DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Patrick Jordan
Petrak & Associates, Inc.
18114 Viceroy Drive
San Diego, CA 92128

RE: ***Expedited Judicial Review Determination***
Citrus Valley Medical Center – Queen of the Valley (Prov. No. 05-0369)
FYE 12/31/2005
Case No. 17-0764

Dear Mr. Jordan:

The Provider Reimbursement Review Board ("Board") has reviewed the records in the above-referenced appeal and, on January 22, 2020, as required by 42 C.F.R. § 405.1842(c), notified the Provider that it was considering, on its own motion, whether Expedited Judicial Review ("EJR") was appropriate for the above referenced case. The Provider has submitted comments as to whether the Board is without the authority to decide the following legal question[1]:

> Whether the Intermediary failed to include all of the Provider's Medicare part C days in the numerator of the Medicaid Proxy used to calculate the Provider's allowable Medicare disproportionate Share hospital (DSH) payment.[2]

The Board sent a letter on December 12, 2019, notifying the provider of its request for comments regarding the above issue in a number of cases applicable to Citrus Valley Health Partners ("CVHP"). This case was not identified among the cases in the original letter, and on January 12, 2020, the Provider requested the above case be included in the Board's own motion EJR review in a set of group cases involving the Provider.[3] As the Board had concerns about whether the Provider was subject to the mandatory CIRP group requirements at 42 C.F.R. § 404.1837(b)(1), the Board sent a letter on January 22, 2020 to the Provider requesting additional information regarding whether the Provider was part of the CVHP system or chain (or any other system/chain) and, if so, to confirm whether there are other providers in the chain who are or will be pursuing the Part C days in the Medicaid proxy issue for fiscal year 2005. The Provider filed a response on January 24, 2020 confirming that, although the Provider was commonly owned for the year under appeal, the other providers in the system are not pursuing and will not pursue the Part C issue for fiscal year 2005. Accordingly, in reliance on this certification, the Board has determined that the Provider's pursuit of the Part C issue for fiscal

[1] FSS did not file any comments and the Provider's comments were received on January 24, 2020.
[2] Request for Hearing, Issue Statement, at Ex. 2 (Jan. 10, 2017) Case No. 17-0764.
[3] Request to Add Individual appeal to Board Own Motion EJR (Jan. 12, 2020).

year 2005 is not subject to the mandatory CIRP group requirements because there are no other related providers that have or will pursue the Part C days issue.

Statutory and Regulatory Background: Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system ("PPS").[4] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5]

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[6] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[7]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[8] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[9] The DPP is defined as the sum of two fractions expressed as percentages.[10] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[11]

[4] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[5] *Id.*
[6] *See* 42 U.S.C. § 1395ww(d)(5).
[7] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[11] Emphasis added.

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[12]

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

> [T]he fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter*, and the denominator of which is the total number of the hospital's patient days for such period.[13]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[14]

Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary[15] stated that:

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

[12] 42 C.F.R. § 412.106(b)(2)-(3).
[13] Emphasis added.
[14] 42 C.F.R. § 412.106(b)(4).
[15] of Health and Human Services.

> Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[16]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[17]

With the creation of Medicare Part C in 1997,[18] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.[19]

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction . . . .*[20]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[21] In response to a comment regarding this change, the Secretary explained that:

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[16] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[17] *Id.*
[18] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[19] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).
[20] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[21] 69 Fed. Reg. at 49099.

> *. . . We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[22]

This statement would require inclusion of Medicare Part C inpatient days in the Medicare fraction of the DSH calculation.

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, no change to the regulatory language was published until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[23] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[24] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[25]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[26] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy

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[22] *Id.* (emphasis added).
[23] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[24] *Id*. at 47411.
[25] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[26] 746 F. 3d 1102 (D.C. Cir. 2014).

adopted in FFY 2005 IPPS rule.[27] However, the Secretary has not acquiesced to that decision.

More recently, in *Allina Health Services v. Price* ("*Allina II*"),[28] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.[29] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[30] Once again, the Secretary has not acquiesced to this decision.

Board's Consideration for Own Motion EJR

In the FFY 2005 Final Rule, the Secretary announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective for discharges on or after October 1, 2004.[31] In *Allina I*, the Court affirmed the district court's decision "that the Secretary's final rule [for FFY 2005] was not a logical outgrowth of the proposed rule [for FFY 2005]."[32] The Providers point out that because the Secretary has not acquiesced to the decision, the regulation announced in the FFY 2005 Final Rule requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as later set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

In this case, the Provider contends that Medicaid-eligible Part C days should be included in the numerator of the Medicaid fraction. To obtain relief, the Provider seeks a ruling on the procedural and substantive validity of the regulation announced in the FFY 2005 Final Rule that the Board lacks the authority to grant. The Provider maintains that since the Secretary has not acquiesced to the decision in *Allina I*, the Board remains bound by the regulation and that, as a result, EJR is appropriate.

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2017), the Board is required to grant an 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.

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[27] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[28] 863 F.3d 937 (D.C. Cir. 2017).
[29] *Id.* at 943.
[30] *Id.* at 943-945.
[31] 69 Fed. Reg. at 49,099.
[32] *Allina* at 1109.

Jurisdiction

The participant addressed in this own-motion EJR determination has filed an appeal involving fiscal year 2005.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[33] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[34]

The Board has determined that the participant's appeal involved with the instant own-motion EJR is governed by the decision in *Bethesda*. The Provider appealed from an original NPR. In addition, the participant's documentation shows that the estimated amount in controversy exceeds $10,000, as required for an individual appeal[35] and that the appeal was timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case. Accordingly, the Board finds that it has jurisdiction for the referenced appeal and the participant.

Board's Analysis Regarding the Appealed Issue

The appeal in this EJR request involves the fiscal year 2005 cost reporting period. Thus, the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in this request, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[36] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Provider would have the right to bring suit in

[33] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[34] *Bethesda*, 108 S. Ct. at 1258-59.
[35] *See* 42 C.F.R. § 405.1837.
[36] *See generally Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

either the D.C. Circuit *or* the circuit within which they are located.[37] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR.

Board's Decision Regarding the Own Motion EJR

The Board finds that:

1) It has jurisdiction over the matter for the subject years and that the participants in the individual appeals are entitled to a hearing before the Board;

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

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

4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2008) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2008) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants its Own Motion EJR for the issue and the subject year. The participant has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, the Board hereby closes this case.

Board Members Participating:

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

For the Board:

7/1/2020

X Clayton J. Nix

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

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

[37] *See* 42 U.S.C. § 1395oo(f)(1).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Stephanie Webster, Esq.
Ropes & Gray, LLP
2099 Pennsylvania Ave, NW
Washington, DC 20006

RE: ***Motion for Reconsideration (Reinstatement)***
Pitt County Memorial Hospital (Prov. No. 34-0040)
FYE 9/30/2009
Case No. 14-2001

Dear Ms. Webster,

The Provider Reimbursement Review Board ("Board") has reviewed the Reconsideration of Motion for Reinstatement ("Request for Reconsideration" or "Reconsideration") submitted by Pitt County Memorial Hospital ("Provider") on May 5, 2020. The decision of the Board is set forth below.

Pertinent Facts:

On January 27, 2014, the Provider filed an Individual Appeal Request from a Notice of Program Reimbursement ("NPR") dated August 1, 2013 for fiscal year ending September 30, 2009 ("FY 2009"). The original appeal contained two issues: (1) DSH/Medicaid Paid/Eligible Days, and (2) Total Patient Days.

On August 24, 2016, the Board received Provider's Withdrawal of Appeal Pursuant to Reopening Agreement ("Withdrawal") in which they withdrew both issues based on the Medicare Contractor's agreement to reopen the cost report. The Withdrawal also included a copy of the Medicare Contractor's Notice of Reopening, which indicated the cost report was being reopened for the following relevant issues:

1. To review additional Medicaid eligible days . . . .
2. To review days included in Medicaid days . . . that have been identified as not being allowable for DSH purposes . . . .

The Provider reserved the right, under Board Rule 46.2 (2015), to request reinstatement of both issues within three years if the Medicare Contractor did not effectuate a reopening and issue a revised determination. On August 29, 2016, the Board acknowledged the withdrawal and closed the appeal.

On August 29, 2019, Provider filed a Motion for Reinstatement of Appeal requesting to reinstate the DSH eligible days issue because, while the Medicare Contractor issued a revised NPR on March 27, 2019, they only included a portion of the Medicaid-eligible days identified by the Provider. As such, the Provider requested the issue be reinstated so they could pursue the

remaining Medicaid-eligible days not included in the March 2019 revised NPR. The Motion for Reinstatement also included copies of the Provider's request to reopen the cost report and the Medicare Contractor's agreement to do so.

On September 26, 2019, the Medicare Contractor filed an Objection to Provider's Motion for Reinstatement based on its contentions that the Board Rules require a motion for reinstatement to set forth the reasons for reinstatement, and that the motion will not be granted if the Provider is at fault. The Medicare Contractor's position was that they agreed to reopen the cost report to review additional Medicaid eligible days for inclusion, ***not*** to include 100 percent of the days requested by the Provider. They went on to explain that the Provider submitted documentation for a sample of patient days, and that the documentation was insufficient to support the entire length of stay claimed. Since the Provider did not submit the necessary documentation to support their requested days, the Medicare Contractor argued that the Provider was at fault for the failure to receive all of its requested days.

On September 23, 2019, the Board also received a "Request for Hearing and Consolidation of Appeal" from the Provider's revised NPR, which seeks to consolidate that new appeal with the instant case, if reinstated.

On March 6, 2020, the Board issued a letter denying the Motion for Reinstatement because the Medicare Contractor did, in fact, issue a revised NPR as agreed. The Board reasoned that the right to reinstatement was extinguished when the Medicare Contractor issued a new determination that specifically dealt with the issues for which the Provider was seeking reinstatement. The Board also noted that, since the Provider had filed an individual appeal request from the revised NPR, the Board would, to the extent that appeal is properly before the Board, process that appeal and issue a new case number under separate cover. The Board assigned the Provider's appeal of the revised NPR to Case No. 20-1892.

Request for Reconsideration

On May 5, 2020, the Provider submitted its Request for Reconsideration, noting that the Medicare Contractor opposes the renewed request to reinstate the case. The Reconsideration argues that the Board's decision not to reinstate the case violates the plain terms of the Board Rules, misapprehends the facts surrounding the reopening, and would discourage providers from withdrawing appeal issues in the future if issues were not fully resolved.

The Provider argues that the Board Rules ***require*** reinstatement of an issue or case upon written motion, and that it does not lose the reinstatement "right" if only part of an issue or case is resolved in the reopening. They argue that "the Board's limiting read of reopening 'as agreed' . . . is inconsistent with the Board's past practice regarding reinstatement of 'issues' withdrawn from appeals." In support of its position, the Provider discusses a 2015 Board decision for Case No. 02-1329, in which the provider withdrew an appeal after the parties agreed to a "full administrative resolution" of the issues, but the Medicare Contractor did not issue a revised NPR "as agreed." The Board reinstated one particular issue because the Medicare Contractor, in issuing its RNPR, "failed to make an adjustment" for that issue in the administrative resolution. They also cite to the 2016 decision of the U.S. District Court for the

District of Columbia ("D.C. District Court") in *Empire Health Found. v. Burwell* ("*Empire*") [1] which discussed the Board's ability to deny a reinstatement when the Provider was "at fault." In particular, the Provider focuses on language in the *Empire* decision stating that the Provider should have the same rights (no greater and no less) that it had in its initial appeal.

The Provider goes on to detail its actual request to the Medicare Contractor for a reopening. It says that its request, from the start, was for the Medicare Contractor to include *all* 2,554 additional days. They also take issue with the methods used by the Medicare Contractor in its sampling and extrapolation to determine how many days would be included in the RNPR: "Having failed to undertake a valid review process and consider the materials that the Provider supplied, Palmetto failed to uphold its obligations and agreement to reopen the cost report." They also rebuke the Medicare Contractor's claim that the Provider was in any way "at fault," claiming that Provider supplied clear documentation to support its position.

The Provider concludes its Request for Reconsideration by arguing that this interpretation of the Board Rules will result in Providers refusing to withdraw their appeals to resolve issues through a reopening. They emphasize throughout their Reconsideration request that, even if they can proceed to correct their grievances by appealing the RNPR, that appeal will likely take years to resolve and include jurisdictional challenges along the way.

Statutory and Regulatory Background

Pursuant to 42 C.F.R. § 405.1885, a Medicare Contractor may reopen a final determination within three years of the date of that determination. Pursuant to Board Rule 48 (July 1, 2015), a provider may withdraw an issue in an appeal for which the Medicare Contractor has agreed to reopen the final determination (*i.e.*, the cost report):

> **Rule 48 Withdrawal of an Appeal or Issue within an Appeal**
>
> A Provider's request to withdraw an issue(s) or case must be in writing. It is the Provider's responsibility to withdraw: (1) an issue(s) or case that the Provider no longer intends to pursue; (2) an issue(s) or case in which an administrative resolution has been executed and attach a copy of such administrative resolution; *(3) an issue(s) for which the Intermediary has agreed to reopen the final determination for that issue(s) and attach a copy of the correspondence from the Intermediary where the Intermediary agreed to that reopening*; and (4) a case in which all issues have been handled, whether by resolution, transfer, dismissal, or withdrawal.
>
> When a Provider notifies the Board that it is withdrawing an issue(s), the Provider's notification must: (1) describe the specific

[1] *Empire Health Found. v. Burwell*, 209 F. Supp. 3d 261 (D.D.C. 2016), *appeal dismissed*, *Empire Health Found. v. Price*, No. 16-5293, 2017WL2373013 (D.C. Cir., Apr. 4, 2017).

> issue(s) being withdrawn; (2) *address whether the withdrawal is conditioned/dependent on the Intermediary's action through an administrative resolution or reopening*; and (3) confirm whether there are any other issues remaining in the case and, if so, provide the status on each remaining issue. Note that the Board will not issue a decision to acknowledge the withdrawal of an issue(s) if the withdrawal does not result in the closure of the case.

Following such a withdrawal, Board Rule 46.2 (July 1, 2015) explains that the provider may file a motion for reinstatement within three years of withdrawing the issue and that the motion must be in writing and include copies of the provider's reopening request and the Medicare Contractor's agreement to reopen the final determination:

> **46.2 – Withdrawals As a Result of Administrative Resolution or Agreement to Reopen**
>
> A. Administrative Resolution Upon written motion, the Board will grant reinstatement of an issue(s)/case if an issue(s)/case was withdrawn as a result of an administrative resolution in which the Intermediary agreed to reopen a final determination under appeal with the Board but failed to issue a new final determination (e.g., Revised NPR) for that issue(s) <u>as agreed</u>. In its motion for reinstatement, the Provider must attach a copy of the relevant administrative resolution). *[July 1, 2015]*
>
> B. Reopening Upon written motion, the Board will also grant reinstatement of an issue(s)/case if a Provider requested to withdraw an issue(s) from its case because the Intermediary agreed to reopen/revise the cost report for that issue(s) but failed to reopen the cost report and issue a new final determination (e.g., Revised NPR) for that issue(s) <u>as agreed</u>. In its motion for reinstatement, the Provider must attach a copy of the correspondence from the Intermediary where the Intermediary agreed to reopen the final determination for that issue(s). *[July 1, 2015]*[2]

This rule further explains that the Board "will . . . grant" the motion for reinstatement of the withdrawn issue/case if the Medicare Contractor fails to reopen the cost report and issue a revised NPR for that issue "as agreed."[3]

[2] (Underline emphasis added.)
[3] *Id.*

Board's Decision:

The Board hereby denies the Request for Reconsideration. In support of its position, the Provider cites to the Board's decision in Case No. 02-1329.[4] At the outset, the Board notes that the Provider refers to but did not include a copy of the Board's decision in 02-1329. Based on the limited records available to it,[5] the Board understands that, in Case No. 02-1329: (1) the parties came to a "full administrative resolution" of the issues; (2) the Medicare Contractor failed to make an adjustment on the revised NPR related to one of those issues, issue 5; (3) the provider requested reinstatement of issue 5 as the Medicare Contractor failed to comply with its agreement to resolve issue 5 as stated in the administrative resolution; and (4) the Board granted reinstatement of issue 5 as the Medicare Contractor failed to comply with its agreement to resolve the issue 5 as stated in the administrative resolution. The instant case is distinguishable because the Medicare Contractor did, in fact, make an adjustment for the very issue which the Provider is seeking reinstatement and issued a revised NPR to implement that adjustment *as agreed*.[6] Per Board Rule 46.2, a *prerequisite* to reinstatement is that the Medicare Contractor fail to issue a revised NPR *as agreed*.

The Provider also cites to the 2016 decision of the D.C. District Court in *Empire* as support that they should have the same rights (no greater and no less) that it had in the initial appeal. However, the Board finds that the Provider's reliance on *Empire* is misplaced and further notes that it is not binding precedent on the Board. *Empire* dealt with the status of a case that was remanded pursuant to CMS Ruling 1498-R and specifically addressed whether a remand pursuant to that Ruling was a final agency action granting the federal court subject matter jurisdiction, or whether the provider was required to continue working through the administrative process before reaching federal court. The D.C. District Court ultimately found that there was no final agency action. There was a brief discussion on what would happen, *theoretically*, if the Provider sought to have their case reinstated after a 1498-R remand, and the Board denied it. The language related to a Provider having "the same rights (no greater and no less) that it had in its initial appeal" comes on the heels of an acknowledgement that those rights would be preserved by subjecting a revised NPR issued after a 1498-R remand to administrative and judicial review.[7]

Finally, the Provider's insistence that their reinstatement should not be denied based on them being "at fault" was not germane to the Board's denial of reinstatement. The Medicare Contractor did allude to this argument with references to insufficient documentation, but "fault" of the Provider was not the basis for the Board's decision to deny reinstatement. The Board's decision was plainly that a revised NPR was issued adjusting Medicaid eligible days as a result of the reopening and the revised NPR extinguished the Provider's right to reinstatement of the Medicaid eligible days issue pursuant to the Board Rules.

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[4] The Board notes that the Provider cites to the Board's decision in Case No. 02-1329 but does not include a copy of it in the record.
[5] The Board notes that, as a result of a fire over the Labor Day holiday weekend in September 2019 and the Covid-19 developments in Spring 2020, its access to its hard copy files (including the hard copy file for Case No. 02-1329) is limited as explained in Board Alerts 18 and 19.
[6] *See* the Board's initial denial of reinstatement for a full discussion of this finding.
[7] *See Empire* at 273.

The extinguishment of the Provider's right to reinstatement is further supported by the fact that what the Provider is now disputing differs from what was originally appealed. Moreover, the record before the Board shows that the current dispute arises in the context of the reopening and issuance of a ***new*** determination (*i.e.*, the revised NPR). Specifically, the Provider now disputes the sampling and extrapolation methodology that the Medicare Contractor used as part of that reopening to review the original Medicaid Eligible days at issue (*i.e.*, the 2554 net additional Medicaid eligible days[8]) ***in the context of the revised determination*** because this sampling and extrapolation only resulted in *partial* relief rather than *full* relief of the Medicaid eligible days requested.[9] Thus, the Provider's dissatisfaction with that methodology would be a *new* issue relating to a ***new*** determination (*i.e.*, the revised NPR) because the alleged sampling and extrapolation methodology was not used in the initial NPR but only in connection with the reopening and revised NPR. In response to the Provider's concern about the length of time it will take to pursue its appeal of the RNPR, the Board notes that the Provider may, pursuant to Board Rule 31, request an accelerated hearing date if it wishes to do so.[10]

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

Board Members Participating:

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

For the Board:

7/22/2020

X Clayton J. Nix

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

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

[8] *See* Provider's Motion for Reconsideration (May 5, 2020) at 6.

[9] It appears that: (1) based on the results of the sampling and extrapolation methodology as embodied in the revised NPR, only 799 days of the original 2554 days remain in dispute and (2) this dispute now revolves around the sampling and extrapolation methodology used in the reopening which resulted in the allowance in the revided NPR of only some of the original days in dispute. In this regard, the Board notes that the issue statement for the Provider's appeal of the revised NPR assigned to Case No. 20-1892 states, in pertinent part: "The issue is whether the MAC properly determined the Provider's number of Medicaid eligible patient days in computing the fraction reflecting the percentage of inpatients who were eligible for medical assistance under an approved State plan (the "Medicaid fraction"). The Provider previously appealed the Medicaid-eligible days issue as part of PRRB Case No. l4-2001. Following the MAC's agreement to reopen the cost report for that issue, the Provider withdrew its appeal pursuant to then PRRB Rule 46.2. Upon reopening, however, *the MAC did not grant the **full** relief requested by the Provider and excluded a total of 799 Medicaid days that the Provider contends should be included in the numerator of the Medicaid fraction*. Specifically, as part of its review, the MAC extrapolated six patient days from its sample based upon the MAC's erroneous determination that the patient days in questions were not appropriately documented as inpatients of the hospital. The Provider contends that the MAC's extrapolation was improper and is *appealing the disallowance of 799 Medicaid patient days **stemming from that extrapolation***." (Emphasis added.)

[10] The Board notes that this determination does not address whether the Board has jurisdiction over Case No. 20-1892 and that it will address jurisdiction in the context of Case No. 20-1892 based on the record of that case.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Baylor White & Scott Health
William Galinsky
Vice President, Government Finance
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MS-AR-M148
Temple, TX 76508

Novitas Solutions, Inc.
Justin Lattimore
Director, JH Provider Audit & Reimb.
707 Grant Street, Suite 400
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RE: ***Jurisdictional Decision***
Baylor Scott & White Medical Center Lake Pointe (Prov. No. 45-0742)
FYE 12/31/2006
Case No. 20-0007

Dear Messrs. Galinsky and Lattimore,

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

Pertinent Facts

The Provider filed an appeal on September 16, 2019 from a revised Notice of Program Reimbursement ("NPR") dated March 15, 2019. The appeal request included the following eight (8) issues:

1. DSH – SSI (Provider Specific) [1]
2. DSH – SSI Percentage
3. DSH – SSI Fraction/Medicare Manage Care Part C Days
4. DSH – SSI Fraction/Dual Eligible Days
5. DSH – Medicaid Eligible Days
6. DSH – Medicaid Fraction/Medicare Managed Care Part C Days
7. DSH – Medicaid Fraction/Dual Eligible Days
8. Standardized Payment Amount

The Provider requested a recalculation of the Medicare SSI percentage based upon the its cost report period in accordance with the regulation 42 C.F.R. § 405.106(b)(3). Through the Provider's Notice of Reopening, the Medicare Contractor agreed to reopen the cost report "to update the SSI percentage and DSH payment percentage per Provider's request to recalculate the

[1] Includes a statement that "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. *See* 42 U.S.C. 1395 (d)(5)(F)(i)."

SSI percentage using their cost report Fiscal Year."[2] The Provider received a revised NPR "[t]o update the DSH calculations to consider updated SSI%." The disputed RNPR only adjusted the SSI% to the realigned ratio (from the Federal Fiscal Year to the Provider's cost report year).

Board Decision

The Board finds that it does not have jurisdiction over ***any*** of the eight issues appealed from the revised NPR, as the specific issues, as described, were not adjusted as part of the revised NPR.

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

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

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

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

These regulations make clear that a provider can only appeal items that are specifically revised from a revised NPR. The adjustment included in the revised NPR, clearly shows it was as a

[2] Notice of Intent to Reopen Cost Report dated June 27, 2017.

result of SSI realignment that changed the time period from September 30 to the Provider's cost reporting period.

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

The Provider requested that its SSI percentage be recalculated from the federal fiscal year to its cost reporting year. CMS does not utilize a new or different data match process when it issues a realigned SSI percentage – all of the underlying data remains the same, it is simply that a different time period is used. The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated and used in the original CMS published SSI percentage) and reports it on the provider's cost reporting period instead of the September 30 Federal Fiscal Year.

The Board finds that the Provider in this appeal is not challenging whether the Medicare Contractor or CMS correctly calculated the realigned SSI ratio for those dates; but rather, the provider is challenging whether the agency "fixed" the SSI methodology problems identified in *Baystate*. However, CMS does not utilize a new or different data match process when it issues a realigned SSI percentage.[3] Further, all of the underlying data which is gathered on a month-by-month basis remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used.[4] Rather, the realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY.

Additionally, as the Provider has already received a realignment, the portion of Issue 1, SSI Provider Specific, that preserves its right to request realignment is moot. The Board finds that the Provider is not arguing the realignment SSI is incorrect, but rather is filing a blanket set of issues unrelated to what was actually adjusted or revised in the revised NPR. The other 6 categories of "DSH" issues were not addressed in the realigned SSI, and the Standardized amount was also not specifically revised as required by 42 C.F.R. § 405.1889.

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

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

In summary, the Board hereby dismisses Case No. 20-0007 in its entirety and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:

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

For the Board:

7/23/2020

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Decision***
Marion General Hospital (Prov. No. 36-0011)
Case No. 20-0180

Dear Mr. Johnston and Ms. Cummings,

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

Pertinent Facts

The Provider filed a timely appeal with the Board on October 21, 2019 from a Revise Notice of Program Reimbursement ("revised NPR") dated April 24, 2019. The appeal has one issue, "The Improper treatment of Part C Days in the DSH calculation".

The revised NPR at issue arose because the Provider requested a recalculation of the Medicare SSI percentage based upon the provider's cost report period in accordance with the regulation 42 C.F.R. § 405.106(b)(3).[1] The regulation, 42 C.F.R. § 412.106(b)(3), permits a provider to request to have its data reported on its cost reporting period instead of the Federal fiscal year. To do so, "It must furnish to CMS, through its Intermediary, a written request including the hospital's name, provider number, and cost reporting period end date. This exception will be performed once per hospital per cost reporting period, and the resulting percentage becomes the hospital's official Medicare Part A/SSI percentage for that period."

The Provider requested that its SSI percentages be recalculated from the federal fiscal year to its cost reporting year. CMS does not utilize a new or different data match process when it issues a realigned SSI percentage.[2] Further, all of the underlying data (which is gathered on a month-by-month basis) remains the same and the realigned SSI percentage simply reflects a different time

[1] Recalculation request dated June 20, 2014.
[2] CMS describes the matching process that it uses as part of the FY 2011 IPPS final rule published on August 16, 2010. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010). Similarly, CMS' policy on Part C days was set in the FFY 2005 Final Rule and is incorporated into and reflected in this data matching process. *See* 75 Fed. Reg. at 50276, 50285-6.

period being used.[3] The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 Federal Fiscal Year.

Through the Provider's Notice of Reopening, the Medicare Contractor agreed to reopen the cost report once a response was received from CMS to update the SSI ratio.[4] The Provider received a RNPR "[t]o update the SSI% and payment factor in accordance with CMS' SSI realignment calculation." The disputed RNPR only adjusted the SSI% to the realigned ratio (from the Federal Fiscal Year to the Provider's cost report year). The issue for the subject appeal states:

> Did the MAC err by not properly including Medicare Part C days when calculating the Provider's DSH percentage?
>
> The Provider believes the MAC failed to properly include appropriate bed days associated with certain Medicare Part C patients in the calculation of the Provider's DSH percentages, including the impact on the Medicare and Medicaid fractions.
>
> Provider believe that the applicable Medicare DSH regulation defines the numerator of the Medicare fraction as the number of days the hospital spent caring for Part A-entitled patients who were also entitled to income support payments under the Social Security Act. *See*, respectively, 42 C.F.R. § 412.106(b)(4) and 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The group members believe that the MAC's treatment of bed days, specifically for those patients who are receiving benefits from the Medicare Part C (Medicare Advantage) program, in the Medicare and Medicaid fractions of the DSH calculation is in violation of the plain language of the applicable regulations, including but not limited to, 42 C.F.R.§ 412.106(b)(4) and the Supreme Court's recent holding in Azar v. Allina Health Services, 139 S. Ct. 1804 (2019).[5]

Board Decision

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

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

[3] As noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data on a month-by-month basis.
[4] Notice of Intent to Reopen Cost Report dated July 2, 2019.
[5] Provider's issue statement (Model Form A)

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

42 C.F.R. § 405.1889 (2018) explains the effect of a cost report revision:[6]

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

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

The Provider appealed the following issue from the revised NPR:

> The Provider believes the MAC failed to properly include appropriate bed days associated with certain Medicare Part C patients in the calculation of the Provider's DSH percentages, including the impact on the Medicare and Medicaid fractions.

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

> Provider believe that the applicable Medicare DSH regulation defines the numerator of the Medicare fraction as the number of days the hospital spent caring for Part A-entitled patients who were also entitled to income support payments under the Social Security Act. *See*, respectively, 42 C.F.R. § 412.106(b)(4) and 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The group members believe that the MAC's treatment of bed days, specifically for those patients who are receiving benefits from the Medicare Part C (Medicare Advantage) program, in the Medicare and Medicaid fractions of the DSH calculation is in violation of the plain language of the applicable regulations, including but not limited to, 42 C.F.R.§ 412.106(b)(4) and the Supreme Court's recent holding in Azar v. Allina Health Services, 139 S. Ct. 1804 (2019).[7]

The adjustment included in the revised NPR and that is the subject of this appeal, clearly show it was as a result of SSI realignment that changed the 12-month time period from the FFY ending September 30 to the Provider's cost reporting period. The Provider in this appeal is not challenging that the Medicare Contractor or CMS didn't calculate the realigned SSI ratio correctly for those dates, but instead challenges an aspect of the agency's methodology for counting the days that are reflected in each months data, specifically they challenge the inclusion of Part C days in the SSI percentage and asserts instead that they should be counted in the Medicaid fraction. CMS does not utilize a new or different data match process when it issues a realigned SSI percentage[8] and, in addition, all of the underlying data (which is gathered on a month-by-month basis) remains the same. The realigned SSI percentage simply reflects a different 12-month time period being used.[9] More specifically, the realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY.

In conclusion, the Board hereby dismisses the DSH Part C Days issue from this appeal as 42 C.F.R. § 405.1889(b) does not allow the Provider to appeal the RNPR at issue. As there are no remaining issues in this appeal, the Board dismisses Case No. 20-0180 and removes it from the

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[7] Provider's issue statement (Model Form A)

[8] *See supra* note 2.

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

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

Board Members Participating:

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

For the Board

7/23/2020

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Decision***
Riverside Methodist Hospital (Prov. No. 36-0006)
Case No. 20-0532

Dear Mr. Johnston and Ms. Cummings,

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

Pertinent Facts

The Provider filed a timely appeal with the Board on December 19, 2019 from a Revised Notice of Program Reimbursement ("revised NPR") dated July 24, 2019. The appeal has one issue: "The Improper treatment of Part C Days in the DSH calculation."

The revised NPR at issue arose because the Provider requested a recalculation of the Medicare SSI percentage based upon the provider's cost report period in accordance with the regulation 42 C.F.R. § 405.106(b)(3).[1] The regulation, 42 C.F.R. § 412.106(b)(3), permits a provider to request to have its data reported on its cost reporting period instead of the Federal fiscal year. To do so, "It must furnish to CMS, through its Intermediary, a written request including the hospital's name, provider number, and cost reporting period end date. This exception will be performed once per hospital per cost reporting period, and the resulting percentage becomes the hospital's official Medicare Part A/SSI percentage for that period."

The Provider requested that its SSI percentages be recalculated from the federal fiscal year to its cost reporting year. CMS does not utilize a new or different data match process when it issues a realigned SSI percentage.[2] Further, all of the underlying data (which is gathered on a month-by-

[1] Recalculation request dated June 20, 2014.
[2] CMS describes the matching process that it uses as part of the FY 2011 IPPS final rule published on August 16, 2010. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010). Similarly, CMS' policy on Part C days was set in the FFY 2005 Final Rule and is incorporated into and reflected in this data matching process. *See* 75 Fed. Reg. at 50276, 50285-6.

month basis) remains the same and the realigned SSI percentage simply reflects a different time 12-month time period being used.[3] The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated and used in the original CMS published SSI percentage) and reports it on the provider's cost reporting period instead of the September 30 Federal Fiscal Year.

Through the Provider's Notice of Reopening, the Medicare Contractor agreed to reopen the cost report once a response was received from CMS to update the SSI ratio.[4] The Provider received a revised NPR "[t]o update the SSI% and payment factor in accordance with CMS' SSI realignment calculation." The disputed revised NPR only adjusted the SSI% to the realigned ratio (from the Federal Fiscal Year to the Provider's cost report year).

The issue for the subject appeal states:

> Did the MAC err by not properly including Medicare Part C days when calculating the Provider's DSH percentage?
>
> The Provider believes the MAC failed to properly include appropriate bed days associated with certain Medicare Part C patients in the calculation of the Provider's DSH percentages, including the impact on the Medicare and Medicaid fractions.
>
> Provider believe that the applicable Medicare DSH regulation defines the numerator of the Medicare fraction as the number of days the hospital spent caring for Part A-entitled patients who were also entitled to income support payments under the Social Security Act. *See*, respectively, 42 C.F.R. § 412.106(b)(4) and 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The group members believe that the MAC's treatment of bed days, specifically for those patients who are receiving benefits from the Medicare Part C (Medicare Advantage) program, in the Medicare and Medicaid fractions of the DSH calculation is in violation of the plain language of the applicable regulations, including but not limited to, 42 C.F.R.§ 412.106(b)(4) and the Supreme Court's recent holding in Azar v. Allina Health Services, 139 S. Ct. 1804 (2019).[5]

[3] As noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data on a month-by-month basis.
[4] Notice of Intent to Reopen Cost Report dated July 2, 2019.
[5] Provider's issue statement (Model Form A)

Board Decision

The Board finds that it does not have jurisdiction over the Part C days issue from the revised NPR, as the specific issue, as described (i.e., Part C days), was not adjusted as part of the revised NPR.

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

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

2 C.F.R. § 405.1889 (2018) explains the effect of a cost report revision:[6]

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

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

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

The Provider appealed the following issue from the revised NPR:

> The Provider believes the MAC failed to properly include appropriate bed days associated with certain Medicare Part C patients in the calculation of the Provider's DSH percentages, including the impact on the Medicare and Medicaid fractions.
>
> Provider believe that the applicable Medicare DSH regulation defines the numerator of the Medicare fraction as the number of days the hospital spent caring for Part A-entitled patients who were also entitled to income support payments under the Social Security Act. *See*, respectively, 42 C.F.R. § 412.106(b)(4) and 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The group members believe that the MAC's treatment of bed days, specifically for those patients who are receiving benefits from the Medicare Part C (Medicare Advantage) program, in the Medicare and Medicaid fractions of the DSH calculation is in violation of the plain language of the applicable regulations, including but not limited to, 42 C.F.R. § 412.106(b)(4) and the Supreme Court's recent holding in Azar v. Allina Health Services, 139 S. Ct. 1804 (2019).[7]

The adjustment included in the revised NPR and that is the subject of this appeal, clearly show it was as a result of SSI realignment that changed the 12-month time period from the FFY ending September 30 to the Provider's cost reporting period. The Provider in this appeal is not challenging whether the Medicare Contractor or CMS calculated the realigned SSI ratio correctly, but instead challenges whether the agency methodology for counting the days that are reflected in each months data, specifically they challenge the inclusion of Part C days in the SSI percentage and asserts instead that they should be counted in the Medicaid fraction. However, CMS does not utilize a new or different data match process or methodology when it issues a realigned SSI percentage[8] and, in addition, all of the underlying data (which is gathered on a month-by-month basis) remains the same. The realigned SSI percentage simply reflects a different 12-month time period being used.[9] More specifically, the realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously

[7] Provider's issue statement (Model Form A)
[8] *See supra* note 2.
[9] *See supra* note 3. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

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

In conclusion, the Board hereby dismisses the DSH Part C Days issue from this appeal as 42 C.F.R. § 405.1889(b) does not allow the Provider to appeal the RNPR at issue. As there are no remaining issues in this appeal, the Board dismisses Case No. 20-0532 and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

7/23/2020

X Clayton J. Nix

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

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

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RE: ***Jurisdictional Decision***
Cleveland Clinic Fdn. CY 2006 Standardized Payment Amount CIRP Group
Case No. 20-1360GC

Dear Ms. Goron and Ms. Cummings,

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

Background

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

> The Provider(s) contend(s) that the MAC's determination for their standardized payment amount was calculated improperly and set too low based on erroneous methodology.
>
> Under the Inpatient Prospective Payment System, hospitals are paid a fixed amount for each Medicare beneficiary that they treat, "regardless of the actual operating costs they incur." *See Sebelius v. Auburn Reg'l Med. Ctr.*, 568 U.S. 145, 133 S. Ct. 817, 822, 184 L. Ed. 2d 627 (2013). This fixed amount is calculated by starting with ***a base rate*** that is then adjusted in various ways for each specific beneficiary at each specific hospital. See 42 U.S.C. § 1395ww(d)(2).
>
> The ***base rate*** used 1981 hospital cost reporting data, and was first developed in 1983 for use in the 1984 fiscal year. The ***base rate*** was partially determined by the average cost-per-discharge. 42 U.S.C. § 1395ww(d)(2). The base year 1981 data did not distinguish between patient discharges and patient transfers. Both were classified as discharges. Therefore, the 1981 data over-

> counted discharges, by including both discharges and transfers in the baseline data.
>
> The result of this error was to spread total operating costs over an artificially high number of discharges, thereby yielding a lower average cost-per-discharge. This in turn lead to a ***base rate*** that was lower than it would have been had the total number of patient discharges been accurately computed. As this error in the ***base rate*** has never been corrected, the standardized payment amount has been lower than it should have been in every year since 1984. Accordingly, for the reason stated above, provider hereby appeals the standardized payment amount for the years at issue in this cost report.[1]

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

A. Background on Participant #1 – Fairview Hospital

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

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

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

B. Background on Participant #2 – Lutheran Hospital

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

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

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

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[1] *Model Form B – Group Appeal Request* (March 6, 2020) (emphasis added).
[2] *Model Form B – Group Appeal Request* (March 6, 2020).
[3] *Model Form B – Group Appeal Request* (March 6, 2020).

Board Decision

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

Relevant Regulations – Revised NPRs

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

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

Additionally, 42 C.F.R. § 405.1889 (2018)[4] explains the effect of a cost report revision:

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

The Board finds that it does not have jurisdiction over the two participants in this appeal because they each appealed from RNPRs that did not adjust the standardized payment amount (*i.e.*, the base rates underling the DRG rates published annually in the Federal Register).

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

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[5] The reopenings in this case were a result of the Providers' request to realign their SSI percentage from the Federal Fiscal Year End to its individual cost reporting fiscal year end. The audit adjustments associated with the RNPRs under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year.[6] The Notices of Reopening explicitly stated that the purpose of the reopening was "to update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the provider's request ..." In other words, the determinations were only being reopened to include realigned SSI percentages. Since the only matters specifically revised in the RNPRs were adjustments related to realigned SSI percentages, the Board does not have jurisdiction over either participant in the subject group appeal.

In conclusion, both participants are dismissed from the appeal as they do not have the right to appeal the RNPRs at issue under 42 C.F.R. § 405.1889. As there are no participants remaining, the Board hereby closes Case No. 20-1360GC and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

FOR THE BOARD:

7/23/2020

X Clayton J. Nix

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

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

[5] 42 C.F.R. § 405.1889(b)(1).

[6] CMS does not utilize a new or different data match process when it issues a realigned SSI percentage. CMS describes the matching process that it uses as part of the FY 2011 IPPS final rule published on August 16, 2010. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010). All of the underlying data which is gathered on a month-by-month basis remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Request for Reconsideration of Bifurcation and Jurisdictional Determination***
CHW 2007 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 09-1600GC

Dear Mr. Knight and Ms. Frewert:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the request that the Board reconsider its September 8, 2016 decision in the CHW 2007 DSH Dual Eligible Days Group. For the reasons explained below, the Board denies the request for reconsideration.

Background

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

> Whether the Medicaid Ratio used to calculate Medicare Disproportionate Share Payments (DSH) accurately reflects the number of patient days furnished to patients eligible for Medicaid in situations where the patient is also enrolled in the Medicare Part A Program but is not entitled to Medicare Part A benefits.
>
> We contend that the number of Medicaid eligible patient days used to calculate the Medicaid ratio are understated due to exclusion of various categories of Medicaid eligible patients who are enrolled in Medicare Part A but are not entitled to Medicare Part A benefits. The applicable regulation governing this issue is 42 CFR 412.106.

On September 8, 2016, the Board issued a decision in which it granted bifurcation for some Providers and denied bifurcation for others. The Board found that French Hospital and Marian Medical Center included the HMO/Part C Days issue in their individual appeal requests, and therefore granted the transfer of that issue from their individual appeals to Case No. 10-0029GC. The Board denied bifurcation for Chandler Regional Medical Center and Mercy Hospital Bakersfield, because those Providers did not appeal the HMO/Part C Days issue in their appeal requests.

The Part C group, Case No. 10-0029GC was established on October 13, 2009. However, Case No. 10-0029GC was ***dismissed*** by the Board on April 26, 2017, for *failure to timely file the Providers' preliminary position paper.*

On September 9, 2016, the Provider representative requested to withdraw Case No. 09-1600GC due to a pending settlement; the Board closed the appeal on September 12, 2016.

Providers' Request for Reconsideration

On November 4, 2016, the Providers' representative, Toyon Associates, Inc. ("Toyon") sent a request for reconsideration and renewed that request for reconsideration by letter dated August 22, 2019. Toyon offers several arguments in support of its position that the Board should reverse its decision as related to the HMO/Dual Eligible Part C days issue. Toyon first argues that the Providers' intent to appeal "the whole dual eligible days issue" was expressed in the language the Providers used in their appeal and transfer requests. Toyon also argues that the factual and historical context of the appeal requests support the conclusion that the Providers intended to appeal both issues. At the time this group appeal request was filed, providers commonly appealed the dual eligible days issue generally, contesting the categorical exclusion of all dual eligible days based on patients' status as Medicare beneficiaries.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841 (2005), a group of providers have a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if they are dissatisfied with their respective final determination of the Medicare contractor, the amount in controversy is $50,000 or more, and the providers' requests for hearing are filed within 180 days of the date of notice of their respective final determinations. Pursuant to 42 C.F.R. § 405.1837(a)(2) (2005), the matter at issue in a group appeal must involve a single common question of fact or interpretation of law, regulation or CMS policy or ruling.

The Board denies the request for reconsideration and reinstatement. The Providers involved in this reconsideration request are Common Issue Related Party ("CIRP") providers. The regulation at 42 C.F.R. § 405.1837(b)(1) ***requires*** that commonly owned or controlled providers file group appeals for each common issue of fact, law or rulings (*i.e.*, file CIRP group appeals) when the amount in controversy exceeds $50,000:

> (b) *Usage and filing of group appeals* -
> (1) ***Mandatory*** *use of 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**.[1]

Because the remaining Providers in this group appeal are CIRP Providers, they needed to be a part of the CIRP group that the chain established for the Part C Days CIRP issue. However, subsequent to the dismissal of those Providers from Case No. 09-1600GC (and subsequent to the original November 4, 2016 request for reconsideration), the Board dismissed the Part C Days CIRP group, Case No. 10-0029GC, on April 26, 2017 for failure to timely file the preliminary position paper. Moreover, the Board notes that the chain never requested reinstatement of the CIRP group pursuant to Board Rule 47.3 (Aug. 29, 2018) and, as such, the chain essentially abandoned the Part C Days CIRP issue. Thus, without the CIRP group being reinstated pursuant to Board Rule 47.3, the Board cannot reconsider reinstatement of the Providers because the CIRP group to which the CIRP Providers desire to be reinstated was dismissed and no longer exists. Accordingly, the Board denies the Request for Reinstatement and Case No. 09-1600GC remains closed.

Board Members:

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

For the Board:

7/24/2020

X Clayton J. Nix

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

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

[1] (Emphasis added.) *See also* Board Rules (July 1, 2015) at Rules 12, 13, and 19 regarding the formation of group appeals (*available at:* https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Instructions.html).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Decision***
Southwest Consulting 2010 DSH Post 1498-R Medicare Part A/SSI Percentage Group 3
PRRB Case No. 18-0223G

Dear Ms. Webster and Mr. Snyder,

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

Pertinent Facts

There are five participants included in Case No. 18-0223G as follows:

1. Rockford Memorial Hospital (14-0239)
2. University of Louisville (18-0141)
3. McCullough-Hyde Hospital (36-0046)
4. Armstrong County Memorial Hospital (39-0163)
5. Penn State Milton S Hershey Medical Center (39-0256)

The five participants listed above each received a revised Notice of Program Reimbursement ("revised NPR") to implement the Realigned SSI ratio pursuant to their individual requests. The disputed revised NPRs only adjusted the SSI percentage to the realigned ratio (from the Federal Fiscal Year to the Provider's cost report year). The issue for the subject appeal, Southwest Consulting 2010 DSH Post 1498-R Medicare Part A/SSI Percentage Group 3 states, in part:

> The issue is whether the Centers for Medicare & Medicaid Services ("CMS") has correctly determined the "SSI fraction" used in calculating the Providers' disproportionate patient percentage for purposes of the DSH adjustment. The Providers contend that the SSI fraction is understated to the extent that CMS has not corrected

> systemic flaws in the data and match process used by CMS in determining the SSI fractions.[1]

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

Medicare Contractor's Position

The Medicare Contractor argues that the issue statement makes it clear that the Providers are appealing an underlying data error in the calculation of the SSI percentage of the DSH calculation. This issue was not addressed in the revised NPR of subject Providers. Therefore, the Providers' participation in this group is outside the scope of the realignment determination.

According to the Medicare Contractor, any dispute of the underlying data accuracy of the SSI percentage should have been addressed from the original determination, however the subject Providers did not do this and the opportunity to do so has long since passed.

The reopening to realign the subject Providers' SSI percentage merely changed the period included in the calculation from the Federal fiscal year to the Providers' fiscal year and contained no specific revision of the underlying data used in the calculation. The Medicare Contractor concludes that, therefore, the realignment determinations used by the subject Providers did not impart appeal rights regarding the Medicare fraction calculation appealed in this case and cannot be used as a determination under 42 C.F.R. §405.1835(a)(1).[2]

Providers' Position

All five participants in this this group appeal joined it based on their appeal of a revised NPRs applying new SSI fractions to their DSH payment calculation as a result of a recalculation of the SSI fraction on the basis of discharges in the hospital's cost reporting period under 42 C.F.R. § 412.106(b)(3).[3] According to the Group Representative, because the adjustments appealed by the Providers applied newly-determined SSI fractions in place of the original SSI fractions, the MAC's objection "is pointless and should be denied."[4]

The Group Representative explains that the new SSI fractions from which the Providers have appealed were created using different patients for both the numerator and denominator and replaced the SSI fractions used in the original NPRs, therefore the Medicare Contractor made

[1] Group Appeal Request at Tab 2.
[2] Medicare Contractor's Jurisdictional Challenge at 5.
[3] Providers' Response to MAC Jurisdictional Challenge at 6.
[4] *Id.* at 7.

"an entirely fresh determination of the SSI fractions that stands separate and apart from the original determination of the SSI fractions."[5] The Group Representative concludes that even if the Board's jurisdiction is properly limited to "[o]nly those matters that are specifically revised in the revised determination," there is no question that the entirety of the SSI fractions were "specifically revised" in these revised NPRs.

Next, the Group Representative argues that even if the Board would not otherwise have jurisdiction over these appeals, long-standing agency precedents establish that the DSH payment calculation is a singular issue and the Board's jurisdiction extends over the "entire issue" relating to the DSH payment, including the calculation of the SSI fraction.[6]

Last, the Group Representative argues that, because the Providers have properly invoked the Board's jurisdiction over various aspects of the DSH payment calculation, the Board also has the power to review and revise the calculation in accordance with § 1878(d) of the Social Security Act.[7]

Board Decision

The Board finds that it does not have jurisdiction over the DSH SSI issue from the revised NPRs, as the issue under appeal was not adjusted as part of the revised NPRs.

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

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

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

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. §§

[5] *Id.* at 8.
[6] *Id.* at 9 – 11.
[7] *Id.* at 11.

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

These regulations make clear that a provider can only appeal items that are specifically revised from a revised NPR. The adjustments included in the revised NPRs and that are the subject of this appeal, clearly show they were as a result of SSI realignment that changed the time period from September 30 to each Providers' cost reporting periods.

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

The Providers requested that their SSI percentages be recalculated from the federal fiscal year to their respective cost reporting years. CMS does not utilize a new or different data match process when it issues a realigned SSI percentage.[8] Further, all of the underlying data (which is gathered on a month-by-month basis) remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used.[9] The realignment solely takes the SSI data for each

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

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

provider and the total Medicare days for each provider (previously accumulated and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 Federal Fiscal Year.

The Board finds that the 5 Providers in this group appeal are not challenging that the Medicare Contractor or CMS did not calculate the realigned SSI ratio correctly for those dates, but instead challenges whether the agency "fixed" the problems according to *Baystate*. Again, CMS does not utilize a new or different data match process when it issues a realigned SSI percentage and all of the underlying month-by-month data remains the same.[10] Rather, it is simply that a different 12-month time period is used.

With respect to the Group Representative's argument that the Board has jurisdiction over the "entire issue" of DSH, the Board has consistently found that it must have jurisdiction over the specific issue and, in the context of appeals of revised NPRs, 42 C.F.R. § 405.1889(b) specifically limits the Board's jurisdiction to "those matters that are specifically revised in a revised determination." The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b), including in the context of appeals involving different aspects of the DSH calculation.[11]

With respect to the Providers' argument that the Board has the power to review and revise the DSH calculation in accordance with 42 U.S.C. § 1395oo(d), the Board finds that this statutory provision is not applicable to Case No. 18-0223G since all of the participants in the group appealed from revised NPRs and their right to so appeal is vested not through § 1395oo but rather administratively through 42 C.F.R. § 405.1889. More specifically, the Board's jurisdiction over an RNPR does not originate from the § 1395oo statutory appeals process but rather is established through a separate § 405.1889 regulatory process that the Secretary permissibly created using his "general rulemaking authority."[12]

Finally, the Board notes that, even if the Board were to have found jurisdiction under § 405.1889(b), the Board may have closed or dismissed this appeal on other grounds based on the following statement in the Group Representative's April 10, 2019 response to the Medicare Contractor's jurisdictional challenge:

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two Federal fiscal years that spanned the hospital's cost reporting period. (emphasis added)); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital **must accept** the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[10] *See supra* notes 8, 9.

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

[12] *See* the D.C. Circuit's 1994 decision in *HCA Health*.

> Alternatively, because ***each*** of the Providers also appealed the determination of their SSI fractions from their original NPRs, the Board may wish to consolidate their appeals from the revised NPRs in this case with the Providers' earlier appeals from the original NPRs, on the same issue, in PRRB case numbers 13-1188GC, 14-1641G, and 15-0036G (*see infra* p. 7).

First, this statement suggests that each of the providers had a duplicate appeal of this issue for 2010 in violation Board Rule 4.6 which makes it clear that a provider may not pursue the same issue for a fiscal year in more than one appeal.[13] Further, the fact the one of the participants in 18-0223G is also pursuing this same issue in a CIRP group (as denoted by the "GC" at the end of the case number, Case No. 13-1188GC) suggests that some of the participants in Case No. 18-0223G were commonly owned in 2010 and are subject to the mandatory group appeal requirements under 42 C.F.R. §§ 405.1835(b)(4) and 405.1837(b).[14]

The Board hereby dismisses all Providers from this group appeal. As there are no remaining provider, the Board hereby closes Case No. 18-0223G and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:

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For the Board:

7/31/2020

X Clayton J. Nix

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

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

[13] The Board's action would necessarily depend on the status and, if closed, disposition of the duplicate appeal (*e.g.*, whether the duplicate appeal is still pending before the Board, had been withdrawn, had been granted expedited judicial review, *etc.*).

[14] Again, the Board's action would necessarily depend on the status and, if closed, disposition of the duplicate appeal (*e.g.*, whether the duplicate appeal is still pending before the Board, had been withdrawn, had been granted expedited judicial review, *etc.*).