the Provider claimed reimbursement on the Medicare bad debts it was able to confirm had been returned as uncollectible, such as accounts associated with (1) debts that were returned from certain secondary collection agencies and (2) Medicaid Crossovers. However, the Provider was unable to ascertain during that time-frame that SARMA had ceased collecting certain traditional Medicare bad debts. In this case, although SARMA ceased collection efforts of the bad debts at issue at the time that the Provider's cost report was filed, the Provider did not include those accounts on its as-filed cost report as SARMA did not return the debts according to the agreed upon process with the Provider.[11]

Finally, the Provider contends that following the termination of its agreement with SARMA, SARMA immediately ceased collection efforts and did not comply with the Provider's close and return policy or otherwise notify the Provider at that time that it would no longer pursue the debts. After the Provider discovered that SARMA had ceased collection efforts in 2008, it initiated this appeal to have these accounts reimbursed in the cost-reporting period in which they were closed by the collection agency consistent with the Medicare Contractor's policy. Although SARMA never returned a usable file of the bad debts at issue, the Provider should not be penalized based on its reliance upon SARMA to carry out the obligations of the Provider's close and return policy as set forth in the agreement.[12]

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1841 (2004), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Board finds that the Provider was able to establish that a practical impediment existed that prevented it from obtaining the data necessary to claim the Traditional Medicare Bad Debts on its as-filed cost report. As such, the Board concludes that it has jurisdiction over the Traditional Medicare Bad debts pursuant to the rationale in *Barberton.*[13]

The evidence in the record, i.e. the SARMA Agreement, revealed that SARMA was required to continue collection efforts for debts placed with the agency within the last 18 months even where a party terminates the contract. If any of the bad debts at issue were placed with the collection agency within 18 months, the Laredo Medical Center could not claim them even when it terminated the contract with the collection agency. It would not have been improper for the

[11] Provider's responsive brief at 14-15.
[12] Provider's responsive brief at 15.
[13] *Barberton Citizens Hosp. vs. CGS Administrators*, PRRB Dec. No. 2015-D5 (March 19, 2015)

Provider to claim the bad debts until the 18 months expired. This represents a practical impediment.

In the instant appeal, the Provider's cost reporting period ended September 30, 2008, thus the Provider was not subject to the Protest requirement that was effective for cost report periods ending on or after December 31, 2008. As the Provider has established that a practical impediment, through no fault of its own, prevented it from identifying and/or verifying the Traditional Medicare Bad Debts prior to the filing of its cost report, the Board concludes that it has jurisdiction over the Traditional Medicare Bad Debts issue in the appeal.

This case is scheduled for a live hearing on March 22, 2018. 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:
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A

FOR THE BOARD

L. Sue Andersen, Esq.
Chairperson

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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NOV 17 2017

CERTIFIED MAIL

Charles T. Pearce
Chief Financial Officer
NW Health Care
310 Sunnyview Lane
Kalispell, MT 59901

RE: NW Health Care
Provider No: 27-0051
FYE: 03/31/2015
PRRB Case No: 18-0021

Dear Mr. Pearce:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's October 4, 2017 request for hearing which was received (filed)[1] by the Board on October 5, 2017. The Board's jurisdictional determination is set forth below.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2016), a provider has a right to a hearing before the Board with respect to a cost 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 and the request for hearing is received by the Board within 180 days of the date of receipt of the final determination by the provider.

Decision of the Board

In this case, the Provider's appeal was filed from the Notice of Program Reimbursement ("NPR") dated March 30, 2017. The Provider is deemed to have received the final determination 5 days after the issuance of the NPR, which would have been April 4, 2017.[2] Thus, the 180 day filing period expired on October 2, 2017[3], but the Board received the Provider's request for hearing on October 5, 2017, which is 184 days after the presumed receipt of the NPR. The Provider did not afford any explanation as to why its appeal request was being filed beyond the deadline for submission of a timely appeal.

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[1] *See*, 42 C.F.R. § 405.1835(a)(3) (2015) (a provider has a right to hearing before the Board if, among other things, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the date of receipt of the final contractor determination.) 42 C.F.R. § 405.1801(a)(2) (2016) (the date of receipt means the date stamped "Received" by the reviewing entity.)

[2] 42 C.F.R. § 405.1801(a)(1)(iii) (the presumption, which is otherwise conclusive, may be overcome if it is established by a preponderance of the evidence that the materials were actually received on a later date.)

[3] The 180th day of the filing period was Sunday, October 1, 2017. Therefore, the Provider's appeal was due no later than the following business day, Monday, October 2, 2017.

Therefore, the Board finds that the Provider's hearing request was not timely filed within 180 days of the date of receipt of the final determination and hereby dismisses this 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:

L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A

FOR THE BOARD:

L. Sue Anderson
Chairperson

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

cc: James R. Ward
Appeals Resolution Manager
Noridian Healthcare Solutions, LLC
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P.O. Box 6722
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Wilson C. Leong, Esq., CPA
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CERTIFIED MAIL

NOV 17 2017

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

RE: Forysth Memorial Hospital
Provider No. 34-0014
FYE 06/30/1997
PRRB Case No. 12-0377

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeal prior to scheduling a hearing date. Upon review, the Board notes that there is an impediment to jurisdiction. The pertinent facts in the case and the Board's determination are set forth below.

Pertinent Facts:

On January 20, 2012, the Medicare Administrative Contractor issued the Provider its revised Notice of Program Reimbursement (RNPR) for it 6/30/1997 cost report. The adjustment report states that the cost report was reopened to adjust the Disproportionate Share Hospital (DSH) SSI Percentage recalculated by CMS on June 20, 2007 using the Provider's cost reporting period rather than the Federal fiscal year.

The Provider appealed the RNPR on June 5, 2012. The appeal included two issues[1]:

1. Medicare SSI (Provider Specific Data/Realignment)
2. Medicare SSI (Accuracy)

The Provider filed a transfer request for the SSI Percentage (Accuracy) issue to Case No. 08-2557GC, the Novant 1997 DSH SSI Group, on January 11, 2013. The Board remanded the group to the Medicare Contractor for recalculation of the DSH payment adjustment, by letter dated March 10, 2014, as it was subject to CMS Ruling 1498-R. The subject Provider was included in the remand.

Board Determination:

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

[1] The Provider labeled both Issues 1 & 2 "Disproportionate Share Hospital/Supplemental Security Income Percentage."

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

In this case, the Provider filed its appeal from a RNPR. The Code of Federal Regulations at 42 C.F.R. § 405.1885 (2008) provides for an opportunity for a RNPR, stating 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).

Further, in accordance with 42 C.F.R. § 405.1889 (2008), a RNPR 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 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.

With regard to the SSI Percentage (Provider Specific), the Board finds that it has jurisdiction over the portion of the issue challenging the data used to calculate the SSI Percentage as there was an adjustment to the SSI Percentage (adj. 3) on the RNPR. However, the Board also finds that this portion of the issue is duplicative of the DSH SSI Percentage issue (Accuracy) which was transferred to Case No. 08-2557GC.[2] The basis of both issues is that the SSI Percentage is improperly calculated, and the Provider does not have the underlying data to determine if the SSI Percentage is accurate.

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[2] Case No. 08-2557GC was remanded to the Medicare Contractor pursuant to CMS Ruling 1498R on March 10, 2014. Forsyth Memorial Hospital was listed as a participant on the Schedule of Providers.

Regarding the portion of Issue No. 1 addressing realignment of the DSH calculation to the Provider's cost reporting year end, the Board finds that the cost report was reopened on January 20, 2012, to adjust the DSH SSI Percentage recalculated by CMS on June 20, 2007, using the Provider's cost reporting period rather than the federal fiscal year.

Pursuant to 42 C.F.R. § 412.106(b)(3),

> If a hospital prefers that CMS use its cost reporting period instead of the Federal fiscal year, it must furnish. . . a written request. . . . This exception will be performed once per hospital per cost reporting period, and the resulting percentage becomes the hospital's official Medicare Part A/SSI percentage for that period.

Therefore, the Board finds that the portion of the challenge regarding not receiving the data of the old 1997 SSI ratio, and any discussion around requesting a realignment (which the Provider already received as it was the basis of the RNPR) is moot. Since there are no other issues remaining in the appeal, the Board hereby closes Case No. 12-0377.

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

Board Members Participating:
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A

For the Board:

L. Sue Andersen, Esq.
Chairperson

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Refer to: 14-1966

CERTIFIED MAIL NOV 28 2017

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

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

RE: Wuesthoff Memorial Hospital
Provider No.: 10-0092
FYE: 9/30/2009
PRRB Case No.: 14-1966

Dear Mr. Ravindran and Mr. Pike,

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

Background:

The Board received an individual appeal request from the Provider, Wuesthoff Memorial Hospital, on January 24, 2014, based on a Notice of Program Reimbursement ("NPR") issued by the Medicare Contractor on July 25, 2013. The Provider appealed nine issues, including the SSI Provider Specific; Medicaid eligible days, and bad debts issues.[1] The Provider transferred several issues to group appeals, including the SSI Systemic errors issues. The Board received the Medicare Contractor's jurisdictional challenge on October 5, 2017.

Medicare Contractor's Position:

Issue No. 1: Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)

The Medicare Contractor argues that the Provider has appealed the SSI percentage issue twice, and has transferred the issue to a group appeal, therefore the issue cannot also be pending in this individual appeal, which would be in violation of PRRB Rule 4.5, which states that a "Provider may not appeal an issue from a final determination in more than one appeal."

[1] These are the three issues that remain pending in this appeal.

Issue No. 2: Disproportionate Share Hospital (DSH) Payment – Medicaid Eligible Days

The Medicare Contractor argues that the Board does not have jurisdiction over the Medicaid eligible days because it did not issue a final determination over the disputed days. The Medicare Contractor identifies the audit adjustment numbers that the Provider identified in its appeal request for this issue and explains what was adjusted for each. According to the Medicare Contractor, none of the adjustments cited renders a determination over the disputed days.

The Medicare Contractor also contends that the Provider did not properly protest the Medicaid eligible days in dispute pursuant to 42 C.F.R. § 405.1835(a)(1)(ii).

Provider's Position:

Issue No. 1: Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)

The Provider states that it is addressing not only a realignment of the SSI percentage but also addressing various errors of omission and commission that do not fit into the "systemic errors" category. Thus, the Provider argues that this is an appealable item because the Medicare Contractor specifically adjusted the Provider's SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year end ("FYE") as a result of its understated SSI percentage.[2]

Further, the Provider asserts that in *Northeast Hospital Corporation v. Sebelius*, the Centers for Medicare and Medicaid Services ("CMS") abandoned the CMS Administrator's December 1, 2008 decision. 657 F.3d 1 (D.C. Cir. 2011). The decision here that was abandoned was that the SSI ratio cannot be revised based upon updated data after it has been calculated by CMS. Thus, the Provider reasons that the Provider can submit data to prove its SSI percentage was understated.[3]

Issue No. 2: Disproportionate Share Hospital (DSH) Payment – Medicaid Eligible Days

The Provider argues that the Board has jurisdiction over this issue because there was an adjustment to DSH on its cost report, and furthermore, adjustments are not required because DSH is not an item that has to be adjusted or claimed on a cost report.[4] The Provider also explains that the documentation necessary to pursue DSH is often not available from the State by the time it has to file its cost report, therefore it properly self-disallowed DSH.[5]

The Provider explains that due to practical impediments, it was precluded from identifying all additional Medicaid eligible days at the time of filing its cost report. It explains that providers

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[2] Provider's Jurisdictional Response at 3.
[3] *Id.*
[4] *Id.* at 4.
[5] *Id.* at 6-7.

generally prefer to prepare listings as close in time to a hearing or audit as possible. Therefore, the number of additional days requests is a good faith estimate.[6]

Board's Decision:

Issue No. 1: Disproportionate Share Hospital ("DSH") Payment/Supplemental Security Income ("SSI") Percentage (Provider Specific)

The Board finds that it does not have jurisdiction over the SSI Percentage (Provider Specific) issue.

The jurisdictional analysis for the SSI Percentage (Provider Specific) issue has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

The first aspect of the SSI Percentage (Provider Specific) issue—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 Systemic Errors issue that was allegedly transferred to a group appeal. Because the Board received a transfer request form only for the Rural Floor Budget Neutrality Adjustment issue (and not for the Systemic Errors issue), it is unclear whether the Systemic Errors issue was actually transferred to a group appeal or whether that issue was abandoned. Thus, this first aspect of the SSI Percentage (Provider Specific) issue is hereby dismissed by the Board because it is duplicative of the Systemic Errors issue or because the Provider abandoned the Systemic Errors issue and thereby lost its appeal rights.

To explain this further, the SSI Percentage (Provider Specific) issue concerns "whether the Medicare Contractor "used the correct [SSI] percentage in the [DSH] calculation."[7] The Provider asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with 42 U.S.C. § 1395ww(d)(5)(F)(i)."[8] The Provider argues that the SSI percentage calculated by CMS "was incorrectly computed . . . ."[9] Similarly, the Systemic Errors issue which the Provider allegedly transferred to a group appeal is whether the "Secretary properly calculated the Provider's [DSH]/[SSI] percentage."[10] The Provider argues—with respect to the Systemic Errors issue—that the Medicare Contractor's "determination of Medicare Reimbursement for [its] DSH Payments [is] not in accordance with . . . 42 U.S.C. § 1395ww(d)(5)(F)(i)."[11] Moreover, the Provider claims that the SSI percentages were incorrect due to the availability of Medicare Provider Analysis and Review ("MEDPAR") and Social Security Administration ("SSA") records, and the consideration of paid days versus eligible days, to name a few

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[6] *Id.* at 15.
[7] Provider's Model Form A – Individual Appeal Request (Jan. 23, 2014) at Issue 1.
[8] *Id.*
[9] *Id.*
[10] *Id.* at Issue 1.
[11] *Id.*

reasons.[12] Therefore, the Provider's disagreement with how the Medicare Contractor calculated the SSI percentage is duplicative of the Systemic Errors issue which was allegedly filed into a group appeal. Because the Systemic Errors issue is allegedly in a group appeal (or was abandoned by the Provider), the Board hereby dismisses this aspect of the SSI Percentage (Provider Specific) issue.

The second aspect of the 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—should be 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[s] 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.

Furthermore, even if the Provider requested a SSI realignment based on its own cost reporting data, 42 C.F.R. § 412.106(b)(3) states that the Provider must use that data from its cost reporting year; this regulation does not give the Provider an appeal right from a request for SSI realignment. Also, 42 C.F.R. § 412.106(b)(3) provides that the resulting percentage "becomes the hospital's official Medicare Part A/SSI percentage for that period." Because the Provider has not submitted a written request for SSI realignment to the Medicare Contractor, there is no final determination from which the Provider can appeal. Thus, the Provider has not satisfied the dissatisfaction requirement pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835–405.1840. Thus, the Board finds that it does not have jurisdiction over the SSI Percentage (Provider Specific) issue.

Issue No. 2: Disproportionate Share Hospital (DSH) Payment – Medicaid Eligible Days

The Provider is appealing from a 9/30/2009 cost report, which means that it either had to claim the cost at issue or it is subject to the protest requirement in order for the Board to have jurisdiction.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination. The jurisdictional issue presented here is whether or not this hospital has preserved its right to claim dissatisfaction with the amount of Medicare payment. "A provider… has a right to a Board hearing… only if – (1) the provider **has preserved its right to claim dissatisfaction… by….[i]ncluding a claim for a specific item(s) on its cost report… or… a self disallowing the specific items(s) by…filing a cost report under protest…**

Based on the record, the Provider did not protest the Medicaid eligible days, therefore in order

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[12] *Id.*

for the Board to have jurisdiction over the issue, there must be a claim for the specific items on the cost report as required by 42 C.F.R. § 405.1835(a). The Board finds that the days the Provider has requested were not claimed on its cost report, therefore it does not have jurisdiction over the Medicaid eligible days issue.

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue or the Medicaid eligible days issue. Case No. 14-1966 remains open as the bad debts issue is still pending 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 upon final disposition of this appeal.

Board Members Participating:
L. Sue Andersen, Esq.
Gregory H. Ziegler, CPA, CPC-A
Charlotte F. Benson, CPA

FOR THE BOARD

L. Sue Andersen, Esq.
Chairperson

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

cc: Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Refer to: 11-0575

NOV 2 8 2017

CERTIFIED MAIL

Carolinas Specialty Hospital
Roger Miller
Regional Director, Central Business Office
2001 Vail Avenue, 7th Floor
Charlotte, NC 28207

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

RE: Carolinas Specialty Hospital
Provider No.: 34-2015
FYE: 7/31/2009
PRRB Case No.: 11-0575

Dear Mr. Miller and Mr. Lamprecht,

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

Background:

Carolina Specialty Hospital was issued an original Notice of Program Reimbursement ("NPR") on September 29, 2010, for fiscal year end ("FYE") 07/31/2009. On April 4, 2011, the Provider filed an individual appeal request with the Intermediary Hearing Officer, challenging disallowed reimbursable bad debts. On April 5, 2011, the Intermediary Hearing Officer forwarded the Provider's appeal request to the Board, because the amount in controversy listed on the cover letter was greater than $10,000, and the appeal should have been filed with the Board.[1] The Board received the Provider's appeal request on April 6, 2011.

Board's Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840, a provider has a right to a hearing before the Board with respect to 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, and the request for hearing is received by the Board within 180 days of the receipt of the final determination. Before the Board can make a determination with respect to the issues appealed, it must first determine that the Provider has filed a jurisdictionally valid appeal.

[1] 42 C.F.R. § 405.1811(a)(2); 42 C.F.R. § 405.1835(a)(2).

After reviewing the record, the Board finds that it does not have jurisdiction over this appeal because it was not timely filed. Pursuant to 42 C.F.R. § 405.1835(a)(3)(i) and PRRB rules, an appeal must be filed with the Board no later than 180 days after the provider has received its final determination.

42 C.F.R. § 405.1835(a)(3)(i) states:

> (3) Unless the provider qualifies for a good cause extension[...], the date of the receipt by the Board of the provider's hearing request is-
>
> (i) No later than 180 days after the date of receipt by the provider of the intermediary or Secretary determination.

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, unless established by a preponderance of the evidence that it was actually received on a later date. Furthermore, 42 C.F.R. § 405.1801(a)(2) establishes that the date of receipt by the Board is the date of delivery where the document is transmitted by a nationally-recognized next-day courier or, alternatively, the date stamped "received" by the reviewing entity where a nationally-recognized next-day courier is not used.

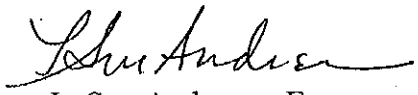
Carolinas Specialty Hospital was issued its NPR on September 29, 2010 and presumed to have received it on October 4, 2010. The Provider did not present evidence that the NPR was received later than the five day presumption. The Provider sent the appeal request to the Intermediary and it was received on April 4, 2011, 184 days after the receipt of the NPR by the Provider. The Intermediary was not the appropriate party to which to send the appeal because the amount in controversy was greater than $10,000.00. 42 C.F.R. § 405.1811(a)(2) allows an appeal to an intermediary in the event that the "amount in controversy ... is at least $1,000 but less than $10,000." The amount in controversy of $55,219.30 exceeds the regulations limitation of less than $10,000 for the Provider to file an appeal request with the Intermediary. Therefore, the proper party for the Provider to request an appeal from was the Board. An appeal request from this original NPR was received by the Board on April 6, 2011. Thus, the receipt date was 184 days after the Provider's presumed date of receipt of the final determination from the Intermediary.

Because the appeal request was not received by the Board within 180 days of receipt of the final determination, as required by 42 C.F.R. § 405.1835, the Board finds that it was not timely filed. PRRB Case No. 11-0575 is hereby closed and removed from the Board's docket.

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

Board Members:
L. Sue Andersen, Esq.
Gregory H. Ziegler, CPA, CPC-A
Charlotte F. Benson, CPA

FOR THE BOARD



L. Sue Andersen, Esq.
Chairperson

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

cc: Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Refer to: 17-0104

NOV 2 8 2017

CERTIFIED MAIL

West Carroll Memorial Hospital
Mandy Grey
Assistant Administrator
706 Ross St.
Oak Grove, LA 71263

Bill Tisdale
Novitas Solutions, Inc.
Director JH Provider and Audit Reim. Dept.
501 Grant St, Suite 600
Pittsburgh, PA 15219

RE: West Carroll Memorial Hospital
Provider No.: 19-0081
FYE: 9/30/2017
PRRB Case No.: 17-0104

Dear Ms. Grey and Mr. Tisdale,

West Carroll Memorial Hospital ("West Carroll" or "Provider") filed a timely appeal from the Notice of Quality Reporting Program Noncompliance Decision issued by the Centers for Medicare & Medicaid Services ("CMS") for FY 2017. The Provider specifically challenged CMS's decision to deny the Provider's reconsideration request. The Board approved the appeal for a record hearing and held the hearing on October 25, 2017.

The Board finds that it does not have jurisdiction under 42 U.S.C. § 1395oo(a) as the Provider has not documented that is had met the amount in controversy requirement of $10,000. The Board's decision is set forth below.[1]

Background:

West Carroll Memorial Hospital is a 33-bed rural hospital located in Oak Grove, Louisiana. In a letter dated May 23, 2016, CMS notified West Carroll that the hospital did not meet one of the Hospital Inpatient Quality Reporting ("IQR") Program requirements for fiscal year ("FY") 2017, and that this finding will result in a one-fourth reduction of West Carroll's FY 2017 Inpatient Prospective Payment System Annual Payment Update. CMS found that West Carroll failed to meet its validation requirements for the clinical process measures, specifically for "Validation Phase 2." West Carroll requested reconsideration of CMS' decision on June 3, 2016, but CMS

[1] 42. C.F.R § 405.1871 requires a Board hearing decision be issued if the Board finds jurisdiction over a specific matter at issue **and** it conducts a hearing on the matter. As the Board has found it lacks jurisdictions over the specific matter at issue, a hearing decision on the merits of the specific matter is not required.

upheld its determination. West Carroll filed the instant request for hearing ("RFH") with the Board on October 17, 2016.

Medicare Contractor's Position:

In its Final Position Paper ("FPP"), the Medicare Administrative Contractor ("MAC") argues that the Provider has not met the minimum requirements for a FPP. The MAC states that the Provider's paper does not supply a statement of the issue, the amount in controversy, a listing of disputed or undisputed facts, or any arguments explaining its position. The MAC asks that the Board dismiss the appeal for not meeting Board requirements.

Provider's Position:

The Provider did not respond to the MAC's arguments.

Board's Decision:

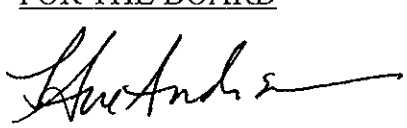
Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more, and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

Based on the record, the Provider did not document in its appeal request the reimbursement impact of the payment reduction. While the Board understands that the amount would be an estimate, the Provider is required to provide the information as the Board's jurisdiction is only for appeals that have an amount in controversy over $10,000. The Provider did not file a FPP as requested, but instead asked the Board to use its appeal request as the FPP, therefore they included no additional documentation in the record. The MAC then filed its FPP challenging the Provider's right to an appeal as it failed to document it met the basic filing requirements for a Board hearing and the Provider did not respond.

Therefore, the Board finds that it does not have jurisdiction over the appeal as the Provider has failed to satisfy the basic jurisdiction requirements of 42 U.S.C. § 1395oo(a)(2) and 42 C.F.R. § 405.1839. As no estimate is given, the Board is also unable to determine if the appeal meets the requirements for a hearing before the Medicare Contractor Hearing Officer. Therefore, the appeal is dismissed.

Board Members Participating:
L. Sue Andersen, Esq.
Gregory H. Ziegler, CPA, CPC-A
Charlotte F. Benson, CPA

FOR THE BOARD



L. Sue Andersen, Esq.
Chairperson

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

cc: Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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NOV 29 2017

CERTIFIED MAIL

Isaac Blumberg
Chief Operating Officer
Blumberg Ribner, Inc.
315 South Beverly Drive, Suite 505
Beverly Hills, CA 90212

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

RE: Saint Luke's Methodist Hospital
Provider No.: 16-0045
FYE: 12/31/04
PRRB Case No.: 12-0129

Dear Mr. Blumberg and Mr. Lamprecht,

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

Background

The Provider submitted a request for hearing on January 5, 2012, based on a Revised Notice of Program Reimbursement ("RNPR") dated August 10, 2011. The hearing request included two issues: 1) DSH – Medicaid Eligible Patient Days and 2) – DSH – Medicare/Medicaid Dual Eligible Patient Days.[1] The Medicare Contractor submitted a jurisdictional challenge on the DSH – Medicaid Eligible Patient Days issue on October 18, 2013. The Provider did not file a responsive brief.

Medicare Contractor's Position

The Medicare Contractor believes the Board lacks jurisdiction over the DSH – Medicaid Eligible Patient Days issue based on the Notice of Correction of Program Reimbursement. The Disproportionate Share Percentage was adjusted only due to the inclusion of other days in the Medicaid fraction; the specific days were not adjusted by the Notice of Correction of Program Reimbursement. C.F.R. § 405.1801(a).[2]

The Medicare Contractor argues that it made no adjustment to the cost report for the issue under appeal. Therefore the Medicare Contractor has not made a determination with respect to the Provider for the issue appealed. In accordance with 42 C.F.R. § 405.1835:

[1] The Provider did not argue the DSH – Medicare/Medicaid Dual Eligible Patient Days issue in its Preliminary Position Paper. As such, the Board deems the issue to have been abandoned by the Provider.
[2] Medicare Contractor's jurisdictional challenge at 1.

> A provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination...(Emphasis added.)[3]

The Medicare Contractor states that it accepted only a portion of the Provider's reopening request. The appeal for the remaining days of the reopening request had already been considered in the original Notice of Program Reimbursement. The appeal request should have been based on the original NPR date.[4]

Provider's Position

The Provider did not submit a jurisdictional response.

Board's Decision

Pursuant to 42 U.S.C. §1395oo(a) and 42 C.F.R. §§ 405.1835 – 1841, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for 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 Provider's DSH - Medicaid Eligible Patient Days appeal from the revised NPR. The Code of Federal Regulations provides an opportunity for a revised NPR. 42 C.F.R. § 1885 provides in relevant part:

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

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

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.

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[3] Medicare Contractor's jurisdictional challenge at 1-2.
[4] Medicare Contractor's jurisdictional challenge at 2.

> (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.

This regulation has also been addressed and explained in the decision *HCA Health Services of Oklahoma v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994). In that case the Court held that when a fiscal intermediary reopens its original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening. The Board concludes that it does not have jurisdiction over the DSH – Medicaid Eligible Patient Days issue in the appeal because it was not specifically adjusted in the revised NPR.

The evidence in the record reveals that the Provider requested the following categories of days in its reopening request:[5]

- 226 Additional Medicaid Eligible Days
- 2,715 Additional Medicaid Eligible Days (with State Match)
- 24 Additional Baby Days with Medicaid Eligible Mothers
- 13 Additional Baby Days with Medicaid Eligible Mothers (with State Match)
- 53 Title XIX Medicaid Eligible Rehab Days

Additionally, the evidence in the record reveals that the Medicare Contractor only allowed the 226 Additional Medicaid Eligible Days and the 24 Additional Baby Days with Medicaid Eligible Mothers in the revised NPR. The Medicare Contractor stated that the 2,715 Additional Medicaid Eligible Days (with State Match) were reviewed at the time of the audit associated with the original NPR. The Medicare Contractor stated that it would not re-audit these Medicaid days as the State eligibility report has limited information and is not sufficient to reverse the audit findings. The Medicare Contractor applied the same rationale to the 53 Title XIX Medicaid Eligible Rehab Days.[6]

The Board finds that the Provider's appeal rights from this RNPR are limited to the specific issue revised on reopening – the 226 Additional Medicaid Eligible Days and the 24 Additional Baby Days with Medicaid Eligible Mothers, and that other determinations related to the original NPR are not relevant to this case. In this appeal, the Provider is seeking days which were not revised in the RNPR. As such, the Board concludes that it does not have jurisdiction over the DSH – Medicaid Eligible Patient Days issue in this appeal and dismisses it from the appeal.

As no issues remain in the appeal, the Board hereby closes the appeal 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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[5] Medicare Contractor's jurisdictional challenge at 5.
[6] Medicare Contractor's jurisdictional challenge at 7.

Board Members Participating:
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Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A

FOR THE BOARD

L. Sue Andersen, Esq.
Chairperson

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

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RE: Salinas Valley Memorial Hospital
Provider No.: 05-0334
FYE: 6/30/08
PRRB Case No.: 13-1047

Dear Mr. Stewart and Ms. Alcantara,

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

Background

The Provider submitted a request for hearing on March 11, 2013, based on a Notice of Program Reimbursement ("NPR") dated October 10, 2012. The hearing request included three issues:

- Issue 1 – Medicaid Eligible Days
- Issue 2 – DSH SSI Ratio – Accuracy
- Issue 3 – DSH – Medicare Advantage Days (i.e. Part C Days)

The Medicare Contractor submitted a jurisdictional challenge on Issue 1 and Issue 4 on March 24, 2014.[1] The Provider did not file a responsive brief.

Medicare Contractor's Position

Issue 1 – Medicaid Eligible Days

The Medicare Contractor explains that in Issue 1, the Provider is contesting the Medicaid ratio utilized in the calculation of the disproportionate share (DSH) payment. The Medicare Contractor states that the Provider contends that its Medicaid ratio reflected on Worksheet E, Part A, line 4.03 is understated due to the exclusion of additional Medicaid eligible days. The Medicare Contractor contends that it did not render a final determination over the additional 598 Medicaid days that the Provider seeks to include in the Medicaid ratio. The Medicare Contactor

[1] The Medicare Contractor states that Issue 4 – DSH – Medicare Dual Eligible Days was not identified in the Provider's original appeal request and was not timely added to the appeal.

contends that there was no adverse finding meeting the requirements of 42 C.F.R. § 405.1801(a). Therefore, the Provider does not have the right to an appeal for this issue.[2]

The Medicare Contractor explains that during its audit, the Medicare Contractor proposed adjustment number 6 to include 745 total labor and delivery room days. Of this number, 153 were related to Medicaid. The implementation of adjustment 6 resulted in increasing the DSH Medicaid ratio from 17.81 to 17.85. The Medicare Contractor notes that the Provider did not identify any protested amounts on its as-filed cost report. The Medicare Contractor contends that the Provider's dissatisfaction stems from its failure to claim the 598 additional days on its as-filed Medicare cost report. The Provider is dissatisfied with its own reporting of Medicaid days.[3]

The Medicare Contractor explains that the regulations at 42 C.F.R. § 405.1835 state in relevant part:

> (a) Criteria. The provider (but no other individual, entity, or party) has a right to a hearing before the Board about any matter designated in §405.1801(a)(1):
>
> (1) An intermediary determination has been made with respect to the provider; and
>
> (2) The provider has filed a written request for a hearing before the Board under the provisions described in §405.1841(a)(1); and
>
> (3) The amount in controversy (as determined in §405.1829(a)) is $10,000 or more

The regulations at 42 C.F.R. § 405.1841 state in relevant part:

> (a) General requirements
>
> (1) 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 or, where notice of the determination was not timely rendered, within 180 days after the expiration of the period specified in § 405.1835(c). Such request for Board hearing must identify the aspects of the determination with which the provider is dissatisfied, explain why the provider believes the determination is incorrect in such particulars, and be accompanied by any documenting evidence the provider considers necessary to support its position (Emphasis added).

The Medicare Contractor also maintains that the regulations at 42 C.F.R. § 408.1835 limit the Provider's right to a hearing of the issues upon which it has made a final determination. In relevant part, this section states:

> The provider…has a right to a hearing before the Board about any matter designated in § 405.1801(a)(1), if …[a]n intermediary determination has been made with respect to the provider.

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[2] Medicare Contractor's jurisdictional challenge at 1.
[3] Medicare Contractor's jurisdictional challenge at 3.

The Medicare Contractor contends that the Provider failed to request reimbursement for all Medicaid days to which it was entitled under applicable rules. In the instant case, the additional Medicaid days were omitted from its as-filed cost report. The Provider's dissatisfaction stems from its failure to claim the additional days. Logically, because the 598 additional days were not claimed by the Provider, the Medicare Contractor did not render a final determination over them or the associated reimbursement. The Medicare Contractor requests that the Board exercise its discretion under 42 U.S.C. § 139500(d) and dismiss this issue consistent with its decision in *St. Vincent Hospital & Medical Center*.[4]

Issue 4 – DSH – Medicare Dual Eligible Days

The Medicare Contractor explains that the Provider filed its appeal request identifying the following issues:

- Issue 1 - Medicaid Eligible Days
- Issue 2 – DSH SSI Ratio – Accuracy
- Issue 3 – DSH – Medicare Advantage Days (i.e., Part C Days)

The Medicare Contractor contends that Issue 4 is a completely new issue – one that was not raised in the Provider's initial appeal request. The Provider is attempting to add Issue 4 via its preliminary position paper.[5]

The Medicare Contractor points to the regulations for adding issues to a hearing request at 42 C.F.R. § 405.1835(c). This section states:

> After filing a hearing request in accordance with paragraph (a) and (b) of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if the following requirements are met:
>
> (1) The request to add issues complies with the requirements of paragraphs (a)(1) and (b) of this section as to each new issue.
>
> (2) The specific matters at issue raised in the initial hearing request and the matters identified in subsequent requests to add issues, when combined, satisfy the requirements of paragraph (a)(2) of this section.
>
> (3) The Board receives the request to add issues no later than 60 days after the expiration of the applicable 180-day period prescribed in paragraph (a)(3) of this section. (Emphasis Added).

The Medicare Contractor explains that the Provider has taken appeal from the Notice of Program Reimbursement dated 10/12/2012. The 180-day period pursuant to 42 C.F.R. § 405.1835(a)(3)

[4] Medicare Contractor's jurisdictional challenge at 4-5.
[5] Medicare Contractor's jurisdictional challenge at 6.

expired on 4/10/2013. This means the Provider had until 6/9/2013 to add Issue 4 to its appeal request. However, the Provider failed to do so. Therefore, the addition of Issue 4 does not comport with the requirements of section 405.1835(c)(3), which mandates that issues added to an appeal must be received no later than 60 days after the expiration of the applicable 180-day period described in 42 C.F.R. § 405.1835(a)(3).[6]

Provider's Position

Issue 1 – Medicaid Eligible Days

The Provider filed a response to Board Alert 10 on July 22, 2014.[7] In the response, the Provider explains that it uses the State of California P.O.S. system to determine Eligible Days for filing. The Provider goes on to state this however is not the approved system set up by the California Department of Health Care Services to determine Medi-Cal eligibility. The approved system set up specifically for Medicare DSH audits does not accept access to the system until at least 13 months after the date of service. The Medicare cost report is due 4 months after the hospital fiscal year end.[8]

The Provider contends that the additional eligible days could not be verified at the time the cost report was filed due to the approved system set up by the California Department of Health Care Services to determine eligibility not allowing access until 13 months after the date of service. Due to the verification system not being available at the time the cost report was filed, the additional days should be considered a proper adjustment and part of the current appeal.[9]

Issue 4 – DSH – Medicare Dual Eligible Days

The Provider did not submit a response to the Medicare Contractor's jurisdictional challenge on this issue.

Board's Decision

Issue 1 – Medicaid Eligible Days

Pursuant to 42 U.S.C. §1395oo(a) and 42 C.F.R. §§ 405.1835 – 1841, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is

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[6] Medicare Contractor's jurisdictional challenge at 6.
[7] On May 23, 2014, the Board issued Alert 10 to give hospitals with an appeal currently pending before the Board that included the Medicaid eligible days issue an opportunity to supplement the record based on the Board's decision in *Danbury* PRRB Dec. No. 2014-D03. The hospitals were given 60 days from the date of the issuance of Alert 10 to supplement the record with additional arguments and/or documentation that would help the Board understand the practical impediment which prevented them from verifying the Medicaid eligible days with the State prior to filing their cost report. The Board issued Alert 10 in order to provide an opportunity to hospitals to explain the process that they used to obtain the Medicaid eligible days reported on their-as filed cost report and explain what barrier(s) that they faced, which were outside of their control, in obtaining State verification of the Medicaid eligible days at issue in advance of their cost report filing.
[8] Provider's Alert 10 response at 1.
[9] Provider's Alert 10 response at 1-2.

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

The Board finds that pursuant to the rationale in *Barberton Citizens Hosp. vs. CGS Administrators*, PRRB Dec. No. 2015-D5 (March 19, 2015)("*Barberton*"), Salinas Valley Memorial Hospital was able to establish that there was a practical impediment to capturing every Medicaid eligible day by the deadline for filing its cost report. In *Barberton* the Board states "pursuant to the concept of futility in *Bethesda*, the Board has jurisdiction of a hospital's appeal of additional Medicaid eligible days for the DSH adjustment calculation if that hospital can establish a "practical impediment" as to why it could not claim these days at the time that it filed its cost report."[10] In responding to Board Alert 10, Salinas Valley states that the additional eligible days could not be verified at the time the cost report was filed due to the approved system set up by the California Department of Health Care Services to determine eligibility not allowing access until 13 months after the date of service.

In the instant appeal, the Provider's cost reporting period ended June 30, 2008, thus the Provider was not subject to the Protest requirement that was effective for cost report periods ending on or after December 31, 2008. As the Provider established that a practical impediment, through no fault of its own, prevented it from identifying and/or verifying the Medicaid Eligible Days prior to the filing of its cost report, the Board concludes that it has jurisdiction

Issue 4 – DSH – Medicare Dual Eligible Days

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

The Board finds that it does not have jurisdiction over Issue 4 because the Provider did not properly and timely appeal this issue. The subject appeal was filed with the Board in March of 2013 and the regulations required the following:

> (b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) An explanation…of the provider's dissatisfaction with the contractor's or Secretary's determination, including an account of…
>
> (i) why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) how and why the provider believes Medicare payment must be determined differently for each disputed item…[11]

[10] *Barberton* at 4.
[11] 42 C.F.R. § 405.1835(b) (2008).

PRRB Rules elaborated on this regulatory requirement as follows:

> Your hearing request must contain an identification and statement of the issue(s) you are disputing. You must identify the specific issues, findings of fact and conclusions of law with which the affected parties disagree; and you must specify the basis for contending that the findings and conclusions are incorrect. . . . You must clearly and specifically identify your position in regard to the issues in dispute. For instance, if you are appealing an aspect of the disproportionate share (DSH) adjustment factor or calculation, do not define the issue as "DSH." You must precisely identify the component of the DSH issue that is in dispute.[12]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals. [13] 42 C.F.R. § 405.1835(e) provides in relevant part:

> (b) *Adding issues to the hearing request.* After filing a hearing request... a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –
>
> ***
>
> (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.

In practice this means that new issues had to be added to Salinas Valley Memorial Hospital's appeal no later than 240 days after receipt of the Medicare Contractor's determination which in the instant case was June 9, 2013. Salinas Valley Memorial Hospital's first mention of Issue 4 in this appeal was in its preliminary position paper submitted on November 27, 2013, well after the June 9, 2013 deadline.

Because the Provider did not raise Issue 4 in its initial appeal request or add the issue to its appeal before the regulatory deadline, the Board concludes that it lacks jurisdiction over this issue, and dismisses the issue from the appeal.

This case is scheduled for a live hearing on March 28, 2018. 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.

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[12] Provider Reimbursement Review Board Instructions, Part I § B.II.a (2008), *available at* http://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB_Instructions.html (last visited December 6, 2013).
[13] *See* 73 Fed. Reg. 30190 (May 23, 2008).

Board Members Participating:
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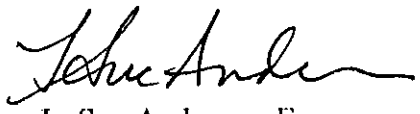
FOR THE BOARD



L. Sue Andersen, Esq.
Chairperson

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

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RE: Loyola University Medical Center
Provider No. 14-0276
FYE 6/30/2005
PRRB Case No. 12-0425

Dear Mr. Connelly and Ms. Hartley,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the Medicare Contractor's Jurisdictional Challenge. The Board's decision is set forth below.

BACKGROUND:

The Provider was issued a revised Notice of Program Reimbursement ("NPR") on January 12, 2012 for fiscal year end ("FYE") 6/30/2005. On July 6, 2012, the Provider filed an appeal request with the Board that identified one issue:

> Roll-Forward of Prior Year Adjustments: Whether the Intermediary properly determined the Provider's DGME & IME payments, based on its failure to reflect the revision of the Provider's prior year DGME and IME FTEs and the IME prior year resident-to-bed ratio.

MEDICARE CONTRACTOR'S CONTENTIONS:

The Medicare Contractor argues that the Board does not have jurisdiction over the following issues appealed by the Provider: prior year Direct Graduate Medical Education ("DGME") and Indirect Medical Education ("IME") full time equivalents ("FTE"), current year resident-to-bed ratio ("RBR"), and IME capital payments because none of these issues were adjusted in the Provider's revised NPR.

PROVIDER'S CONTENTIONS:

The Provider argues that the Medicare Contractor made a determination to "all appealed statistics." The Provider goes on to explain how the Medicare Contractor reopened the FYE 2005 cost report and made seven adjustments, including specific adjustments to the DGME and IME FTE caps for new medical residency training programs and the prior year RBR.[1] The Provider then goes on to identify specific lines on various worksheets that it argues the Medicare Contractor adjusted, including the lines for the three-year rolling FTE average and current year RBR.[2] The Provider then argues that although the Medicare Contractor did not adjust the prior-year DGME and IME FTEs, the three year rolling averages were adjusted, which includes prior-year FTEs.[3] The Provider concludes that the Medicare Contractor's errors are appealable because the prior-year FTE counts are "intimately related" to the adjustments to the caps.[4]

BOARD'S DECISION:

The Board finds that it does not have jurisdiction over the following issues: prior year DGME and IME FTEs; IME prior year resident-to-bed ratio; IME current year resident-to-bed ratio; and IME Capital payments because these issues were not adjusted in the Provider's revised NPR.

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (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.

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[1] Provider's Response to Jurisdictional Challenge at 4.
[2] *Id.* at 5.
[3] *Id.*
[4] *Id.* at 7.

> (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.

Loyola's revised NPR was issued as the result of a Provider reopening request that requested the Medicare Contractor to adjust FTE Cap for New Programs. In doing so, the Medicare Contractor adjusted the cap and then updated the prior year RBR.

Once the revised NPR was issued, the Provider subsequently wanted adjustments made to FTEs for the prior year updated for both GME and IME and also wanted the current year RBR revised. As these components were not part of the reopening appealed (there were no adjustments to any of those components in the revised NPR), the Board finds that it does not have jurisdiction over those issues. Had the Provider wanted to preserve its appeal rights of prior year FTEs or its current year RBR, it could have (and should have) appealed those issues from the original NPR.

The Provider argues that when the Medicare Contractor used the prior year RBR it in fact used the correct number of prior year FTEs, as the RBR is computed by dividing the prior-year FTE count by the prior-year beds. The Provider's allegation seems logical, but for the fact that they are separate and distinct line items on the cost report. Therefore, the Board finds that it does not have jurisdiction over the prior year FTEs.

The revised NPR regulations make clear that a Provider can only appeal items that are specifically adjusted from a revised NPR. The Provider has appealed capital payments for DSH and IME, neither of which were adjusted in the revised NPR. The Provider argues that adjustments should have been made to capital payments because they are a flow through item on the cost report; however this arguments does not satisfy the jurisdictional requirements of 42 C.F.R. §§ 405.1885, 405.1889, therefore the Board finds that it does not have jurisdiction over the capital payments issue..

The Provider reiterated in its Final Position Paper that the IME prior year resident to bed ratio is under appeal as well as the current year, however in Exhibit P-1, the Provider states the prior year ratio should be .713157 (line 3.19). Per ADJ 5, Exhibit I-2, the Medicare Contractor already made that adjustment on the revised NPR under appeal. Therefore, the Board dismisses the prior year RBR because nothing remains in dispute.

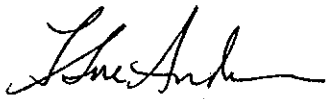
CONCLUSION:

The Board finds that it does not have jurisdiction over any of the sub-issues in PRRB Case No. 12-0425, therefore the appeal is hereby closed and removed from the Board's docket.

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

Board Members Participating:
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Gregory Ziegler, CPA, CPC-A

For the Board:



L. Sue Andersen, Esq.
Chairperson

cc: Federal Specialized Services
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RE: Asante Three Rivers Community
Juris. Challenge DSH – SSI (Provider Specific) and Medicaid Eligible Days
PN: 38-0002
FYE: 9/30/2011
PRRB Case Number: 14-3962

Dear Mr. Kramer and Mr. Ward,

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

Background

Asante Three Rivers Community Hospital ("Asante" or "Provider") filed a timely appeal on August 19, 2014 from its February 24, 2013 Notice of Program Reimbursement ("NPR"). The issues initially raised included:

(1) Disproportionate Share Hospital Payment ("DSH") – Supplemental Security Income ("SSI") (Provider Specific-Realignment)
(2) DSH – Medicaid Eligible Days

The Medicare Contractor filed a jurisdictional challenges on October 06, 2014 and January 18, 2015 regarding Issue #1, DSH – SSI (Provider Specific) and Issue #2 DSH-Medicaid Eligible Days. Asante filed their jurisdictional responsive brief on October 27, 2014 and July 16, 2015.

Medicare Contractor's Position

Provider Specific SSI

The Medicare Contractor contends the SSI issue is a duplicative issue as Asante directly appealed the SSI issue to a group appeal.[1] Since the Board Rule 4.5 states a Provider may not appeal an issue from a final determination in more than one appeal. The Medicare Contractor requests that the Board find that its lacks jurisdiction as the Provider is in violation of Board rule 4.5.[2]

Medicaid Eligible Days

[1] Case # 14-3099GC.
[2] *See* Jurisdictional challenge dated June 18, 2015 (Received June 23, 2015).

The Medicare Contractor contends the Board doesn't have jurisdiction over the additional Medicaid eligible days under 42 C.F.R. §405.1835, since the Medicare Contractor did not make an adjustment to disallow the disputed days. The Medicare Contractor contends Asante included an amount in the protested line of W/S E Part A line 30, however this relates to the SSI rebasing of the Sole Community Hospital rates and the Rural Floor Budget Neutrality Adjustment issues. The Medicare Contractor further insists it is clear that the protested amount does not relate to the additional Title XIX eligible days issue.[3]

Provider's Contentions

Provider Specific SSI

Asante contends each of the SSI issues is a separate and distinct issue and the Board should find jurisdiction over the SSI issue. Asante contends that the Board has jurisdiction over the SSI Provider Specific issue, since the Medicare Contractor specifically adjusted the Providers SSI percentage and the Provider is dissatisfied with the amount of DSH payment it received for the cost report fiscal year of 2011. Asante further contends it will analyze the Medicare Part A records and will be able to identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS. The Provider believes that the SSI percentage determined by CMS is incorrect due to understated days in the SSI ratio. Asante contends it is addressing not only the realignment issue but also the various errors of omission and commission that do not fit into the "systematic errors" category.[4]

Medicaid Eligible Days

Asante states that Adjustment #19 relates to Provider's DSH calculation and this adjustment is enough to warrant Board jurisdiction over DSH/Medicaid Eligible day's issue. Asante also argues that an adjustment is not required, as DSH is an issue that does not have to be adjusted or claimed on the cost report therefore the Presentment requirement should not apply. Asante further questions the validity of applying the Presentment rule. Asante also contends they self-disallowed Medicaid Eligible Days in accordance with Board Rule 7.2(B).

Asante also responded to the Board's Alert 10 stating that Board's proposal to dismiss appeals for lack of jurisdiction if the Provider does not claim on its cost report the exact number of Medicaid eligible days for which it seeks payment on appeals and does not establish practical impediments for doing so is legally incorrect.[5]

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 - 405.1840 (2014), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if 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.

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[3] *See* Jurisdictional challenge dated October 2, 2014 (Received October 6, 2014) and June 18, 2015 (Received June 23, 2015).
[4] *See* Provider's Jurisdictional Response dated July 16, 2015.
[5] Provider's Jurisdictional Response dated October 27, 2014 and July 16, 2015.

Provider Specific SSI

The Provider filed in its original appeal request, Issues # 1 as "Whether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation" with the contentions that the SSI percentage was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits so the SSI percentage issued by CMS is 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. For issue #1, it went on to state 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."[6]

Asante filed its Final Position paper on August 23, 2017 briefing the SSI provider specific issue. The provider fails to mention the recalculation of the SSI% based on its cost reporting period in the paper, and states that when it receives data from CMS it will identify patients that were not included in the SSI percentage.[7]

The Board therefore finds that it lacks jurisdiction over the Provider Specific issue as it relates to realignment from the FFY to Cost Report Year. The issue was abandoned by the Provider in its Final Position Paper. 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.19). However, the Board finds that this issue is duplicative of the SSI Systemic Errors issue appealed in Group Case No. Case No. 14-3099GC. Since the remaining "provider specific" arguments put forth in this appeal request are categories of the same argument (not separate issues) related to the accuracy of the SSI fraction within the DSH adjustment (Provider has not identified how the two issues are different, and as it's been three years since the NPR, they should have requested the data to identify by now).

Accordingly, the Board dismisses Issue #1 DSH – SSI (Provider Specific-Realignment), from this appeal.

Medicaid Eligible Days

After reviewing Asante's Individual Appeal Request and the Position Papers the Board finds that the Provider did not submit any supporting documentation that indicates that the Medicare Contractor made an adjustment to disallow the disputed days or that the days the Provider is making a claim for were filed under Protest on the Medicare Cost Report. The Provider further acknowledges they submitted a fiscal year 2011 cost report that does not reflect an accurate number of Medicaid Eligible days as the documentation is often not available from the State in time to include all DSH/Medicaid Eligible days on the cost report.[8]

The regulation at 42 C.F.R. § 405.1835(a)(1) provides, in relevant part:

> (a) 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 --
> (1) The provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue, by either –

[6] *See* Providers Individual Appeal Request dated August 15, 2014.
[7] *See* Provider's Final Position Paper, page 9.
[8] *See* Provider's Jurisdictional Response dated July 16, 2015 and Position Paper.

(i) Including a claim for specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or

(ii) Effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item(s) by following the applicable procedures for filing a cost report under protest, where the provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy (for example, if the intermediary lacks discretion to award the reimbursement the provider seeks for the item(s)).

Per Board Rule 7.2 C :

> "Effective for cost reporting periods ending on or after December 31, 2008, items not being claimed under subsection A above must be adjusted through the protested cost report process. The Provider must follow the applicable procedures for filing a cost report under protest as contained in CMS Pub. 15-2, Section 115. See 42 C.F.R. § 405.1835(a)(1)(ii)".

Although Asante did include a protested amount on W/S E Part A, they did not document that claim included a request for additional Medicaid Eligible Days. The Board finds that Asante failed to claim the Medicaid eligible days nor did they provide documentation that the protested amount on the cost report included a claim for additional Medicaid Eligible Days. The Provider also acknowledged that it was standard that additional Medicaid Eligible Days were identified after the cost report was filed, therefore they had knowledge prior to the submission of the cost report that they should have included a protested amount for costs they could not identify on the as-filed report. Therefore the appealed issue of Medicaid Eligible Days in this instance does not meet the jurisdictional requirements of the 42 C.F.R. § 405.1835(a)(1) and Board Rule 7.2(C).

As there are no issues remaining in this appeal the case will be closed. Review of this determination is available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating

L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A

FOR THE BOARD

L. Sue Andersen, Esq.
Chairperson

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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NOV 2 9 2017

Certified Mail

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RE: Expedited Judicial Review Request
McKay Consulting Part C Days Group Appeals
FYEs: 12/31/2007 through and 12/31/2013
PRRB Case Nos.: 13-0855GC, 13-1574GC, 13-3455GC, 13-3564GC, 13-3888GC
14-0112GC, 14-0113GC, 14-0119GC, 14-0121GC, 14-4327GC, 14-4328GC, 15-0102GC,
15-0104GC, 15-0571GC, 15-0572GC, 15-2585GC, 15-2586GC, 16-1581GC & 16-1582GC

Dear Ms. Webster:

On November 16, 2017, the Provider Reimbursement Review Board ("PRRB" or "Board") received a request for expedited judicial review ("EJR") for the above-referenced appeals. The Board has reviewed the request and hereby grants the request, as explained below.

The issue in these appeals is:

> . . . [W]hether "enrollees in Part C are 'entitled to benefits' under Part A, such that they should be counted in the Medicare [Part A/SSI] fraction, or whether, if not regarded as 'entitled to benefits under Part A,' they should be instead be included in the Medicaid fraction" of the DSH adjustment.[1]

Statutory and Regulatory Background: Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system ("PPS").[2] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[3]

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[4] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly

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[1] November 15, 2017 EJR Request at 4.
[2] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[3] *Id.*
[4] *See* 42 U.S.C. § 1395ww(d)(5).

disproportionate number of low-income patients.[5] A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[6] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[7] The DPP is defined as the sum of two fractions expressed as percentages.[8] Those two fractions are referred to as the "Medicare/SSI"[9] fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), defines the Medicare/SSI fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . . (emphasis added)

The Medicare/SSI fraction is computed annually by CMS, and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[10]

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), defines the Medicaid fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period. (emphasis added)

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[11]

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[5] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] "SSI" stands for "Supplemental Security Income."
[10] 42 C.F.R. § 412.106(b)(2)-(3).
[11] 42 C.F.R. § 412.106(b)(4).

Medicare Advantage Program

The Medicare program permits its beneficiaries to receive services from managed care entities. The managed care statute implementing payments to health maintenance organizations ("HMOs") and competitive medical plans ("CMPs") is found at 42 U.S.C. § 1395mm. The statute at 42 U.S.C. § 1395mm(a)(5) provides for "payment to the eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter . . ." Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days.

In the September 4, 1990 Federal Register, the Secretary[12] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[13]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[14]

With the creation of Medicare Part C in 1997,[15] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their

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[12] of Health and Human Services
[13] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).
[14] *Id.*
[15] The Medicare Part C program did not begin operating until January 1; 1999. *See* P.L. 105-33, 1997 HR 2015; *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.

care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.[16]

No further guidance regarding the treatment of Part C days in the DSH calculation was provided until the 2004 Inpatient Prospective Payment System ("IPPS") proposed rules were published in the Federal Register. In that notice the Secretary stated that:

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction.* (emphasis added)[17]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[18] In response to a comment regarding this change, the Secretary explained that:

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A.* We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[19] (emphasis added)

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[16] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).
[17] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).
[18] 69 Fed. Reg. at 49,099.
[19] *Id.*

This statement denotes a requirement to include Medicare Part C inpatient days in the Medicare fraction of the DSH calculation.

Although the change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 final rule was issued.[20] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule. As a result, Part C days were required to be included in the Medicare fraction as of October 1, 2004.

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius,*[21] vacated the FFY 2005 IPPS rule. However, as the providers point out, the Secretary has not acquiesced or taken action to implement the decision[22] and the decision is not binding in actions by other hospitals.

Providers' Request for EJR

The underlying issue in this EJR request involves the question of whether Medicare Part C patients are "entitled to benefits" under Part A, thereby requiring them to be counted in the Medicare Part A/SSI fraction and excluded from the Medicaid fraction numerator or vice versa.

Prior to 2004, the Secretary treated Part C patients as not entitled to benefits under Part A. From 1986-2004, the Secretary interpreted the term "entitled to benefits under Part A" to mean covered or paid by Medicare Part A. In the final rule for the FFY 2005, the Secretary reversed course and announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective October 1, 2004.[23]

In *Allina*, the Court affirmed the district court's decision "that the Secretary's final rule was not a logical outgrowth of the proposed rule."[24] The providers claim that because the Secretary has not acquiesced to the decision, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

In these cases, the providers contend that all Part C days should be excluded from the Part A/SSI fraction and the Medicaid-eligible Part C days should be included in the numerator of the Medicaid fraction. To obtain relief, the providers seek a ruling on the procedural and substantive validity of the 2004 rule that they claim the Board lacks the authority to grant. The providers argue that since the Secretary has not acquiesced to the decision in *Allina*, the Board remains bound by the regulation and EJR is appropriate.

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[20] 72 Fed. Reg. 47,130, 47,384 (Aug. 22, 2007).
[21] 746 F. 3d 1102 (D.C. Cir. 2014).
[22] November 15, 2017 EJR Request at 8.
[23] 69 Fed. Reg. at 49,099.
[24] *Allina* at 1109.

Decision of the Board

Under the Medicare statute codified at 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1) (2016), the Board is required to grant a provider's EJR request if it determines that (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

Jurisdictional Determination for Providers

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the providers requesting EJR. Pursuant to the pertinent regulations governing Board jurisdiction, 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 for an individual appeal or $50,000 or more for a group, and the request for hearing is filed within 180 days of the date of receipt of the final determination.[25]

All of the participants in the subject groups appealed from original NPRs that were for the cost reporting periods ending from 2007 through 2013. For purposes of Board jurisdiction over a cost reporting period that ends on or before December 30, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen*.[26]

For appeals of original NPRs for cost reporting time periods ending on or after December 31, 2008, the Providers preserve their respective rights to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either including a claim for the specific item on their cost report for the period where the Provider seeks payment they believe to be in accordance with Medicare policy, or self-disallowing the specific item by following the applicable procedures for filing a cost report under protest. See 42 C.F.R. § 405.1835(a)(1) (2008).

Each of the Providers involved with the instant EJR request have a specific adjustment to the SSI fraction/dual-eligible Part C days such that the Board has jurisdiction to hear their respective appeals. In addition, the Providers' documentation shows that the estimated amount in controversy for each group appeal exceeds $50,000, as required for a group appeal and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor.

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[25] 42 C.F.R. § 405.1835(a) (2008).
[26] 108 S.Ct. 1255 (1988).

Board's Analysis Regarding Its Authority to Consider the Appealed Issue

The providers within this EJR request filed appeals covering cost reporting periods with fiscal years ending 2007 through 2013, thus the cost reporting periods fall squarely within the time frame that covers the Secretary's final rule being challenged.[27] The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

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

2) based upon the providers' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;

3) it is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

4) it is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), are valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the providers' request for EJR for the issue and the subject years. The providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes these cases.

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[27] As stated in the FY 2014 IPPS Final Rule, the Secretary "proposed to readopt the policy of counting the days of patients enrolled in MA plans in the Medicare fraction of the DPP[,]" thus "sought public comments from interested parties . . ." following publication of the FY 2014 IPPS Proposed Rule, 78 Fed. Reg. 27578 (May 10, 2013). Ultimately, the Secretary finalized this DSH policy for FFY 2014 and subsequent years on August 19, 2013, in the FY 2014 IPPS Final Rule. *See* 78 Fed. Reg. 50496, 50615 (Aug. 19, 2013). The provider appeals in the instant EJR request are all based upon FYs that began prior to 10/1/2013.

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FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

Enclosures: 42 U.S.C. § 1395oo(f)
Schedules of Providers

cc: Pam VanArsdale, National Government Services, Inc. (J-K) (Certified w/Schedules)
Bruce Snyder, Novitas Solutions, Inc. (J-L) (Certified w/Schedules)
Wilson Leong, FSS (w/Schedules)

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RE: Own – Motion EJR
Stamford Memorial Hospital, Provider No. 45-0306, PRRB Case No. 15-1522
Wisteria Place Retirement Living, Provider No. 67-5593, PRRB Case No. 15-1528
Anson General Hospital, Provider No. 45-0078, PRRB Case No 15-1527
Continue Care Hospital at HMC. Provider No. 45-2019, PRRB Case No 15-1564

Jurisdictional Reconsideration
Hendrick Medical Center, Provider No. 45-0224, PRRB Case No. 15-1081

Dear Messrs. Roth and Leong:

On September 27, 2017, the Provider Reimbursement Review Board notified the parties in 15-1522, 15-1528, 15-1527 and 15-1564 that it was considering own motion Expedited Judicial Review ("EJR") over the wage index issue which is the sole issue under dispute in each of the above identified appeals. On the same date, the Board dismissed Hendrick Medical Center's appeal because Hendrick failed to exhausted its administrative remedies (did not check the May PUF and request a correction pursuant to the Federal Register notice). Both parties have responded providing comments, the Provider on October 26, 2017 and Federal Specialized Services (FSS) on October 26, 2017.

The Board has reviewed the record in the above-referenced appeal, and determined it has jurisdiction over the providers' appeals, but lacks the authority to grant the relief sought. The Board's rational is set forth below.

Issue under Appeal

The issue under appeal in these cases is:

> Whether the Medicare Inpatient Prospective Payment System [IPPS] wage index assigned to the Abilene, Texas Core-Based Statistical Area for [F]ederal fiscal year ("FFY) 2015 was

incorrectly low, thereby causing the Providers' 2015 Medicare payments to be understated.[1]

Factual Background

The statute, 42 U.S.C. § 1395ww(d)(3)(E), requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary adjust the standardized amounts "for area differences in the hospital wage level which reflects the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level."[2] The wage index is calculated and assigned to hospitals on the basis of the labor market area in which the hospital is located. Pursuant to 42 U.S.C. § 1395ww(d)(3)(E), beginning in 2005, the delineation of hospital labor market areas is based on the Core-Based Statistical Areas (CBSAs) established by the Office of Management and Budget.[3]

The Federal Fiscal (FFY) wage index for 2015 information was made available through the Hospital Open Door forum on the internet. Hospitals were encouraged to sign up for automatic notifications of information and scheduling of the Open Door Forums. In addition, the Centers for Medicare & Medicaid Services sent out a memorandum on September 16, 2013, in which the Medicare Administrative Contractors (MACs) were instructed to inform all inpatient prospective payment hospitals of the availability of the wage data files and the process and timeframe for requesting revisions.[4] A timetable for the FFY 2015 wage index was also publish on the internet.[5]

Hendrick Medical Center (Hendrick), who is located in the Abilene MSA noted that the average hourly wage (AHW) and other wage dated in its 2012 unaudited cost report was not correct. Hendrick contacted the MAC and supplied the correct information. The result of this submission was an increase in the Hendrick's AHW. This corrected dated was reflected in the revised FFY 2015 Public Use File (PUF) published on February 20, 2014. This was the data used to calculate the wage indices published in the FFY 2015 IPPS Proposed Rule in the May 15, 2014 Federal Register.[6] The Providers note that the Proposed Rule included the correctly calculated wage index for the Abilene, Texas CBSA,[7] the area where this Provider is located.

On May 2, 2014, just before the IPPS Proposed Rule was published, and in accordance with the FY 2015 Hospital Wage Index Time Table, CMS added the FYE 2015 wage index and occupational mix PUF to its website. Hendrick's wage data in this PUF was incorrect, resulting in a lower AHW. This contradicted the March 24, 2014 approval the MAC had given Hendrick Medical Center when it submitted corrected wage data.

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[1] Providers' February 28, 2017 cover letter to the position paper.
[2] 79 Fed. Reg. 27,978, 28,054 (May 15, 2014).
[3] *Id.*
[4] *Id. at 28,080.*
[5] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2015-WI-Timeline.pdf.
[6] 79 Fed. Reg. 27,978 (May 15, 2014).
[7] Providers' February 28, 2017 Position Paper at 4.

The Providers believe that the MAC was to notify hospitals of the release of the May 2, 2014 PUF in April of 2014. This notice was to inform providers to review the PUF and that this will be their last opportunity to request corrections to errors in the final data. Hendrick asserts that it received no communication from the MAC after the March 24, 2014 email from the MAC.[8] Hendrick realized that the incorrect wage index was used when the Secretary published the FFY 2015 IPPS Final Rule on August 22, 2014. The wage data error effects not only Hendrick, but the other facilities in the CBSA because the wage index is calculated and assigned to hospitals on the basis of the labor market area in which the hospital is located. Each of the Providers in this appeal are located in the Abilene CBSA and were affected by the error. The Board dismissed Hendrick Medical Center's appeal on September 27, 2017 (case number 15-1081) because Hendrick failed to exhausted its administrative remedies (did not check the May PUF and request a correction pursuant to the Federal Register notice).

In its position paper, the MAC explained that when it transmitted the final wage index data to CMS, the original, unrevised data was mistakenly transmitted. As a result, this data was incorporated into the PUF that was release May 2, 2014.[9]

FSS' Response to the Board's request for comments regarding own-motion EJR

FSS acknowledges that the IPPS rate for this Abilene Texas CBSA is incorrectly low because the MAC submitted incorrect wage data to CMS. FSS contend that the Providers are asking that the Board find that the wage index data is incorrect, something which the MAC has admitted. FSS asserts the wage data is final and the Board can grant the relief the Providers are requesting, which is ". . . a reopening, sub silenio, of the time for submitting the wage index data."[10] Assuming that the Board finds that the wage index is incorrect, FSS agrees there is no further action the Board can take; therefore EJR is appropriate.

Provider's Response to the Board's request for comments regarding own-motion EJR

In the October 20, 2017 response to the Board's notice of proposed EJR, the Providers state that the issue as described by the Board in its September 27, 2017 request does not include the updated issues statement. The Provider alleges that it filed stipulations jointly signed by the MAC and the Providers', which were submitted to the Board in the April 27, 2017 Consolidated Response to MAC's Final Position Paper, Ex. 12, page 10.[11] The statement of the issue, as it appears in the stipulations and in the Providers' EJR response is:

> On August 22, 2014, CMS published the FFY 2015 Inpatient Hospital PPS Final Rule in the Federal Register, which included a

[8] *Id. at 6. See also* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2015-WI-Timeline.pdf.
[9] MAC's March 27, 2017 Position Paper at 6.
[10] FSS' October 26, 2017 own-motion EJR response at 2.
[11] The stipulations included at Exhibit 12 are not signed, contrary to the Provider's statement.

> wage index of .7926 for the Abilene, Texas CBSA. This wage index was too low because it was based on incorrectly low wage data from HMC, which the MAC caused to be included in the May 2, 2014 PUF. The Providers are seeking to have the wage index for the Abilene, Texas CBSA recalculated using the correct wage information for HMC, which was the information included in the March 24, 2014 email from Ms. Akandu to Mr. Marbry.[12]

The Providers contend that the Board's statement of the issue (taken from the Providers' cover letters) is incorrect to the extent it suggests that there is a factual dispute about whether the wage index for the Abilene Texas CBSA was incorrectly low and whether the Providers' Medicare payments were low.

The Providers state they are seeking an order from the Board directing the MAC to recalculate the Providers FFY 2015 Medicare payments after its wage index is recalculated using the data Hendrick is incorporated into the calculation. The Providers believe this is appropriate, for among other reasons, because the MAC has admitted its error in sending the incorrect wage data to the CMS.

The Providers also argue that the MAC's reliance on Santa Cruz CA 03-05 MSA Hospital Wage Index, PRRB Dec. 2015-D6 (2015 WL 10381779, Apr. 2, 2015)[13] is misplaced. In *Santa Cruz*, Watonsville Community Hospital failed to submit its corrected wage data. Here, the MAC admits it submitted the wrong data to CMS after Hendrick's wage data correction which was accepted by the MAC. Based on the different facts, the Providers believe that Santa Cruz is inapplicable.

The Providers also contend that the Board's September 27, 2017 dismissal of Hendrick Medical Center, 15-1081 is incorrect.[14] The Providers assert that Hendrick met all of the deadlines for the substantive wage data correction process. They believe this excludes correcting errors that did not arise from a hospital's substantive request for a wage data revision. Because Hendrick is challenging its wage index, and not the MAC's failure to correct its wage data, the wage data substantive correction process exhaustion requirement does not limit the Board's jurisdiction over Hendrick's appeal. The Providers do not believe that the failure to request a correction of incorrect wage data that the MAC sent to CMS is part of the substantive wage data correction process.

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[12] Providers' October 26, 2017 Response the Notice of Board's Own Motion Consideration of Whether EJR is Appropriate at 3. (Providers' October 26, 2017 Response).

[13] *See Dignity Health (d/b/a Dominican Hospital) v. Price,* 243 F.Supp.3d 43 (D.D.C. 2017) (in reviewing PRRB Dec. 2015-D6, the Court concluded that the Plaintiff's administrative appeal stands on different ground which the Plaintiff did not challenge in its complaint. The Court concluded that Dignity Health lacked Article III standing and dismissed the case for lack of subject matter jurisdiction. The Providers were not challenging their own wage data and were not permitted to challenge the data that CMS used for a different hospital in the MSA. The Court concluded that the Providers would not be entitled to relief even if they were to prevail on the claims, the claims were not redressable and the Plaintiff lacked standing to pursue the claims.

[14] Providers' October 26, 2017 Response at 6.

The Providers argue that Hendrick met the wage data correction procedural deadlines which enabled it to challenge CMS' failure to make a requested substantive data revision as set forth in the May 15, 2014 proposed inpatient prospective payment system (IPPS) proposed rule:

> We created the processes described above to resolve all substantive wage index data correction disputes before we finalize the wage and occupational mix data for the FY 2015 payment rates. Accordingly, hospitals that do not meet the procedural deadlines set forth above will not be afforded a later opportunity to submit wage index data corrections or to dispute the MAC's decision with respect to requested changes. Specifically, our policy is that hospitals that do not meet the procedural deadlines set forth above will not be permitted to challenge later, before the PRRB, the failure of CMS to make a requested data revision.[15]

Decision of the Board

The Board has reviewed the Provider's requests for hearing and EJR. The regulation at 42 C.F.R. § 405.1842(a) permits the Board to consider whether it lacks the authority to decide a legal question relevant to the matter at issue once it has made a finding that it has jurisdiction to conduct a hearing under the provisions of 42 C.F.R. §§ 405.1835 and 405.1840(a). The Board concludes that each Provider timely filed its request for hearing from the issuance of the August 22, 2014 Federal Register[16] and the amount in controversy in each appeal exceeds the $10,000 threshold necessary for an individual appeal.[17]

The Board finds that EJR on the Board's own motion is appropriate for the issue of whether the wage index for the Providers' CBSA should be recalculated using Hendrick's wage data. The Board finds there is no dispute that the wage index is incorrect, both parties agree that the MAC sent the incorrect data to CMS. However, the Board also finds that it that it lacks the authority to review and/or change the published rate for Abilene. The wage index is published through notice and comment and as such it is binding on the Board unless the Secretary has granted the Board the authority to review it. Here, the Secretary has only given the Board the authority to review wage index data revisions, and the parties have agreed that data is not in dispute. The

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[15] 79 Fed. Reg. 27,978, 28081 (May 15, 2014).
[16] *Washington Hospital Center v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986) ([A] year end cost report is not a report necessary in order for the Secretary to make PPS payments, and the appeals provisions applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal) and *District of Columbia Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993), *Medicare & Medicaid Guide* (CCH) ¶ 41,025 (publication of the wage index in the Federal Register is a final determination which can be appealed to the Board).
[17] *See* 42 C.F.R. § 405.1835.

Board does not have the authority to review and change a published rate as the Providers have requested in this appeal[18]; therefore EJR is appropriate.

The Board also denies the Providers request for an order directing the MAC to recalculate the Providers FFY 2015 Medicare payments after its wage index is recalculated using the data from Hendrick Medical Center. The Board cannot order a change to the wage index published in the Federal Register. The Providers' request is akin to a request for summary judgment, an action not within the Board's purview. *See* 42 C.F.R. § 405.1871 (if the Board finds jurisdiction over a specific matter at issue, the Board must issue a hearing decision on the merits of the specific matter at issue).

The Board finds that:

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

2) based upon the Provider's assertions regarding the incorrectly low wage index reported for the Abilene, Texas CBSA there are no findings of fact for resolution by the Board;

3) it is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

4) it is without the authority to decide the legal question of whether the Secretary incorrectly assigned a low IPPS wage index rate to the Abilene, Texas CBSA for FFY 2015.

Accordingly, the Board finds that the understatement of the Medicare IPPS wage index assigned to the Abilene, Texas Core-Based Statistical Area for FFY 2015 falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants for expedited judicial review on for the issue and the subject year. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in each appeal (15-1522, 15-1527, 15-1528 and 15-1564), the Board hereby closes the cases.

In addition, the Board affirms the Board's previous denial of jurisdiction over Hendrick for failure to exhaust its administrative remedies when it failed to check the PUF as instructed in the May 2014 Federal Register. The Provider is deemed to have notice of this instruction at the time the Federal Register is published. The Providers use of the words "substantive correction process" is somewhat of a misdirection because any time there is an action that would have significant impact on reimbursement it becomes a "substantive correction" whether or not labeled as such. The Provider was, by virtue of the Federal Register notice, obligated to check

[18] "[H]ospitals are entitled to appeal any denial of a request for a wage data revision made as a result of HCFA's wage data correction process to the Provider reimbursement Review Board." 64 Fed. Reg. 41490, 41513 (July 30, 1999).

the PUF file for an error. The Board cannot overlook the requirements of these Federal Register notices and a provider's duty to comply.

Board Members Participating

L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

Enclosures: 42 U.S.C. § 1395oo(f)(1).

cc: Bill Tisdale, Novitas