DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: Novant 2004 DSH Medicaid Eligible Days Group
Provider No. 34-0014, Forsyth Memorial, as a member of 08-2574GC
FYE 12/31/2004
PRRB Case No. 08-2574GC

Dear Mr. Romano and Ms. Polson,

Novant Presbyterian Hospital ("Presbyterian") and Novant Forsyth Memorial Hospital ("Forsyth") each timely filed individual appeal requests with the Board for fiscal year ("FY") 2004. Presbyterian filed its request from a Notice of Program Reimbursement ("NPR") and Forsyth filed its request from a Revised Notice of Program Reimbursement. As part of both individual appeals, each Provider specifically challenged the accuracy of the Disproportionate Share Hospital ("DSH") payment.[1] The basis for each claim was the Provider's belief that the Medicare Contractor failed to include all of the Medicaid Eligible Days in the numerator of the Medicaid fraction of the DSH calculation.

On August 8, 2008, Presbyterian and Forsyth requested to establish the current mandatory Common Issue Related Party Group ("CIRP") appeal, Case No. 08-2574GC, by way of transferring the Medicaid Eligible Days issue from their respective individual appeals. The Board held a hearing for 08-2574GC on May 12, 2016.

BACKGROUND re: FORSYTH JURISDICTIONAL CHALLENGE:

The Medicare Contractor filed a jurisdictional challenge over Forsyth on December 9, 2015. Forsyth submitted a response to the jurisdictional challenge on January 5, 2016.[2] The parties also discussed jurisdiction over Forsyth in their post hearing briefs, which the Provider submitted

[1] The original individual appeal requests for FY 2004 included other issues. The Medicaid Eligible days issue was transferred to the current CIRP group.

[2] Presbyterian rested on the evidence presented in its FY's 2001 and 2002 cases which related to the treatment of Medicaid adolescent psychiatric days in the DSH calculation and the Medicare Contractor incorporated its evidence and arguments from those cases. The Board will issue a separate decision for Presbyterian.

to the Board on July 25, 2016, and which the Medicare Contractor submitted to the Board on July 29, 2016.

Forsyth included 38,622 days on its cost report for FYE December 31, 2004. The Medicare Contractor issued an NPR on December 22, 2006 without audit of the Medicaid eligible days. Subsequently, Forsyth identified additional Medicaid eligible days and submitted a listing to the Medicare Contractor for review. The Medicare Contractor reopened the cost report on September 14, 2007, in order to include 1,119 days of the submitted days in the Provider's Medicaid Fraction and issued a revised NPR.[3,4]

Forsyth appealed from the September 14, 2007 revised NPR and submitted 3,236 additional Medicaid eligible days as part of its appeal request from the revised NPR. The Medicare Contractor refused to audit the 3,236 days and has contested jurisdiction on the basis that the Provider was not "dissatisfied" with the amount of reimbursement it received through the revised NPR, and that the Provider's appeal was outside the permissible scope of appeal from a revised NPR.

PARTIES' CONTENTIONS:

The Medicare Contractor contends the Board does not have jurisdiction over Forsyth's appeal because it was not dissatisfied with the reimbursement it received in the September 14, 2007 revised NPR. The Medicare Contractor contends that the Provider's appeal is outside the scope of 42 C.F.R. § 405.1889, which governs appeals from a revised NPR. 42 C.F.R. § 405.1889 permits appeals from a revised NPR of "only those matters that are specifically revised in a revised determination or decision." The Medicare Contractor argues that the Provider is appealing additional Medicaid eligible days that were not specifically revised in its revised NPR, therefore it cannot prove dissatisfaction with respect to those additional days.[5]

Forsyth contends it properly appealed from the revised NPR for the purpose of adding Medicaid eligible days to the numerator of its Medicaid Fraction. According to the Provider, the Medicare Contractor reopened the Provider's cost report "to consider the entire universe of Medicaid eligible days" because the Medicare Contractor issued the original NPR without reviewing any of the Medicaid eligible days due to budgetary constraints.[6]

Forsyth cites 42 U.S.C. § 1395oo(a) which outlines the jurisdictional requirements for a Board hearing. Section 1395oo(a) states that a provider has a right to a Board hearing if it meets the amount in controversy requirement, files a timely appeal, and:

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[3] The parties were asked to determine whether Forsyth requested reopening but neither party was able locate any such request (or a Medicare Contractor response to such a request). The Medicare Contractor apparently reopened because it had not previously audited the Medicaid eligible days. Transcript ("Tr.") at 97-98.
[4] Tr. at 97-98.
[5] Medicare Contractor's Jurisdictional Challenge at 7.
[6] Provider's Post Hearing Brief at 5-6.

> (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1816 as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this title for the period covered by such report, or
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> (ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1886.

Forsyth notes that the dissatisfaction requirement applies to appeals filed from both original and revised NPRs, and points out that, when a provider has appealed Medicaid eligible days from an original NPR, the Board has not found that the provider fails the dissatisfaction requirement because it is claiming more Medicaid eligible days than it filed on its cost report.[7]

Forsyth contends that dismissing its appeal from a revised NPR for failure to show dissatisfaction because additional Medicaid eligible days were identified after the revised NPR was issued would be illogical, inconsistent with the approach taken with respect to appeals from original NPRs, and is prohibited by the regulations.[8] In support of its assertions, the Provider points to the May 2008 revision to the PRRB appeals regulations, specifically 42 C.F.R. § 405.1835(b)(2)(i), in which CMS proposed that the hearing request include a demonstration that the provider satisfies the jurisdictional requirements for a hearing, which includes the dissatisfaction requirement.[9] The Provider points out the exception that CMS included to this requirement, in that a provider is not required to demonstrate dissatisfaction with the amount of Medicare reimbursement it received when it did not have the information needed to determine dissatisfaction, specifically identifying when a provider does not have access to data from a State agency as an example.[10] Based on this, the Provider concludes that it has met the dissatisfaction requirement.

The Provider acknowledges that an appeal from a revised NPR must be on a matter or issue that was reopened and revised, but argues that it is illogical and contrary to precedent to define the matter or issue as the specific Medicaid eligible days that were revised.[11] Forsyth offers *Anaheim Memorial Hosp. v. Shalala*, 130 F.3d 845 (9th Cir. 1997) ("*Anaheim*") and *French Hosp. v. Shalala*, 89 F.3d 1411 (9th Cir. 1996) ("*French Hospital*") as decisions where the Court drew a distinction between the revision of a matter (appeal allowed) and a mere incidental application of a matter (appeal not allowed).[12] Forsyth thus argues that where a provider seeks to appeal a revised NPR that revised the number of Medicaid eligible days, for the purpose of having Medicaid eligible days added to its Medicaid Fraction, the provider is not appealing

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[7] *Id.* at 6.
[8] *Id.* at 6.
[9] *Id.* at 7 (referring to 73 Fed. Reg. 30190, 30200 (May 23, 2008)).
[10] *Id.*
[11] *Id.* at 8.
[12] *Id.* at 9.

something that was a mere incidental or consequential effect of the revision, but instead is appealing the very matter that was revised.

BOARD'S DECISION:

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2007) provides in relevant part:

> A determination of an intermediary . . . may be reopened with respect to findings on matters at issue in such determination or decision, by such intermediary . . . either on motion of such intermediary . . . or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings.

A revised NPR is considered a separate and distinct determination from which the provider may appeal.[13] 42 C.F.R. § 405.1889, effective through May 22, 2008, stated:

> Where a revision is made in a determination or decision on the amount of program reimbursement after such a determination or decision has been reopened . . . such revision shall be considered a separate and distinct determination or decision to which the provisions of Secs. 405.1811, 405.1835, 405.1875, and 405.1877 are applicable.

In *Illinois-Masonic Med. Ctr. V. Sebelius*, 859 F. Supp. 2d 137 (D.D.C. 2012) ("*Illinois-Masonic*"), the U.S. District Court for D.C. ("Court") addressed virtually the same situation as the one in this case. The revised NPR at issue in *Illinois-Masonic* added 230 Medicaid eligible days to the numerator of the Medicaid fraction of the provider's DSH calculation and the provider then appealed that revised NPR to add 2,244 more Medicaid eligible days to the numerator of the Medicaid fraction of its DSH calculation. At the outset, the Court confirmed that the DC Circuit has interpreted § 405.1889 to apply only to the revisions made in the revised NPR:

> Because section 405.1889 expressly provides that a revision to a NPR is a 'separate and distinct determination' from the initial NPR, the D.C. Circuit has joined a number of other Circuits in holding that *the right to appeal a revised NPR attaches only to the* ***scope of the revision***.[14]

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[13] In this regard, the Board notes the Supreme Court's decision in *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399, (1988) only addresses initial NPRs and, as such, it does not apply to revised NPRs. *See French Hosp.*, 89 F.3d at 1417.

[14] 859 F. Supp. 2d 137 at 144 (citations omitted) (emphasis added).

In applying this holding, the Court affirmed the reasonableness of the Secretary's position that the scope of the revision was limited to the 230 days and also made the following findings which dispel many of the arguments made by Forsyth in this case:

> . . . [P]laintiff's contention that its appeal addresses the very item that was reconsidered and adjusted in the revised NPR—"the number of eligible but unpaid days under the Medicaid Fraction of the DSH Adjustment"—is similarly misplaced. Plaintiff use of the term "issue" is far too broad. . . .
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> Furthermore, the court finds that plaintiff's interpretation of section 405.1889 makes little pragmatic sense. The posture of this case illustrates the problem with allowing a provider to "add" to an appeal. The 2,244 days that plaintiff seeks to include in the appeal have never been presented to or reviewed by the FI. Therefore, if the court were to accept plaintiff's position, the Board would be forced to make a determination on days that have not been reviewed by the FI. In addition, the regulations set a deadline of 180 days for a provider to appeal a cost report. If the court were to accept plaintiff's interpretation of section 405.1889, a provider could skirt the 180 day limit by seeking additional reimbursement within 180 days of a revised NPR, long after the time to appeal the original NPR had expired. In other words, if the Board were to address the 2,244 additional days, yet another revised NPR would issue, and plaintiff could use the revised NPR's attendant appeal rights to introduce further days. This would create a never-ending cycle of appeals without a meaningful cut-off point.[15]

The Board is persuaded by the rationale of *Illinois-Masonic*. The record shows that the 3,236 days Forsyth is seeking to add through its appeal are days that were not presented to the Medicare Contractor prior to when the NPR or the revised NPR were issued, thus no final determination has been made with respect to these days and the particular matters revised in the revised NPR did not include any of the 3,236 days at issue.[16] As these days were not part of the revised NPR final determination itself from which the Provider has appealed, the Board finds

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[15] 859 F. Supp. 2d at 146-47. *See also HCA Health Servs. of Okla., Inc. v. Shalala*, 27 F.3d 614, 620 (D.C. Cir. 1994) (stating: "In light of the explicit language in 42 C.F.R. § 405.1885 limiting reopenings to 'findings on matters at issue in [the original NPR]' and in 42 C.F.R. § 405.1889 characterizing revisions as 'separate and distinct determination[s]' for purposes of Board appeals, *we do not think it impermissible for the Secretary to interpret the 'intermediary determination' on reopening as limited to the particular matters revisited on the second go-round.*" (Emphasis added)); *French Hosp.*, 130 F.3d at 851-52 (stating "when Anaheim asked for the PRRB to review the revised NPR, it could only be asking the PRRB to review the *revisions* to the NPR, not the entire NPR or the RCL" (emphasis in original)).

[16] Tr. at 157-158.

that, pursuant to 42 C.F.R. § 405.1889, the Provider cannot be dissatisfied with those days. Therefore, the Board finds that it does not have jurisdiction over the Medicaid eligible days Forsyth has appealed from its revised NPR.

CONCLUSION:

The Board finds that, pursuant to 42 C.F.R. § 405.1889, it does not have jurisdiction over Forsyth because it is appealing from a revised NPR that did not specifically consider or adjust the Medicaid Eligible Days under appeal. Forsyth is therefore dismissed from the group appeal.

After the dismissal of Forsyth, the current CIRP group appeal will consist of only one Participant (Presbyterian). 42 C.F.R. § 405.1837(b)(1) sets forth the following requirements, in pertinent part, for mandatory group appeals (*i.e.,* CIRP group appeals):

> (i) Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, must bring the appeal as a group appeal.
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> (ii) One or more of the providers under common ownership or control may appeal more than one cost reporting period with respect to the issue that is the subject of the group appeal for purposes of meeting the $50,000 amount in controversy requirement, and, subject to the Board's discretion, may appeal more than one cost reporting period with respect to the issue that is the subject of the group appeal for other purposes, such as convenience.

As only one participant remains in the CIRP group appeal, it no longer meets the regulatory requirement of a CIRP group appeal. Therefore, the Board is converting the current appeal to an *individual* appeal. As such, the Board has revised the case number for this appeal from 08-2574GC to simply 08-2574 and all further communications will reference the revised case number. The Board will issue a determination as to the remaining provider, Presbyterian Hospital, 34-0053, under separate cover

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

BOARD MEMBERS PARTICIPATING:

Clayton J. Nix, Esq.
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FOR THE BOARD:

1/3/2019

X Clayton J. Nix

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

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

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RE: Novant Presbyterian Hospital
Provider No.: 34-0053
FYE: 12/31/2004
PRRB Case No: 08-2574

Dear Mr. Romano and Ms. Polson,

Novant Presbyterian Hospital ("Presbyterian") and Novant Forsyth Memorial Hospital ("Forsyth") each timely filed individual appeal requests with the Board for fiscal year ("FY") 2004. Presbyterian filed its request from a Notice of Program Reimbursement ("NPR") and Forsyth filed its request from a Revised Notice of Program Reimbursement. As part of both individual appeals, each Provider specifically challenged the accuracy of the Disproportionate Share Hospital ("DSH") payment.[1] The basis for each claim was the belief that the Medicare Contractor failed to include all of the Medicaid Eligible Days in the numerator of the Medicaid fraction of the DSH calculation.

As both Presbyterian and Forsyth are owned by a common organization, Novant Health ("Novant"), Presbyterian and Forsyth requested on August 8, 2008 to establish the current mandatory Common Issue Related Party Group ("CIRP") appeal, Case No. 08-2574GC, by way of transferring the Medicaid Eligible Days issue from their respective individual appeals. The Board held a hearing for 08-2574GC on May 12, 2016 in which the issue of jurisdiction over the participants was addressed. Under separate cover, the Board has found that it does not have jurisdiction over Forsyth's appeal from its revised NPR because it did not meet the dissatisfaction requirement. In that decision, the Board also indicated that, as Case No. 08-2574GC no longer met the regulatory requirements of a group appeal because only Presbyterian remains a participant, going forward the Board will refer to the appeal as Case No. 08-2574.

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 Presbyterian for fiscal year ("FY") 2004. Further, the

[1] The original individual appeal requests for FY 2004 included other issues. The Medicaid Eligible days issue was transferred to the current CIRP group.

Board declines to exercise its discretion under 42 U.S.C. § 1395oo(d) to hear this issue as part of Presbyterian's appeal. The Board's decision is set forth below.[2]

BACKGROUND

A. NOVANT'S FY 2004 APPEAL

In the instant appeal, Presbyterian appealed the following issue: "whether the [Medicare Contractor] properly included all eligible Medicaid days, regardless of whether such days were paid days, in the numerator of the Medicaid fraction of the DSH calculation."[3] Upon review of the days requested, the Medicare Contractor determined there were two types of days being requested. The Medicare Contractor agreed to resolve the issue regarding traditional unpaid Medicaid days, but refused to review or resolve the issue pertaining to Medicaid adolescent psychiatric days.[4]

In August 2018, the Medicare Contractor and Novant entered into a partial Administrative Resolution to resolve the traditional Medicaid eligible days issue as it relates to inpatient hospital days for provider number 34-0053, Presbyterian. The partial Administrative Resolution indicates that the Medicare Contractor has not reviewed additional Medicaid eligible days occurring in Presbyterian's adolescent psychiatric unit, and that issue is the sole issue now before the Board in this appeal.

B. FACTS FROM FY 2001/2002 APPEAL APPLICABLE TO FY 2004 APPEAL

Novant previously appealed the same issue for Presbyterian for FYs 2001 and 2002.[5] In those appeals, the Board held one hearing and issued a decision finding that it did not have jurisdiction over the adolescent psychiatric days because, due to choice, error, and/or inadvertence, Presbyterian 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.[6]

At the hearing for FY 2004, Novant submitted into the record exhibits from the FY 2001 and 2002 appeals, including statements regarding jurisdiction as well as the transcript from that hearing.[7] Additionally, Novant's witness testified that this appeal involves the same provider (*i.e.*, Presbyterian), the same state Medicaid agency of North Carolina, and confirmed that there is ***no*** difference between the FY 2001/2002 appeals (one hearing was held for both FYs) and this appeal with respect to the matching process and the issue of practical impediments.[8] Therefore, the Board will include the background information and jurisdictional arguments presented in the

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[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 6-7.
[4] Tr. at 82-87.
[5] *See generally* Attachment A (PRRB Case Nos. 06-1851 & 06-1852 (Nov. 17, 2017)).
[6] *Id.* at 7.
[7] Tr. at 8.
[8] Tr. at 29-30.

FYs 2001 and 2002 appeals and hearing, as Novant has indicated that the arguments still apply for the current FY 2004 appeal. To facilitate its discussion of the FYs 2001 and 2002 appeals, the Board has marked as "Attachment A" a copy of the jurisdictional decision it issued for FYs 2001 and 2002.

At the hearing for FYs 2001 and 2002, Novant recognized that the Medicaid adolescent psychiatric days at issue were not included on the Presbyterian's cost reports for FYs 2001 and 2002[9] and asserted that, prior to issuing the NPRs, the Medicare Contractor made no adjustment to any category of Medicaid eligible days.[10] Although there is no discrepancy that an audit adjustment was not made for FY 2002, the Medicare Contractor documented that the FY 2001 NPR issued in December 2005 included an audit adjustment to increase Medicaid eligible days for FY 2001 by 1033 days.[11] Novant filed appeals with the Board, generically appealing Medicaid eligible days.[12]

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 Presbyterian's 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.[13]

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 Presbyterian's adolescent psychiatric unit. The Medicare Contractor refused to include any of the additional Medicaid days associated with the adolescent psychiatric unit because it "contend[ed] 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."[14]

Novant stated that CMS promulgated regulations to implement the DSH statute through the interim final rule published on May 6, 1986 ("May 1986 Interim Final Rule")[15] and the final rule on September 3, 1986 ("September 1986 Final Rule").[16] Novant asserted 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. 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 pointed 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

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[9] Exhibit P-19 at 11 (copy of the transcript from the Sept. 25, 2015 Hearing for FYs 2001 and 2002).
[10] Attachment A at 1-2 n.4.
[11] *Id.* at 2 n.5.
[12] *Id.* at 2.
[13] *Id.* at 2 n.7.
[14] *Id.* at 2 n.8.
[15] *See* 51 Fed. Reg. 16772 (May 6, 1986).
[16] *See* 51 Fed. Reg. 31454 (Sept. 3, 1986).

and separate and distinct from the actual DSH adjustment.[17] Thus, Novant asserted that the Board had jurisdiction over these cases because Novant is *generally* dissatisfied with the Medicare Contractor's determination of its Medicaid eligible days.[18]

Novant recognized, however, that the Board may require something more than general dissatisfaction. Specifically, Novant recognized 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.[19] In this regard, Novant contended for the cost years at issue that it 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 were 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.[20] Specifically, Novant identified the following practical impediments and claimed that they prevented it from identifying the Medicaid eligible adolescent psychiatric days at the time of filing Presbyterian's 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.[21]

2. *Inability to Exactly Match the North Carolina Medicaid Database.*—Novant further emphasized 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").[22]

3. *Difficulty in identifying Medicaid eligibility when Medicaid is not primary.*—Novant contended 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. Novant contended however, a more complex

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[17] Attachment A at 2 n.11.
[18] *Id.* at 2.
[19] *Id.* at 3 n.13.
[20] *Id.* at 3 n.14.
[21] *Id.* at 3 n.15.
[22] *Id.* at 3 n.16.

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.[23]

4. *Uncooperative patients*.—Novant summarized 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).[24]

Based on these practical impediments, Novant contended 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.[25]

The Board issued a decision finding that it did not have jurisdiction over the adolescent psychiatric days because, due to choice, error, and/or inadvertence, Novant failed to identify and include the days at issue on Presbyterian's as-filed cost reports or the new listings submitted during the desk review process.[26]

BOARD'S DECISION ON THE NOVANT PRESBYTERIAN FY 2004 APPEAL

As with the previous FY 2001 and 2002 appeals, 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*"),[27] 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.[28] 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.[29]

Novant in this case failed to claim the Medicaid adolescent psychiatric days at issue on Presbyterian's as-filed cost report for FY 2004. The Board 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.

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[23] *Id.* at 3 n.17.
[24] *Id.* at 4 n.18.
[25] *Id.* at 4 n.19.
[26] *Id.* at 7.
[27] PRRB Dec. No. 2013-D39 at 13-16 (Sept. 13, 2013), *declined review*, CMS Adm'r (Oct. 25, 2013).
[28] *Id.* at 13.
[29] *See id.* at 15.

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 Blue Shield Ass'n* ("*Norwalk*")[30] and *Danbury Hosp. v. Blue Cross Blue Shield Ass'n* ("*Danbury*"),[31] 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.[32] 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 "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."[33]

At the hearing for the current appeal, the Board requested that Novant identify post-hearing how many, if any, adolescent psychiatric days were claimed on Presbyterian's as-filed cost report for FY 2004.[34] Notwithstanding this request, Novant's post hearing brief does not indicate whether or not it claimed any adolescent psychiatric days on the FY 2004 as-filed cost report. Although Novant submitted listings with additional Medicaid eligible days, including adolescent psychiatric days, these listings were submitted subsequent to the as-filed cost report and, based on the record before it, the Board must find that Novant did not submit any of these adolescent psychiatric days to the Medicare Contractor prior to the issuance of Presbyterian's FY 2004 NPR.

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. However, while Novant has identified these practical impediments, the Board cannot put them in the proper

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[30] PRRB Dec. No. 2012-D14, (Mar. 19, 2012), *vacated*, CMS Adm'r Dec. (May 21, 2012).
[31] PRRB Dec. No.2014-D03 (Feb. 11, 2014), *declined review*, CMS Adm'r (Mar. 26, 2014).
[32] 42 C.F.R. § 412.106(b)(4)(iii). *See also Danbury*, PRRB Dec. No. 2014-D03 at 13, 15; *Norwalk*, PRRB Dec. No. 2012-D14 at 6.
[33] *Bethesda*, 485 U.S. at 404. *See also Danbury*, PRRB Dec. No. 2014-D03 at 15-18.
[34] Tr. at 37, 61-62, 91.

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 disagrees with Novant's assertion that the testimony from its consultant in the FY 2001 and 2002 appeals, which was incorporated into and relied upon for the current appeal,[35] provided an adequate description of the process that Novant used to identify and report Medicaid eligible days on its as-filed cost reports.[36] The record is clear that Novant's consultant was *not* involved with Novant until after the FY 2001 and 2002 appeals were filed and, as such, had no direct knowledge of the process that Novant used for them. The record similarly confirms that Novant's consultant could not have been involved with the FY 2004 cost report filing since the consultant was not engaged when the FY 2004 cost report was filed in 2005.[37]

Moreover, even if Novant's consultant had provided an accurate description of the process Novant used to report days on Presbyterian's as-filed cost reports, it would not have been adequate because: (1) Novant admits that it billed services furnished in Presbyterian's adolescent psychiatric unit using Presbyterian's Medicare excluded unit billing number;[38] 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 process.[39] 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 as-filed cost reports 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.[40]

Indeed, it is the cloud surrounding Novant's alleged misrepresentation of Presbyterian's 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*[41] where the Board was dealing

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[35] *See* Tr. at 8, 36-41. A Novant witness testified that that there is ***no*** difference between the FY 2001 and FY 2002 appeals and this appeal with respect to the matching process and the issue of practical impediments. Tr. at 29-30.
[36] *See* Attachment A at 5 n.25.
[37] Exhibit P-19 at 443-444 (Novant witness confirming that she was not involved with Novant until sometime after the NPR for FY 2002 dated December 20, 2005 *and* after this FY 2002 NPR had been appealed to the Board).
[38] Exhibit P-19 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"); Exhibit P-19 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").
[39] Exhibit P-19 at 467-468. *See also id.* 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."); *id.* 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."); *id.* 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.").
[40] *See id.* at 444-447 (Novant witness stating: "And so I don't know what happened to that period"). *See also id.* at 119-120 (Novant witness confirming there was no adjustment for these cost years, on the issue of adolescent psych days.)
[41] PRRB Dec. No. 2015-D05 (Mar. 19, 2015), *declined review*, CMS Adm'r (Apr. 22, 2015).

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 Presbyterian's 20-bed adolescent psychiatric unit was an excluded Medicare unit.[42] As a result, Novant claims there has been a history of incorrectly attesting that Presbyterian's IPPS exempt beds totaled 60 (*i.e.*, the 40 bed adult psychiatric unit plus the 20-bed adolescent psychiatric unit).[43]

(2) Novant admits that it used Presbyterian's 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 Presbyterian's psychiatric units (*i.e.*, use one billing number for both the exempt and non-exempt psychiatric units).[44]

Once the extent of Novant's self-professed internal confusion and inconsistencies are appreciated, it is not surprising then that Novant failed to report the universe of Medicaid adolescent psychiatric days during the cost reporting process for FY 2004. In this same vein, it stretches credulity to believe that, prior to filing the as-filed cost reports for FY 2004, Novant had not received payment and remittance advices from North Carolina Medicaid on virtually *any* of the universe of Presbyterian's Medicaid adolescent psychiatric days for FY 2004, and that Novant essentially had no internal records on the Medicaid eligibility for the universe of Presbyterian's Medicaid adolescent psychiatric days for FY 2004.

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 for Presbyterian or the new listings submitted during the desk review process for Presbyterian. 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)

Presbyterian's original appeal request filed with Board included other issues for which the Board had jurisdiction under 42 U.S.C. § 1395oo(a), including the Medicaid eligible days that the parties resolved through an Administrative Resolution. As such, the Board has jurisdiction over

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[42] *See* Attachment A at 6 n.30.
[43] *See Id.* at 6 n.31.
[44] *See id.* at 6 n.32.

Presbyterian'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*,[45] 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 Presbyterian's adolescent psychiatric Medicaid days at issue for FY 2004 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 for FY 2004.[46]

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 2004 for Presbyterian. 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 Presbyterian's NPR for FY 2004. This appeal is now closed.

BOARD MEMBERS PARTICIPATING:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, C.P.A., CPC-A

FOR THE BOARD:

1/4/2019

X Clayton J. Nix

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

Enclosure: Attachment A – Copy of the Board's jurisdictional decision dated Nov. 17, 2017

cc: Wilson Leong, Federal Specialized Services

[45] PRRB Dec. No. 2013-D39 at 15.
[46] Note that 42 C.F.R. § 405.1869(a) as revised in May 2008 to limit the Board's discretionary authority under 42 U.S.C. § 1395oo(d) is not applicable to the time period at issue in this appeal.

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RE: Jurisdictional Determination
Beacon Health Rehab LIP Appeals
Provider Nos.: Various
FYEs: 2008-2009
PRRB Case Nos.:
15-2834GC - Beacon Health 2008 Rehab Medicare Fraction Dual Eligible CIRP Group
15-2851GC - Beacon Health 2009 Rehab Medicare Fraction Dual Eligible CIRP Group

Dear Ms. Elias and Mr. Lamprecht:

This case involves the Providers' appeals of its Medicare reimbursement for the fiscal years ending ("FYE") in 2008 and 2009. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' documentation on its own motion in response to the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar*, on June 8, 2018 ("*Mercy*").[1] Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Providers' Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") reimbursement issue and dismisses the instant appeals.

Pertinent Facts

On June 7, 2015 and June 16, 2015, the Board received the group representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR"), corresponding to fiscal years ending in 2008 and 2009. In its RFHs, the Providers' list a single issue for appeal — the calculation of the Medicare percentage associated with the Low-Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

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

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2012), a provider has a right to a Board hearing with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date of receipt of the final determination. Under 42 C.F.R. § 405.1835(a)(1) (2012), a provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either: (i) including a claim for the specific item 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 by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be in accordance with Medicare policy.

Rehab Days in LIP Adjustment Calculations

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

In *Mercy*, the Court describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year."[2] One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The Court in *Mercy* affirmed the United States District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[3] The Court of Appeals concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[4]

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[2] *Mercy*, 891 F.3d at 1064.

[3] *Mercy Hosp., Inc. v. Burwell*, No. 15-1236 (JDB), 2016 WL 4007072, at *8 (D.D.C. July 25, 2016).

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

In the instant appeals, the Providers seek Board review of one of the components utilized by the Medicare Contractor to determine the Provider's LIP adjustment, namely its SSI—or Medicare—Ratio. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the issue in the instant appeals that challenge this adjustment. In making this finding, the Board notes that the Court of Appeals decision in *Mercy* is controlling precedent for the interpretation of the statutory provisions at issue because the Providers could bring suit in the D.C. Circuit.[5]

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

Board Members Participating:

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

For the Board:

1/4/2019

X Clayton J. Nix

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

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

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

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Byron Lamprecht
WPS Government Health Administrators
2525 N 117th Avenue, Suite 200
Omaha, NE 68164

RE: Jurisdictional Determination
FYE: 2011
PRRB Case No.: 16-1362GC - Beaumont Health 2011 Rehab LIP Dual Eligible Days CIRP Group

Dear Ms. O'Brien Griffin and Mr. Lamprecht:

This case involves the Providers' appeals of its Medicare reimbursement for the fiscal year ending ("FYE") in 2011. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' documentation on its own motion in response to the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar* on June 8, 2018 ("*Mercy*").[1] Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Providers' Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") reimbursement issue and dismisses the instant appeals.

Pertinent Facts

On March 29, 2016, the Board received the group representative's request for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR"), corresponding to FYE ending in 2011. In its RFH, the Providers list a single issue for appeal — the calculation of the Medicare percentage associated with the Low-Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2012), a provider has a right to a Board hearing with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is

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

$10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date of receipt of the final determination. Under 42 C.F.R. § 405.1835(a)(1) (2012), a provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either (i) including a claim for the specific item 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 by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be in accordance with Medicare policy.

Rehab Days in LIP Adjustment Calculations

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

In *Mercy*, the Court describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year."[2] One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The Court in *Mercy* affirmed the United States District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[3] The Court of Appeals concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[4]

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[2] *Mercy*, 891 F.3d at 1064.
[3] *Mercy Hosp., Inc. v. Burwell*, No. 15-1236 (JDB), 2016 WL 4007072, at *8 (D.D.C. July 25, 2016).
[4] *Mercy*, 891 F.3d at 1068.

In the instant appeals, the Providers seek Board review of one of the components utilized by the Medicare Contractor to determine the Provider's LIP adjustment, namely its SSI—or Medicare—Ratio. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the issue in the instant appeals that challenge this adjustment. In making this finding, the Board notes that the Court of Appeals decision in *Mercy* is controlling precedent in the interpretation of the statutory provisions at issue because the Providers could bring suit in the D.C. Circuit.[5]

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

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
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For the Board:

1/4/2019

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

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

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2525 N 117th Avenue, Suite 200
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RE: Jurisdictional Determination
FYEs: 2015
PRRB Case Nos.: 18-1741GC - McLaren Health CY 2015 LIP SSI Fraction Dual Eligible Days CIRP Group

Dear Ms. Griffin and Mr. Lamprecht:

This case involves the Providers' appeals of its Medicare reimbursement for the fiscal years ending ("FYE") in 2015. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' documentation on its own motion in response to the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar* on June 8, 2018 ("*Mercy*").[1] Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Providers' Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") reimbursement issue and dismisses the instant appeals.

Pertinent Facts

On September 24, 2018, the Board received the group representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR"), corresponding to FYEs ending in 2015. In its RFHs, the Providers list a single issue for appeal — the calculation of the Medicare percentage associated with the Low-Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2012), a provider has a right to a Board hearing with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is

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

$10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date of receipt of the final determination. Under 42 C.F.R. § 405.1835(a)(1) (2012), a provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either (i) including a claim for the specific item 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 by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be in accordance with Medicare policy.

Rehab Days in LIP Adjustment Calculations

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

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

In the instant appeals, the Providers seek Board review of one of the components utilized by the Medicare Contractor to determine the Provider's LIP adjustment, namely its SSI—or Medicare—Ratio. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the issue in the instant appeals that challenge this adjustment. In making this finding, the Board notes that the Court of Appeals decision in *Mercy* is controlling precedent in the interpretation of the statutory provisions at issue because the Providers could bring suit in the D.C. Circuit.[5]

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

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For the Board:

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

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Omaha, NE 68164

RE: Jurisdictional Determination
FYEs: 2008-2009, 2015
PRRB Case Nos.:
15-2846GC - IU Health 2008 Rehab Medicare Fraction Dual Eligible Days CIRP Group
15-2829GC - IU Health 2009 Rehab Medicare Fraction Dual Eligible CIRP Group
18-1722GC - Indiana University CY 2015 Rehab LIP SSI Ratio Dual Eligible Days CIRP Group

Dear Ms. Elias and Mr. Lamprecht:

This case involves the Providers' appeals of its Medicare reimbursement for the fiscal years ending ("FYE") in 2008, 2009, and 2015. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' documentation on its own motion in response to the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar* on June 8, 2018 ("*Mercy*").[1] Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Providers' Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") reimbursement issue and dismisses the instant appeals.

Pertinent Facts

On June 16, 2015, and September 20, 2018, the Board received the group representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR"), corresponding to FYEs ending in 2008, 2009, and 2015. In its RFHs, the Providers list a single issue for appeal — the calculation of the Medicare percentage associated with the Low-Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

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

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2012), a provider has a right to a Board hearing with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date of receipt of the final determination. Under 42 C.F.R. § 405.1835(a)(1) (2012), a provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either (i) including a claim for the specific item 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 by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be in accordance with Medicare policy.

Rehab Days in LIP Adjustment Calculations

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

In *Mercy*, the Court describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year."[2] One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The Court in *Mercy* affirmed the United States District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[3] The Court of Appeals concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[4]

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[2] *Mercy*, 891 F.3d at 1064.

[3] *Mercy Hosp., Inc. v. Burwell*, No. 15-1236 (JDB), 2016 WL 4007072, at *8 (D.D.C. July 25, 2016).

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

In the instant appeals, the Providers seek Board review of one of the components utilized by the Medicare Contractor to determine the Provider's LIP adjustment, namely its SSI---or Medicare---Ratio. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the issue in the instant appeals that challenge this adjustment. In making this finding, the Board notes that the Court of Appeals decision in *Mercy* is controlling precedent in the interpretation of the statutory provisions at issue because the Providers could bring suit in the D.C. Circuit.[5]

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

Board Members Participating:

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

For the Board:

1/4/2019

X Clayton J. Nix

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

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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500 N. Meridian St., Suite 400
Indianapolis, IN 46204

Byron Lamprecht
WPS Government Health Administrators
2525 N 117th Avenue, Suite 200
Omaha, NE 68164

RE: Jurisdictional Determination
Provider Nos.: Various
FYEs: 2007
PRRB Case Nos.: 15-2822GC - Trinity Health 2007 Rehab Medicare Fraction Dual Eligible CIRP Group

Dear Ms. Griffin and Mr. Lamprecht:

This case involves the Providers' appeals of its Medicare reimbursement for the fiscal years ending ("FYE") in 2007. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' documentation on its own motion in response to the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar* on June 8, 2018 ("*Mercy*").[1] Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Providers' Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") reimbursement issue and dismisses the instant appeals.

Pertinent Facts

On June 11, 2015, the Board received the group representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR"), corresponding to FYEs ending in 2007. In its RFHs, the Providers list a single issue for appeal — the calculation of the Medicare percentage associated with the Low-Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2012), a provider has a right to a Board hearing with respect to costs claimed on a timely filed cost report if it is

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

dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date of receipt of the final determination. Under 42 C.F.R. § 405.1835(a)(1) (2012), a provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either (i) including a claim for the specific item 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 by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be in accordance with Medicare policy.

Rehab Days in LIP Adjustment Calculations

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

In *Mercy*, the Court describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year."[2] One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The Court in *Mercy* affirmed the United States District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[3] The Court of Appeals concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[4]

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[3] *Mercy Hosp., Inc. v. Burwell*, No. 15-1236 (JDB), 2016 WL 4007072, at *8 (D.D.C. July 25, 2016).

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

In the instant appeals, the Providers seek Board review of one of the components utilized by the Medicare Contractor to determine the Provider's LIP adjustment, namely its SSI—or Medicare—Ratio. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the issue in the instant appeals that challenge this adjustment. In making this finding, the Board notes that the Court of Appeals decision in *Mercy* is controlling precedent in the interpretation of the statutory provisions at issue because the Providers could bring suit in the D.C. Circuit.[5]

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

Board Members Participating:

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

For the Board:

1/4/2019

X Clayton J. Nix

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

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

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WPS Government Health Administrators
2525 N 117th Avenue, Suite 200
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Judith Cummings
CGS Audit & Reimbursement
P.O. Box 20020
Nashville, TN 37202

RE: Jurisdictional Determination
Quorum Health Rehab LIP Appeals
FYEs: 2013-2016
PRRB Case Nos.:
18-0036GC - Quorum Health 2013-2014 LIP Post 1498R SSI Data Match CIRP Group
17-1882GC - Quorum Health 2015 LIP SSI Fraction Dual Eligible Days CIRP Group
19-0041GC - Quorum Health CY 2016 LIP SSI Fraction Dual Eligible Days CIRP Group

Dear Ms. O'Brien Griffin, Mr. Lamprecht, and Ms. Cummings:

This case involves the Providers' appeals of its Medicare reimbursement for the fiscal years ending ("FYE") in 2013-2016. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' documentation on its own motion in response to the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar* on June 8, 2018 ("*Mercy*").[1] Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Providers' Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") reimbursement issue and dismisses the instant appeals.

Pertinent Facts

On July 20, 2017, October 3, 2017, and October 15, 2018, the Board received the group representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR"), corresponding to FYE ending in 201through 2016. In its RFHs, the Providers list a single issue for appeal — the calculation of the Medicare percentage associated with the Low-Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

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

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2012), a provider has a right to a Board hearing with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date of receipt of the final determination. Under 42 C.F.R. § 405.1835(a)(1) (2012), a provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either (i) including a claim for the specific item 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 by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be in accordance with Medicare policy.

Rehab Days in LIP Adjustment Calculations

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

In *Mercy*, the Court describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year."[2] One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The Court in *Mercy* affirmed the United States District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[3] The Court of Appeals concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory

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[3] *Mercy Hosp., Inc. v. Burwell*, No. 15-1236 (JDB), 2016 WL 4007072, at *8 (D.D.C. July 25, 2016).

adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[4]

In the instant appeals, the Providers seek Board review of one of the components utilized by the Medicare Contractor to determine the Provider's LIP adjustment, namely its SSI—or Medicare—Ratio. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the issue in the instant appeals that challenge this adjustment. In making this finding, the Board notes that the Court of Appeals decision in *Mercy* is controlling precedent in the interpretation of the statutory provisions at issue because the Providers could bring suit in the D.C. Circuit.[5]

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

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
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Robert A. Evarts, Esq.
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For the Board:

1/4/2019

X Clayton J. Nix

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

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

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500 N. Meridian St., Suite 400
Indianapolis, IN 46204

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

RE: Jurisdictional Determination
FYE: 2009 -
PRRB Case Nos.: 15-2850GC - ProMedica HS 2009 Rehab Medicare Fraction Dual Eligible Days CIRP Group

Dear Ms. Elias and Ms. Cummings:

This case involves the Providers' appeals of its Medicare reimbursement for the fiscal years ending ("FYE") in 2009. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' documentation on its own motion in response to the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar* on June 8, 2018 ("*Mercy*").[1] Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Providers' Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") reimbursement issue and dismisses the instant appeals.

Pertinent Facts

On June 16, 2015, the Board received the group representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR"), corresponding to FYEs ending in 2009. In its RFHs, the Providers list a single issue for appeal — the calculation of the Medicare percentage associated with the Low-Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2012), a provider has a right to a Board hearing with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is

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$10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date of receipt of the final determination. Under 42 C.F.R. § 405.1835(a)(1) (2012), a provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either (i) including a claim for the specific item 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 by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be in accordance with Medicare policy.

Rehab Days in LIP Adjustment Calculations

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy*, answers this question and clarifies what is shielded from review in its analysis of this issue.[2]

In *Mercy*, the Court describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year."[3] One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The Court in *Mercy* affirmed the United States District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[4] The Court of Appeals concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[5]

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In the instant appeals, the Providers seek Board review of one of the components utilized by the Medicare Contractor to determine the Provider's LIP adjustment, namely its SSI—or Medicare—Ratio. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the issue in the instant appeals that challenge this adjustment. In making this finding, the Board notes that the Court of Appeals decision in *Mercy* is controlling precedent in the interpretation of the statutory provisions at issue because the Providers could bring suit in the D.C. Circuit.[6]

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

Board Members Participating:

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

For the Board:

1/4/2019

X Clayton J. Nix

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

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

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Byron Lamprecht
WPS Government Health Administrators
2525 N 117th Avenue, Suite 200
Omaha, NE 68164

RE: Jurisdictional Determination
FYEs: 2009-2011
PRRB Case Nos.:
18-1452GC - Ascension Health 2009 Rehab LIP Medicare/Medicaid Part C Days CIRP
18-1453GC - Ascension Health 2010 Rehab LIP Medicare/Medicaid Part C Days CIRP
18-1574GC - Ascension Health 2011 LIP SSI Fraction Dual Eligible Days CIRP Group

Dear Ms. O'Brien Griffin and Mr. Lamprecht:

This case involves the Providers' appeals of its Medicare reimbursement for the fiscal years ending ("FYE") in 2009 through 2011. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' documentation on its own motion in response to the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar* on June 8, 2018 ("*Mercy*").[1] Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Providers' Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") reimbursement issue and dismisses the instant appeals.

Pertinent Facts

On July 12, 2018, July 16, 2018, and August 6, 2018, the Board received the group representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR"), corresponding to FYEs ending in 2009 to 2011. In its RFHs, the Providers list a single issue for appeal — the calculation of the Medicare percentage associated with the Low-Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2012), a provider has a right to a Board hearing with respect to costs claimed on a timely filed cost report if it is

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dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date of receipt of the final determination. Under 42 C.F.R. § 405.1835(a)(1) (2012), a provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either (i) including a claim for the specific item 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 by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be in accordance with Medicare policy.

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

In the instant appeals, the Providers seek Board review of one of the components utilized by the Medicare Contractor to determine the Provider's LIP adjustment, namely its SSI—or Medicare—Ratio. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the issue in the instant appeals that challenge this adjustment. In making this finding, the Board notes that the Court of Appeals decision in *Mercy* is controlling precedent in the interpretation of the statutory provisions at issue because the Providers could bring suit in the D.C. Circuit.[5]

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

Board Members Participating:

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

For the Board:

1/4/2019

X Clayton J. Nix

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

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

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DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Byron Lamprecht
WPS Government Health Administrators
2525 N 117th Avenue, Suite 200
Omaha, NE 68164

RE: Jurisdictional Determination
Hall Render Rehab LIP Appeals
FYEs: 2015-2016
PRRB Case Nos.:
18-1809G - Hall Render CY 2016 Rehab SSI Post-1498 Data Match Group
18-1561G - Hall Render 2015 LIP SSI Fraction Dual Eligible Days Group

Dear Ms. O'Brien Griffin and Mr. Lamprecht:

This case involves the Providers' appeals of its Medicare reimbursement for the fiscal years ending ("FYE") in 2015 and 2016. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' documentation on its own motion in response to the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar* on June 8, 2018 ("*Mercy*").[1] Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Providers' Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") reimbursement issue and dismisses the instant appeals.

Pertinent Facts

On July 30, 2018, and September 7, 2018, the Board received the group representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR"), corresponding to FYEs ending in 2015 and 2016. In its RFHs, the Providers list a single issue for appeal — the calculation of the Low-Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2012), a provider has a right to a Board hearing with respect to costs claimed on a timely filed cost report if it is

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

dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date of receipt of the final determination. Under 42 C.F.R. § 405.1835(a)(1) (2012), a provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either (i) including a claim for the specific item 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 by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be in accordance with Medicare policy.

Rehab Days in LIP Adjustment Calculations

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

In *Mercy*, the Court describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year."[2] One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The Court in *Mercy* affirmed the United States District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[3] The Court of Appeals concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[4]

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[2] *Mercy*, 891 F.3d at 1064.

[3] *Mercy Hosp., Inc. v. Burwell*, No. 15-1236 (JDB), 2016 WL 4007072, at *8 (D.D.C. July 25, 2016).

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

In the instant appeals, the Providers seek Board review of one of the components utilized by the Medicare Contractor to determine the Provider's LIP adjustment, namely its SSI—or Medicare—Ratio. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the issue in the instant appeals that challenge this adjustment. In making this finding, the Board notes that the Court of Appeals decision in *Mercy* is controlling precedent in interpreting the statutory provisions at issue because the Providers could bring suit in the D.C. Circuit.[5]

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

Board Members Participating:

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

For the Board:

1/4/2019

X Clayton J. Nix

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

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

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Elizabeth Elias
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500 N. Meridian St., Suite 400
Indianapolis, IN 46204

Byron Lamprecht
WPS Government Health Administrators
2525 N 117th Avenue, Suite 200
Omaha, NE 68164

RE: Jurisdictional Determination
FYEs: 2016
PRRB Case Nos.:
18-1690GC - Community Healthcare CY 2016 Rehab Part C Days CIRP Group
18-1694GC - Community Healthcare CY 2016 Rehab SSI Ratio Dual Eligible CIRP
18-1695GC - Community Healthcare CY 2016 Rehab SSI Data Match CIRP Group

Dear Ms. Elias and Mr. Lamprecht:

This case involves the Providers' appeals of its Medicare reimbursement for the fiscal years ending ("FYE") in 2016. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' documentation on its own motion in response to the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar* on June 8, 2018 ("*Mercy*").[1] Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Providers' Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") reimbursement issue and dismisses the instant appeals.

Pertinent Facts

On August 30, 2018, the Board received the group representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR"), corresponding to FYEs ending in 2016. In its RFHs, the Providers list a single issue for appeal — the calculation of the Low-Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2012), a provider has a right to a Board hearing with respect to costs claimed on a timely filed cost report if it is

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dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date of receipt of the final determination. Under 42 C.F.R. § 405.1835(a)(1) (2012), a provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either (i) including a claim for the specific item 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 by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be in accordance with Medicare policy.

Rehab Days in LIP Adjustment Calculations

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

In *Mercy*, the Court describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year."[2] One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The Court in *Mercy* affirmed the United States District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[3] The Court of Appeals concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[4]

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In the instant appeals, the Providers seek Board review of one of the components utilized by the Medicare Contractor to determine the Provider's LIP adjustment, namely its SSI—or Medicare—Ratio. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the issue in the instant appeals that challenge this adjustment. In making this finding, the Board notes that the Court of Appeals decision in *Mercy* is controlling precedent in the interpretation of the statutory provisions at issue because the Providers could bring suit in the D.C. Circuit.[5]

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

Board Members Participating:

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

For the Board:

1/4/2019

X Clayton J. Nix

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

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

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DEPARTMENT OF HEALTH & HUMAN SERVICES

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

John Bloom
Noridian Healthcare Solutions
JF Provider Audit Appeals
P.O. Box 6722
Fargo, ND 58108

RE: Jurisdictional Determination
QRS Providence Rehab Lip Appeals
Provider Nos.: Various
FYEs: 2011, 2014, 2015
PRRB Case Nos.:
17-1286GC – QRS Providence 2011 LIP SSI Percentage CIRP Group
17-2116GC – QRS Providence 2014 LIP No Pay Part A CIRP Group
17-2117GC – QRS Providence 2014 LIP SSI Dual Eligible CIRP Group
17-2119GC – QRS Providence 2014 LIP SSI Part C CIRP Group
17-2120GC – QRS Providence 2014 LIP SSI Systemic CIRP Group
18-0274GC – QRS Providence 2015 LIP SSI Systemic CIRP Group

Dear Mr. Ravindran and Mr. Bloom:

This case involves the Providers' appeals of its Medicare reimbursement for the fiscal years ending ("FYE") in 2011 through 2015. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' documentation on its own motion in response to the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar* on June 8, 2018 ("*Mercy*").[1] Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Providers' Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") reimbursement issue and dismisses the instant appeals.

Pertinent Facts

On March 30, 2017, August 28, 2017, and November 27, 2017, the Board received the group representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR"), corresponding to FYEs ending in 2011-2015. In its RFH, the Providers' list a single issue for appeal — the calculation of the Low-Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

Board's Analysis and Decision

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

Applicable Regulatory Provisions and Board Rules

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2012), a provider has a right to a Board hearing with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date of receipt of the final determination. Under 42 C.F.R. § 405.1835(a)(1) (2012), a provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either (i) including a claim for the specific item 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 by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be in accordance with Medicare policy.

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

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In the instant appeals, the Providers seek Board review of one of the components utilized by the Medicare Contractor to determine the Provider's LIP adjustment, namely its SSI—or Medicare—Ratio. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the issue in the instant appeals that challenge this adjustment. In making this finding, the Board notes that the Court of Appeals decision in *Mercy* is controlling precedent in the interpretation of the statutory provisions at issue because the Providers could bring suit in the D.C. Circuit.[5]

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

Board Members Participating:

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

For the Board:

1/10/2019

X Clayton J. Nix

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

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DEPARTMENT OF HEALTH & HUMAN SERVICES

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Baltimore, MD 21207
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Stephanie A. Webster
Akin Gump Strauss Hauer & Feld, LLP
1333 New Hampshire Avenue, NW
Washington, DC 20036-1564

RE: ***Jurisdictional Decision***
New York Presbyterian/Lawrence Hospital (33-0061)
FYE: 12/31/2014
PRRB Case: 17-2149

Dear Ms. Webster,

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

Pertinent Facts:

The Provider filed an Individual Appeal Request on September 1, 2017, and a subsequent Request to Add Issues to Individual Appeal on October 27, 2017. The sole remaining issue in the appeal is a challenge to the DSH payment for uncompensated care costs ("UCC"), and the final rules governing those determinations,[1] including the provisions governing the determination of the aggregate payment amounts available to all qualifying hospitals.[2]

The Provider is challenging the calculations used by the Secretary to determine their DSH UCC payment amounts for Federal Fiscal Year 2014. The Provider contends that the Secretary's determinations and rule are arbitrary, capricious, reflect an abuse of discretion, are not based upon substantial evidence, violate the notice and comment rulemaking requirements prescribed by the Medicare Act and the Administrative Procedure Act, and are otherwise contrary to law.[3]

The Medicare Contractor ("MAC") filed a Jurisdictional Challenge on June 29, 2018, claiming this issue is barred from administrative and judicial review per 42 U.S.C. § 1395ww(r)(3), 42 C.F.R. § 412.106(g)(2), and the *Tampa General*[4] case.[5] They emphasize that the estimates used by the Secretary, as well as the underlying data used to generate those estimates, are both precluded from review and that the Board should dismiss this appeal for lack of subject matter jurisdiction.[6]

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[1] 78 Fed. Reg. 50496 (Aug. 14, 2013).
[2] Provider's Preliminary Position Paper at 1 (May 1, 2018).
[3] *Id.*
[4] *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.*, 830 F.3d 515 (D.C. Cir. 2016).
[5] *See* Medicare Administrative Contractor's Jurisdictional Challenge (June 29, 2018).
[6] *Id.* at 6.

The Provider filed a Response to the MAC's Jurisdictional Challenge on July 20, 2018, arguing that administrative review of the final payment amounts of the DSH UCC are not precluded by statute, and that only select components of the methodology for deriving those final amounts are precluded.[7] Specifically, they claim that a "limited reading of the preclusion clause" is appropriate when considering what constitutes the "estimates of the Secretary" and "periods selected by the Secretary."[8] Provider insists that they are not challenging an "estimate" of the Secretary, and that challenging the underlying data related to the estimate distinguishes their challenge from one of the actual estimate, because an "estimate[, which is precluded from review,] is a value projected from the data, not the actual data."[9] Finally, Provider states that, if the review of the DSH UCC payment amounts is precluded by law, they should still be permitted to pursue general declaratory relief related to the rules governing the methodology for determining the DSH UCC payment amounts,[10] or whether the estimate made was *ultra vires*.[11]

Board's Decision:

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). Based on these provisions, judicial and administrative review is not available under 42 U.S.C. §§ 1395ff and 1395oo for:

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[12]
(B) Any period selected by the Secretary for such purposes.

Further, the D.C. Circuit Court[13] upheld the D.C. District Court's decision[14] that there is no judicial or administrative review of uncompensated care DSH payments. In *Tampa General*, the Provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The Provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The Provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The District Court found that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update

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[7] Provider's Response to MAC's Jurisdictional Challenge, 1 (July 20, 2018).
[8] *Id.* at 14.
[9] *Id.* at 22.
[10] *Id.* at 25-26.
[11] *Id.* at 27.
[12] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.
[13] *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.*[13]("*Tampa General*"), 830 F.3d 515 (D.C. Cir. 2016).
[14] 89 F. Supp. 3d 121 (D.D.C. 2015).

data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[15] The Court also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[16]

The Board finds that the same findings are applicable to the Provider's challenge to their 2014 uncompensated care payments. As in *Tampa General*, the Provider here is challenging the calculation of the amount they received for uncompensated care for FY 2014. The Board finds that, in challenging the MAC's calculation of their uncompensated care final payment amounts, the Provider is seeking review of an "estimate" used by the Secretary to determine the factors used to calculate their final payment amounts. The Board therefore finds that the Provider is challenging the underlying data relied on by the Secretary to obtain those final payment amounts. The D.C. Circuit Court in *Tampa General* held the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well.

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

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

Board Members Participating:

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

For the Board:

1/15/2019

X Clayton J. Nix

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Chair
Signed by: Clayton J. Nix -A

cc: Wilson C. Leong, Esq., Federal Specialized Services
Pam VanArsdale, National Government Services, Inc. (J-K)

[15] 830 F.3d 515, 517.
[16] *Id.* at 519.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

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

RE: Jurisdictional Challenge
Heart Hospital of Bakersfield (05-0724)
FYE: 9/30/2010
PRRB Case: 14-3517

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above referenced appeal and finds that it does not have jurisdiction over the DSH/SSI – Provider Specific issue because it is the same as the DSH/SSI - Systemic Errors issue that was transferred to PRRB Case No. 14-1815G. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

On May 22, 2014, the Board received Heart Hospital of Bakersfield's ("Provider's") Individual Appeal Request appealing their December 16, 2013 Notice of Program Reimbursement ("NPR") from the Medicare Contractor ("MAC"). The initial appeal contained eight (8) issues, six (6) of which were transferred to group appeals on January 20, 2015. One of the issues transferred to an optional group appeal (PRRB Case No. 14-1815G) was "DSH/SSI - Systemic Errors." On December 4, 2018, Provider requested a seventh issue "be excluded because it is being corrected on a reopening" by the MAC, leaving just the DSH/SSI - Provider Specific issue.

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

> The provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[1]

[1] Individual Appeal Request, Tab 3 at 1 (May 22, 2014).

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

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

On May 2, 2015, the Board received a jurisdictional challenge filed on behalf of the MAC in which it argued that the Board lacks jurisdiction over these DSH/SSI issues because the MAC did not render a final determination over them, and also because the Provider did not properly preserve its right to claim dissatisfaction for the issues as self-disallowed items.[3]

The Board received Provider's response to the jurisdictional challenge on March 25, 2015. In the response, Provider argues in support of Board jurisdiction by claiming that there was, in fact, an adjustment to their DSH with Audit Adjustment Numbers 10 and 11. Furthermore, they argue that the adjustments were not even required, as DSH is not an item that has to be adjusted or claimed on a cost report.[4] Though not an issue raised by the MAC, the Provider also discussed whether its DSH/SSI – Provider Specific issue differs from its DSH/SSI – Systemic Errors issue, stating that it is "not addressing a realignment of the SSI percentage, but is addressing the various errors of omission and commission that do not fit into the 'systemic errors' category."[5]

Board Decision

Based upon review of the two DSH/SSI issue statements, Provider is challenging the same underlying SSI data in both of the issues and they do not appear to be different in any significant way. Pursuant to Board Rule 4.6, a provider may not appeal an issue from a final determination in more than one appeal. Therefore, the Board finds that Provider's two DSH/SSI issues are the same and, because Provider transferred its DSH/SSI - Systemic Errors issue to a group appeal, dismisses their DSH/SSI Provider Specific issue from the instant appeal. Since the Provider Specific issue was the last issue in this case, the Board also hereby closes the appeal.

In addition, with respect to Provider's statement that it "hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period[,]" the Board should note that such request is a provider election that must be submitted in writing to the MAC and is not an appealable issue before the Board. Indeed, without the MAC rendering a determination of the realignment issue, the Provider would not have exhausted its available remedy of requesting CMS to recalculate the SSI ratio using the Provider's fiscal year under 42 C.F.R. § 412.106(b)(3).

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[2] *Id.* at 1-2.
[3] Medicare Administrative Contractor's Jurisdictional Challenge, 1, 19 (March 2, 2015).
[4] Provider's Jurisdictional Response, 4-8 (March 25, 2015).
[5] *Id.* at 2.

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

Board Members Participating:

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

For the Board:

1/17/2019

X Gregory H. Ziegler

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

cc:

Wilson C. Leong, Esq., Federal Specialized Services
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Nancy Repine
WVU Medicine
PO Box 8261
3040 University Ave., ROC 2
Morgantown, WV 26506

RE: Jurisdictional Challenge
City Hospital d/b/a/ Berkeley Medical Center (51-0008)
FYE: 12/31/2014
PRRB Case: 18-0075

Dear Ms. Repine,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above referenced appeal and finds that it does not have jurisdiction over the DSH/SSI – Provider Specific issue because it is the same as the DSH/SSI - Systemic Errors issue that was transferred to PRRB Case No. 18-1332GC. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

On October 16, 2017, the Board received City Hospital d/b/a Berkeley Medical Center's ("Provider's") Individual Appeal Request appealing their April 13, 2017 Notice of Program Reimbursement ("NPR") from the Medicare Contractor ("MAC"). The initial appeal contained two (2) issues: DSH/SSI – Provider Specific, and DSH/SSI – Systemic Errors. The Systemic Errors issue was transferred to a CIRP group appeal, Case Number 18-1332GC, on June 27, 2018. The only remaining issue in this appeal is the SSI Provider Specific issue.

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

> The provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[1]

[1] Individual Appeal Request, Tab 3 at 1 (Oct. 16, 2017).

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

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

On October 4, 2018, the Board received a jurisdictional challenge filed on behalf of the MAC in which it argued that the Board should dismiss the Provider Specific issue because it is duplicative of the Systemic Errors issue transferred to Case Number 18-1332GC.[3] The MAC also addressed Provider's attempt to "preserve[] its right to request under separate cover [realignment pursuant to] 42 U.S.C. 1395(d)(5)(F)(i)." The MAC states that this is premature, and that Provider has not exhausted its available remedy of requesting CMS to recalculate the SSI ratio using the Provider's fiscal year under 42 C.F.R. § 412.106(b)(3).[4] The Board has not received a response to the jurisdictional challenge from Provider in this case.

Board Decision

Based upon review of the two DSH/SSI issue statements, Provider is challenging the same underlying SSI data in both of the issues and they do not appear to be different in any significant way. Pursuant to Board Rule 4.6, a provider may not appeal an issue from a final determination in more than one appeal. Therefore, the Board finds that Provider's two DSH/SSI issues are the same and, because Provider transferred its DSH/SSI - Systemic Errors issue to a group appeal, dismisses their DSH/SSI Provider Specific issue from the instant appeal. Since the Provider Specific issue was the last issue in this case, the Board also hereby closes the appeal.

In addition, with respect to Provider's statement that it "hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period[,]" the Board should note that such request is a provider election that must be submitted in writing to the MAC and is not an appealable issue before the Board. Indeed, without the MAC rendering a determination of the realignment issue, the Provider would not have exhausted its available remedy of requesting CMS to recalculate the SSI ratio using the Provider's fiscal year under 42 C.F.R. § 412.106(b)(3).

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[2] *Id.* at 1-2.
[3] Medicare Administrative Contractor's Jurisdictional Challenge, 1-3 (Oct. 4, 2018)
[4] *Id.* at 4.

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

Board Members Participating:

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

For the Board:

1/24/2019

X Gregory H. Ziegler

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

cc:

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

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

RE: Jurisdictional Challenge
Sycamore Shoals Hospital (44-0018)
FYE: 6/30/2010
PRRB Case: 14-2037

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above referenced appeal and finds that it does not have jurisdiction over the DSH/SSI – Provider Specific issue because it is the same as the DSH/SSI - Systemic Errors issue that was transferred to PRRB Case No. 14-3592GC. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

On January 27, 2014, the Board received Sycamore Shoals Hospital's ("Provider's") Individual Appeal Request appealing their July 31, 2013 Notice of Program Reimbursement ("NPR") from the Medicare Contractor ("MAC"). The initial appeal contained nine (9) issues, six (6) of which were transferred to group appeals on September 17, 2014. One of the issues transferred to a CIRP group appeal (PRRB Case No. 14-3952GC) was "DSH/SSI - Systemic Errors." Another issue was withdrawn by Provider on September 25, 2014, with the submission of their Preliminary Position Paper, and one more was withdrawn on October 4, 2018. The only remaining issue is the SSI Provider Specific issue.

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

> The provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[1]

[1] Individual Appeal Request, Tab 3 at 1 (Jan. 27, 2014).

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

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

On March 31, 2015, the Board received a jurisdictional challenge filed on behalf of the MAC in which it argued that the Board lacks jurisdiction over the DSH/SSI Provider Specific issue because the MAC did not render a final determination over it.[3]

On December 3, 2018, the Board received a second jurisdictional challenge filed on behalf of the MAC in which it argued that the DSH/SSI – Provider Specific issue which remains in the instant appeal is a duplicate of the DSH-SSI – Systemic Errors issue that was transferred to Group Case 14-3952GC.[4] The MAC also addressed Provider's attempt to "preserve[] its right to request under separate cover [realignment pursuant to] 42 U.S.C. 1395(d)(5)(F)(i)." The MAC states that this is premature, and that Provider has not exhausted its available remedy of requesting CMS to recalculate the SSI ratio using the Provider's fiscal year under 42 C.F.R. § 412.106(b)(3).[5]

Provider has not replied to either of the MAC's jurisdictional challenges, but in its Final Position Paper, it claims that "CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (June 30)," and that the SSI percentage issued by CMS is flawed.[6]

Board Decision

Based upon review of the two DSH/SSI issue statements, Provider is challenging the same underlying SSI data in both of the issues and they do not appear to be different in any significant way. Pursuant to Board Rule 4.6, a provider may not appeal an issue from a final determination in more than one appeal. Therefore, the Board finds that Provider's two DSH/SSI issues are the same and, because Provider transferred its DSH/SSI - Systemic Errors issue to a group appeal, dismisses their DSH/SSI Provider Specific issue from the instant appeal. Since the Provider Specific issue was the last issue in this case, the Board also hereby closes the appeal.

In addition, with respect to Provider's statement that it "hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period[,]" the Board should note that such request is a provider election that must be submitted in

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[2] *Id.* at 1-2.
[3] Medicare Administrative Contractor's Jurisdictional Challenge, 1-3 (Mar. 31, 2015).
[4] Medicare Administrative Contractor's Jurisdictional Challenge, 2 (Dec. 3, 2018).
[5] *Id.* at 3-4.
[6] Provider's Final Position Paper, 8 (Aug. 29, 2018).

writing to the MAC and is not an appealable issue before the Board. Indeed, without the MAC rendering a determination of the realignment issue, the Provider would not have exhausted its available remedy of requesting CMS to recalculate the SSI ratio using the Provider's fiscal year under 42 C.F.R. § 412.106(b)(3).

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

Board Members Participating:

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

For the Board:

1/24/2019

X Gregory. H. Ziegler

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

cc:

Wilson C. Leong, Esq., Federal Specialized Services
Jerrod Olszweski, Esq., Federal Specialized Services
Cecile Huggins, Palmetto GBA (J-J)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Corinna Goron
Health Reimbursement Services, Inc.
17101 Preston Road, Suite 220
Dallas, TX 75248

RE: Jurisdictional Challenge
St. John Medical Center (36-0123)
FYE: 12/31/2014
PRRB Case: 18-0315

Dear Ms. Repine,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above referenced appeal and finds that it does not have jurisdiction over the DSH/SSI – Provider Specific issue because it is the same as the DSH/SSI - Systemic Errors issue that was transferred to PRRB Case No. 17-1092GC. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

On December 6, 2017, the Board received St. John Medical Center's ("Provider's") Individual Appeal Request appealing their June 7, 2017 Notice of Program Reimbursement ("NPR") from the Medicare Contractor ("MAC"). The initial appeal contained three (3) issues, one (1) of which was transferred to a group appeal on July 23, 2018. Another issue was withdrawn by Provider on July 23, 2014, with the submission of their Preliminary Position Paper. The only remaining issue is the SSI Provider Specific issue.

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

> The provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[1]

On November 12, 2018, the Board received a jurisdictional challenge filed on behalf of the MAC in which it argued that the DSH/SSI – Provider Specific issue which remains in the instant appeal is a

[1] Individual Appeal Request, Tab 3 at 1 (Dec. 6, 2017).

duplicate of the DSH-SSI – Systemic Errors issue in group case 17-1092GC, to which Provider was directly added on November 29, 2017 – appealing the same June 7, 2017 NPR at issue in this case.[2]

In that group appeal, the DSH/SSI – Systemic Errors issue is described as "[w]hether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage." More specifically, Provider lists the following reasons for challenging its SSI percentage:

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

The Board received Provider's response to the jurisdictional challenge on December 12, 2018. The Provider discussed whether its DSH/SSI – Provider Specific issue differs from its DSH/SSI – Systemic Errors issue, stating that it is "not only addressing a realignment of the SSI percentage, but also addressing the various errors of omission and commission that do not fit into the 'systemic errors' category."[4] They go on to argue that the two appeal issues "represent different aspects/components of the SSI issue.[5]

Board Decision

Based upon review of the two DSH/SSI issue statements, Provider is challenging the same underlying SSI data in both of the issues and they do not appear to be different in any significant way. Pursuant to Board Rule 4.6, a provider may not appeal an issue from a final determination in more than one appeal. Therefore, the Board finds that Provider's two DSH/SSI issues are the same and, because Provider transferred its DSH/SSI - Systemic Errors issue to a group appeal, dismisses their DSH/SSI Provider Specific issue from the instant appeal. Since the Provider Specific issue was the last issue in this case, the Board also hereby closes the appeal.

In addition, with respect to Provider's statement that it "hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period[,]" the Board should note that such request is a provider election that must be submitted in writing to the MAC and is not an appealable issue before the Board. Indeed, without the MAC rendering a determination of the realignment issue, the Provider would not have exhausted its available remedy of requesting CMS to recalculate the SSI ratio using the Provider's fiscal year under 42 C.F.R. § 412.106(b)(3).

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[2] Medicare Administrative Contractor's Jurisdictional Challenge, 1-2 (Nov. 12, 2018).
[3] *See id.* at Exhibit C-2, 8.
[4] Provider's Jurisdictional Response, 2 (Dec. 12, 2018).
[5] *Id.* at 1-2.

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

Board Members Participating:

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

For the Board:

1/24/2019

X Gregory H. Ziegler

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

cc:

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

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

RE: Jurisdictional Challenge
Sycamore Shoals Hospital (44-0018)
FYE: 6/30/2011
PRRB Case: 14-2436

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above referenced appeal and finds that it does not have jurisdiction over the DSH/SSI – Provider Specific issue because it is the same as the DSH/SSI - Systemic Errors issue that was transferred to PRRB Case No. 14-4296GC. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

On February 14, 2014, the Board received Sycamore Shoals Hospital's ("Provider's") Individual Appeal Request appealing their August 21, 2013 Notice of Program Reimbursement ("NPR") from the Medicare Contractor ("MAC"). The initial appeal contained nine (9) issues, six (6) of which were transferred to group appeals on September 18, 2014. One of the issues transferred to a CIRP group appeal (PRRB Case No. 14-4296GC) was "DSH/SSI - Systemic Errors." Another issue was withdrawn by Provider on September 25, 2014, with the submission of their Preliminary Position Paper, and one more was withdrawn on October 4, 2018. The only remaining issue is the SSI Provider Specific issue.

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

> The provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[1]

[1] Individual Appeal Request, Tab 3 at 1 (Feb. 14, 2014).

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

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

On March 31, 2015, the Board received a jurisdictional challenge filed on behalf of the MAC in which it argued that the Board lacks jurisdiction over the DSH/SSI Provider Specific issue because the MAC did not render a final determination over it.[3]

The Board received Provider's response to the jurisdictional challenge on April 23, 2015. In the response, Provider argues in support of Board jurisdiction by claiming that there was, in fact, an adjustment to their DSH with Audit Adjustment Number 21. Furthermore, they argue that the adjustment was not even required, as DSH is not an item that has to be adjusted or claimed on a cost report.[4] Though not an issue raised by the MAC, the Provider also discussed whether its DSH/SSI – Provider Specific issue differs from its DSH/SSI – Systemic Errors issue, stating that it is "not only addressing a realignment of the SSI percentage, but also addressing the various errors of omission and commission that do not fit into the 'systemic errors' category."[5]

On December 4, 2018, the Board received a second jurisdictional challenge filed on behalf of the MAC in which it argued that the DSH/SSI – Provider Specific issue which remains in the instant appeal is a duplicate of the DSH-SSI – Systemic Errors issue that was transferred to Group Case 14-4296GC.[6] The MAC also addressed Provider's attempt to "preserve[] its right to request under separate cover [realignment pursuant to] 42 U.S.C. 1395(d)(5)(F)(i)." The MAC states that this is premature, and that Provider has not exhausted its available remedy of requesting CMS to recalculate the SSI ratio using the Provider's fiscal year under 42 C.F.R. § 412.106(b)(3).[7]

Provider submitted a response to the MAC's second jurisdictional challenge on January 3, 2019, in which it claims that "each of the appealed SSI issues are separate and distinct . . . ."[8]

Board Decision

Based upon review of the two DSH/SSI issue statements, Provider is challenging the same underlying SSI data in both of the issues and they do not appear to be different in any significant way. Pursuant to

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[2] *Id.* at 1-2.
[3] Medicare Administrative Contractor's Jurisdictional Challenge, 4 (Mar. 31, 2015).
[4] Provider's Jurisdictional Response, 3 (Apr. 23, 2015).
[5] *Id.* at 2.
[6] Medicare Administrative Contractor's Jurisdictional Challenge, 2 (Dec. 4, 2018).
[7] *Id.* at 3-4.
[8] Provider's Jurisdictional Response, 1 (Jan. 3, 2019).

Board Rule 4.6, a provider may not appeal an issue from a final determination in more than one appeal. Therefore, the Board finds that Provider's two DSH/SSI issues are the same and, because Provider transferred its DSH/SSI - Systemic Errors issue to a group appeal, dismisses their DSH/SSI Provider Specific issue from the instant appeal. Since the Provider Specific issue was the last issue in this case, the Board also hereby closes the appeal.

In addition, with respect to Provider's statement that it "hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period[,]" the Board should note that such request is a provider election that must be submitted in writing to the MAC and is not an appealable issue before the Board. Indeed, without the MAC rendering a determination of the realignment issue, the Provider would not have exhausted its available remedy of requesting CMS to recalculate the SSI ratio using the Provider's fiscal year under 42 C.F.R. § 412.106(b)(3).

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

Board Members Participating:

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

For the Board:

1/28/2019

X Gregory H. Ziegler

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

cc:

Wilson C. Leong, Esq., Federal Specialized Services
Jerrod Olszweski, Esq., Federal Specialized Services
Cecile Huggins, Palmetto GBA (J-J)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Electronic Mail

Jason M. Healy, Esq.
The Law Offices of Jason M. Healy PLLC
1750 Tyson Blvd.
Suite 1500
McLean, VA 22012

RE: Expedited Judicial Review Determination

19-0407GC LifeCare Health Partners FY 2019 LTCH Site Neutral Outlier Budget Neutrality Adjustment Group
19-0408GC Post Acute Medical FY 2019 LTCH Site Neutral Outlier Budget Neutrality Adjustment Group
19-0409GC Kindred Healthcare FY 2019 LTCH Site Neutral Outlier Budget Neutrality Adjustment Group
19-0410GC Vibra Healthcare FY 2019 LTCH Site Neutral Outlier Budget Neutrality Adjustment Group

Dear Mr. Healy:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' hearing request and request for expedited judicial review (EJR) that was submitted on November 20, 2018 (received November 21, 2018). When the original hearing request was received, it was noted that it was submitted as one large group appeal containing the four healthcare corporations identified above. The Board sent you a development letter on December 12, 2018, and advised that the group appeal was filed as an invalid optional group appeal that violated 42 C.F.R. § 405.1837(b), and that the Board has established four common issue related party (CIRP) groups (identified above). You were instructed to submit a Schedule of Providers with the associated jurisdictional documentation for each group, along with a copy of the EJR request and exhibits for each group. This request for additional information affected the 30-day period to respond to the EJR.[1] The requested information was submitted on January 3, 2019. The Board has subsequently reviewed the request for EJR and the Schedules of Providers and associated jurisdictional documents. The determination regarding EJR is set forth below.

[1] *See* 42 C.F.R. § 405.1842(b)(2), (e)(2)(i) and (e)(3)(ii).

Issue under Appeal

The issue under appeal in these cases is:

> Whether the Centers for Medicare & Medicaid Services ("CMS") incorrectly applied the negative 5.1 percent outlier budget neutrality adjustment twice to Long-Term Care Hospital Prospective Payment System ("LTCH PPS") site neutral case payments in violation of the Administrative Procedure Act ("APA"), the Social Security Act ("SSA"), and other federal laws.[2]

Background

The LTCH PPS was established through Section 123 of the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113) as amended by section 307(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554). These statutes provided for payment for both the operating and capital-related costs of hospital inpatient stays in LTCHs under Medicare Part A based on prospectively set rates. The Medicare prospective payment system (PPS) for LTCHs applies to hospitals that are described in section 42 U.S.C. § 1395ww(d)(1)(B)(iv) and is effective for cost reporting periods beginning on or after October 1, 2002. The LTCH PPS replaced the reasonable cost-based payment system that had been established under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).[3]

To be classified as a LTCH, a hospital must have an average length of stay greater than 25 days.[4] In the Federal Fiscal Year (FFY) 2008 final rule, the Secretary adopted the use of the Medicare severity long term care diagnosis related groups (MS-LTC-DRGs) which are assigned to each patient discharged from a LTCH as the basis for payment. The payment amount for each MS-LTC-DRG is intended to reflect the average cost of treating a Medicare patient assigned to an MS-LTC-DRG.[5] Weights are assigned to MS-LTC-DRGs on an annual basis that are multiplied against a Federal standardized rate[6] to arrive at a payment for the discharged patient after taking other adjustments into consideration.[7]

Site Neutral Payment

For LTCH Part A discharges for cost report periods beginning on or after October 1, 2015 (FFY 2016), Congress established a new dual-rate payment structure for LTCH PPS hospitals, with

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[2] Providers' EJR requests at 1.
[3] 80 Fed. Reg. 49,326, 49,599 (August17, 2015).
[4] 42 C.F.R. § 412.23(e)(2).
[5] 72 Fed. Reg. 47,130, 47,278 (August 22, 2007).
[6] The standardized rate is the average standardized charge for each DRG that is calculated by summing the charges for all cases in the DRG and dividing that amount by the number of cases classified in the DRG. *See* Medicare Hospital Prospective Payment System How DRG Rates Are Calculated and Updated (Office of the Inspector General, Report OEI-09-00-00200 (Aug. 2001)) on the internet at https://oig.hhs.gov/oei/reports/oei-09-00-00200.pdf.
[7] *See* 42 C.F.R. §§ 412.515, 412.521.

two distinct payment rates.[8] The first payment rate is the LTCH PPS standard Federal payment rate.[9] This rate only applies to discharges that meet one of two patient criteria: 3 or more days in a subsection(d) hospital[10] intensive care unit or LTCH ventilator services of at least 96 hours and a principle diagnosis that is not psychiatric or rehabilitation.[11] All other LTCH discharges are reimbursed at the site neutral payment rate which is the lesser of the IPPS comparable per diem amount (including applicable outlier payments) or 100 percent of the estimated services involved.[12]

LTCH are transitioning to the new LTCH PPS dual rate with a blended payment rate that applies to site neutral case discharges in cost reporting periods beginning on or after October 1, 2015 (FFY 2016) and on or before September 30, 2019 (FFY 2019).[13] During this transition period, the blended payment rate for site neutral cases is equal to one-half of the site neutral payment rate and one-half of the LTCH PPS standard Federal payment rate.[14] Beginning on October 1, 2019 (FFY 2020), site neutral cases will be paid at 100 percent of the site neutral payment rate.

High Cost Outlier Payments

Both the standard Federal payment rate and the site neutral payment rates include additional payments for high cost outliers (HCO) that have extraordinarily high costs relative to most discharges. For cases paid under the Federal payment rate, the HCO outlier rate is set annually by the Secretary. LTCH cases that are paid under the site neutral basis receive outlier payments that equal 80% of the estimated cost of the case above the HCO threshold which is the sum of the LTCH PPS payment for the case and the applicable fixed-loss amount for such case.[15] The calculation of the site neutral payment cases is separate from the standard LTCH Federal payment rate cases.[16] For LTCH site neutral cases, the HCO threshold is the site neutral payment rate for the case plus the IPPS fixed loss amount.

Budget Neutrality Adjustment

The site neutral payment rate for LTCH was first implemented in FFY 2016 though the IPPS[17]/LTCH PPS rulemaking. In the 2016 IPPS/LTCH PPS Final Rule, the Secretary adopted a budget neutrality factor adjustment for the site neutral portion of the LTCH site neutral blended payment rate.[18] The Secretary stated that this budget neutrality adjustment was necessary "to ensure that estimated HCO payments payable to site neutral payment rate cases in [FFY] 2016 do not result in any increase in estimated aggregate FY 2016 LTCH PPS payments."[19] The

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[8] *See generally* 80 Fed. Reg. 24,323, 24,525-24,553 (April 30, 2015) and 80 Fed. Reg. 49,436, 49,599-49,623 (Aug. 17, 2017).
[9] 42 U.S.C. § 1395ww(m)(6)(A)(ii) and 42 C.F.R. § 412.522(b).
[10] 42 U.S.C. § 1395ww(d).
[11] 42 U.S.C. § 1395ww(m)(6)(A)(ii), (iii), (iv).
[12] *Id.* at § 1395ww(m)(6)(B)(ii) and 42 C.F.R. §412.522(a).
[13] *Id.* at § 1395ww(m)(6)(B)(i)(I).
[14] *Id.* at § 1395ww(m)(6)(B)(ii).
[15] 42 C.F.R. § 412.525(a)(3). *See also* 83 Fed. Reg. 41,144, 41,734 (August 17, 2018).
[16] *See e.g.* 80 Fed. Reg. at 49,804.
[17] Inpatient Prospective Payment System.
[18] 80 Fed. Reg. at 49,805.
[19] *Id.*

budget neutrality adjustment reduced the LTCH site neutral payment rate amount by 5.1 percent.[20] In the same final rule, the Secretary also finalized high cost outlier budget neutrality adjustment of 5.1 percent to the IPPS operating and capital standardized amounts.[21] The IPPS payment rate, as reduced by the IPPS outlier budget neutrality adjustment, is used to determine the IPPS comparable per diem amount under the LTCH PPS site neutral payment rate discussed above.

Providers' Position

The Providers explain that during the comment period for the FFY 2016 LTCH PPS rulemaking, the Providers and other stakeholders submitted comments objecting to the budget neutrality adjustment to both the site neutral high cost outlier payments and the operating standardized amount. The Providers believe that proposed budget neutrality adjustment (BNA) was duplicative of the outlier budget neutrality adjustment already applied to the IPPS payment rate. The American Hospital Association (AHA) explained that they believed that:

> [T]he inpatient PPS rates used as the basis for the site-neutral payment rates are already subject to a BNA for the inpatient PPS's 5.1 percent outlier pool. However, within the LTCH payment framework, CMS [the Centers for Medicare & Medicaid Services] proposes a second BNA of 2.3[22] percent for the site neutral outlier pool. CMS's rationale for this second BNA is to ensure that the site-neutral HCO payments do not increase aggregate LTCH PPS payments. However, we strongly disagree that the additional 2.3 percent BNA is necessary to achieve this goal; rather, it was already achieved when the 5.1 percent BNA was applied to the inpatient PPS rates used as the basis for the site neutral rates. We recommend that CMS calculate standard LTCH PPS and site neutral rates separately, without any co-mingling of these payments, as mentioned previously. Furthermore, the second BNA prevents LTCH site-neutral payments from aligning with inpatient PPS payments for the associated MS-DRGs and MS-LTCH-DRGs, which would counter the goals of BiBA [Bipartisan Budget Act of 2015].[23]

In response to this and other comments, in the FFY 2016 Final rule the Secretary stated that she disagreed with the commenters statements that a budget neutrality adjustment for the site neutral

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[20] *Id.*
[21] *Id.* at 49,785.49,794-95.
[22] *See* Providers' EJR requests at 8, Ftnt. 6. *See also Id.* at 49,785.49,794-95. (The AHA's 2016 comment letter references at 2.3 percent budget neutrality adjustment. CMS initially proposed a 2.3 percent adjustment in the FY 2016 Proposed Rule because CMS planned to apply a budget neutrality adjustment to all LTCH PPS payments. FY 2016 IPPS/LTCH PPS Proposed Rule, 80 Fed. Reg. 23,324, 24,649 (Apr. 30, 2015). However, in the FY 2016 Final Rule, CMS decided that it would instead apply a 5.1 percent adjustment only to the site neutral portion of the blended rate.)
[23] Providers' EJR Request at 8.

payment rate HCO payments is unnecessarily duplicative and declined to adopt the commenters recommendations. The Secretary explained that:

> While the commenters are correct that the IPPS base rates that are used in site neutral payment rate calculation include a budget neutrality adjustment for IPPS HCO payments, that adjustment is merely a part of the calculation of one of the inputs (that is, the IPPS base rates) that are used in the LTCH PPS computation of site neutral payment rate. The HCO budget neutrality factor that is applied in determining the IPPS base rates is intended to fund estimated HCO payment made under the IPPS, and is therefore determined based on estimated payments made under the IPPS. As such, the HCO budget neutrality factor that is applied to the IPPS base rates does not account for the additional HCO payments that would be made to site neutral payment rate cases under the LTCH PPS. Without a budget neutrality adjustment when determining payment for a case under the LTCH PPS, any HCO payment payable to site neutral payment rate cases would increase aggregate LTCH PPS payments above the level of expenditure if there were no HCO payments for site neutral payment rate cases. Therefore, our proposed approach appropriately results in LTCH PPS payments to site neutral payment rate cases that are budget neutral relative to a policy with no HCO payments to site neutral payment rate cases.[24]

These types of comments continued in subsequent Federal Register notices through the current Federal fiscal year. The Providers had hoped that the Secretary would corrected the alleged error before the end of the LTCH site neutral transition period on September 30, 2019. In FFY 2020, the entire payment for site neutral cases will be lesser of the IPPS comparable per diem amount or 100 percent of the estimated cost of the case.[25] The Providers explain that if the Secretary continues to insist on applying the duplicative outlier budget neutrality adjustment in FFY 2020, the adjustment will apply to the entire site neutral payment. The Providers believe that LTCH's have already experienced a significant reduction in payments for site neutral cases and that applying a budget neutrality adjustment twice to site neutral payments only increases the financial pressure on these facilities.

The Providers are disputing the application of a budget neutrality adjustment to LTCH site neutral case payments that reduces the payments below what they would otherwise be in the absence of HCO payments for qualifying site neutral cases. They contend this is not budget neutrality, rather it is a payment cut that is arbitrary and unsupported. They argue that the Secretary set the target amount of the LTCH HCO payments at 5.1% of total site neutral payments, but the extra budget neutrality adjustment reduces the total LTCH site neutral payments by another 5.1%.[26] The Providers assert that this action is arbitrary and capricious, an

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[24] 80 Fed. Reg. at 49,622.
[25] 42 U.S.C. § 1395ww(m)(6)(B)(i)-(ii).
[26] Providers' EJR requests at 19.

abuse of discretion and not in accordance with the Administrative Procedure Act, the Social Security Act and the laws authorizing the LTCH PPS and not supported by substantial evidence.

The Providers believe EJR is appropriate because the Board has jurisdiction over the appeals and lacks the authority to decide the legal question in these cases. There are no material facts in dispute and the challenge here is whether the budget neutrality adjustment violates the dual-rate structure of the LTCH PPS in the SSA and exceeds the Secretary's authority under the authorizing legislation for LTCH PPS.[27] The Providers believe that the duplicative budget neutrality adjustment is arbitrary and capricious and violates the APA.

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.

The Board has determined that the participants involved with the instant EJR requests which appealed from the issuance of the August 17, 2018 Federal Register[28, 29] are timely filed. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[30] The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year and the Providers in these appeals are entitled to a hearing before the Board;

2) Based upon the remaining Providers' assertions regarding whether the Secretary incorrectly applied the outlier budget neutrality adjustment

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[27] *Id.* at 28.

[28] In accordance with the Administrator's decision in District of Columbia Hospital Association Wage Index Group Appeal, (HCFA Adm. Dec. January 15, 1993) Medicare & Medicaid Guide (CCH) ¶ 41, 025, the wage index notice published in the Federal Register is a final determination. Likewise, other rate notices published in the Federal Register can be considered final determinations.

[29] The Board notes that the participants in these group appeals have cost report periods beginning on or after January 1, 2016, which would subject their appeals to the newly-added 42 C.F.R. § 405.1873 and the related revisions to 42 C.F.R. § 413.24(j) regarding submission of cost reports. *See* 80 Fed. Reg. 70298, 70555-70604 (Nov. 13, 2015). However, the Board notes that § 405.1873(b) has not been triggered because neither party has questioned whether any Provider's cost report included an appropriate claim for the specific item under appeal. *See* 80 Fed. Reg. at 70,556.

[30] *See* 42 C.F.R. § 405.1837.

twice to the LTCH site neutral case payments, 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 the Secretary incorrectly applied the outlier budget neutrality adjustment twice to the LTCH site neutral case payments for FFY 2019 as delineated in the August 17, 2018 Federal Register.

Accordingly, the Board finds that the question of whether the Secretary incorrectly applied the outlier budget neutrality adjustment twice to the LTCH site neutral case payments properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' requests for EJR for the issue and the subject year. 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 appeal the Board hereby closes the cases.

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For the Board:

1/28/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Bill Tisdale, Novitas Solutions (Electronic Mail w/Schedules of Providers)
Bruce Synder, Novitas Solutions (Electronic Mail w/Schedules of Providers)
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