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Refer to: 10-0942GC

CERTIFIED MAIL

MAY 05 2017

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President
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Byron Lamprecht
Cost Report Appeals
Wisconsin Physicians Service
2525 N 117th Avenue, Suite 200
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RE: Group Name: QRS HMA 2008 Medicare DSH Labor Room Days CIRP Group
FYE: 2008
PRRB Case No.: 10-0942GC

Dear Mr. Ravindran and Mr. Lamprecht:

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documentation submitted in the above-captioned case. The Board determined that Participants 14, 15, 23, 32, and 41 are dismissed for failing to provide essential jurisdictional documentation. The Board also determined that Participants 3, 7, 8, 20, 21, 22, 24, 25, 27, 28, 29, 30, 33, 34, 40, and 43 are dismissed for filing untimely appeals. The Board will remand the remaining Participants pursuant to CMS Ruling 1498-R.

## BACKGROUND

The Group Representative, QRS, filed a group appeal request on behalf of the providers on April 19, 2010. The group issue is described as "[w]hether the [Medicare contractor] properly excluded Medicaid eligible Labor Room days from the DSH calculation."[1] QRS stated that, specifically, the Medicare contractor failed to include Medicaid maternity patients in the Medicaid DSH fraction.[2] QRS attached a list of 46 providers, but stated that the group was not closed.

On April 27, 2010, the Medicare contractor, WPS, sent a letter to the Board regarding jurisdictional requirements.[3] WPS cited Board Rule 12.2, stating that "[p]roviders in a group appeal must have final determinations for their cost reporting periods that end within the same calendar year."[4] WPS stated that it found only one provider (Prov. No. 50-0037) that had a July 24, 2009 Notice of Program Reimbursement ("NPR") issued, which was over 180 days old. Accordingly, WPS requested that the Board close the case due to the lack of final

[1] Group Appeal Request Tab 2, Apr. 19, 2010.
[2] *Id.*
[3] *See* Letter from WPS Re: Jurisdictional Requirements to Board ("First Jurisdictional Challenge"), Apr. 27, 2010.
[4] *Id.* (citing Board Rule 12.2 at 10, Mar. 1, 2013).

determinations. QRS responded, stating that the Board has jurisdiction even without a final determination pursuant to Board Rule 7.4.[5]

WPS filed a second Jurisdictional Challenge in September 2010. WPS argued:

> On April 22, 2010, we notified the Board that only one provider had received an NPR. However, since the NPR was issued July 24, 2009, the April 15, 2010 request must be considered late. Also, given the fact that the remaining providers had yet to receive an NPR, the appeal request is premature as well. Not[]withstanding, the provider's justification, 'the [Medicare contractor]'s failure to timely issue final determinations' should be addressed under a separate appeal request.[6]

The provider that received its NPR was Toppenish Community Hospital (Prov. No. 50-0037). QRS responded, on October 8, 2010, that Toppenish had not filed an appeal and had no intention of filing one for the Labor Room Days ("LDR") or any other issue.[7] QRS stated that Toppenish was inadvertently included in the list of providers in the group appeal request. As a result, QRS formally requested that this provider be withdrawn from the case. QRS further stated that, in conjunction with Board Rule 7.4, the Board does have jurisdiction over this group appeal as the Medicare contractor did not timely issue NPRs for the 2008 fiscal year.[8] QRS noted that once NPRs are issued for all of the providers wanting to appeal this issue, QRS will close the group and complete the Schedule of Providers with the appropriate jurisdictional documentation.[9]

On June 22, 2015, the Board e-mailed QRS regarding a Status Request and Request for Schedule of Providers:

> The Board notes that the majority of the participants used to form the initial group filed from lack of receipt of timely final determinations. Upon review, it appears that most, if not all, participants have now received final determinations that were issued after the issuance of [CMS Ruling 1498-R, Apr. 28, 2010]. These participants would not [be] subject to the Ruling and will be bifurcated into a new group appeal.[10]

The Board required two Schedules of Providers to be filed within 30 days of the e-mail, stating that one Schedule should be filed for "no timely NPR" and one Schedule should be filed for participants with "NPRs issued." The Board also referred QRS to Board Rule 7.4 for instructions on filing a Schedule of Providers for those providers without a timely NPR. The Board stated that:

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[5] *See* Letter from QRS Re: Response to Jurisdictional Requirements, Jun. 9, 2010.
[6] WPS Second Jurisdictional Challenge, Sep. 13, 2010.
[7] QRS Response to Second Jurisdictional Challenge, Oct. 8, 2010.
[8] *Id.* at 1.
[9] *Id.*
[10] E-mail from the Board to QRS, Jun. 22, 2015 (footnote omitted).

> Upon receipt of the Schedule(s) and associated jurisdictional documentation, the Board will review jurisdiction to determine whether the case is appropriate for remand under CMS Ruling CMS-1498-R for participants that appealed the lack of receiving a timely final determination. Failure to submit the Schedules . . . within the 30 day period will result in dismissal of case number 10-0942GC.[11]

Lastly, the Board requested that QRS verify the fiscal year end for Seven Rivers Regional Medical Center (Participant 14).[12]

QRS responded via e-mail, stating that all providers had received their NPRs, and all of these NPRs were issued after CMS 1498-R.[13] "As such, remand may not be appropriate for any of the providers in these CIRP group appeals."[14] QRS requested to consolidate the instant case with Case No. 13-2326GC, which was formed to handle providers with NPRs issued. The Board responded that the LDR issue in the instant case, Case No. 10-0942GC, deals with CMS' policy to exclude LDR days whereas the issue in Case No. 13-2326GC deals with the change in CMS' policy to allow LDR days.[15] Consequently, the Board stated that it was not appropriate to consolidate these two cases. The Board informed QRS that the revised due date for the Schedule of Providers is September 21, 2015. The Board again requested that QRS address the fiscal year end for Participant 14, and for QRS to inform the Board whether the NPR-based group was complete.[16]

The Board received the Schedule of Providers on September 17, 2015. QRS also submitted a letter. The letter stated that all providers received their NPRs, and all were issued after the effective date of CMS 1498-R. QRS also confirmed that Participant 14, Seven Rivers, has a 05/31/2008 fiscal year end.

## ANALYSIS AND DECISION

42 U.S.C. § 1395*oo*(a)(1) provides that a group of hospitals may obtain a hearing with respect to their Medicare reimbursements if (1) the amount in controversy is $50,000 or more, (2) such providers have not received their final determination from the Medicare contractor on a timely basis after filing their cost reports, and (3) such providers file a request for a hearing within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.[17] 42 C.F.R. § 405.1835(a)(3) (2009) adds that the Medicare contractor's determination must be issued within 12 months of the date of receipt of the provider's perfected cost report or amended cost report. The date of receipt is presumed to be the date the Medicare contractor stamped "received" unless it is shown by a preponderance of

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[11] *Id.*
[12] *See id.*
[13] QRS E-mail to the Board in Response to Board's E-mail, Aug. 10, 2015.
[14] *Id.*
[15] E-mail from Board to QRS Regarding Consolidation, Aug. 11, 2015.
[16] *Id.*
[17] 42 U.S.C. § 1395*oo*(a)-(b) (2009).

the evidence that the Medicare contractor received the cost report on an earlier date.[18] Further, the delay cannot be the fault of the provider.[19]

According to the statute and regulation previously cited, providers do not have to wait for NPRs in order to file a valid appeal with the Board. Moreover, providers have broader appeal rights from "no NPR" appeals. In its First Jurisdictional Challenge, WPS argued that the Board should dismiss this appeal since none of the providers had final determinations except for Toppenish Community Hospital (Prov. No. 50-0037). Since WPS is incorrect, the Board denies WPS's First Jurisdictional Challenge.

WPS's Second Jurisdictional Challenge reiterated its original challenge that the appeal was premature since the providers were lacking final determinations. WPS argued that only one provider, Toppenish Community Hospital, had a final determination; however, the appeal was late because the final determination was issued on July 24, 2009 and the appeal was filed past the 180 day deadline. For the reasons stated earlier, the Board concludes that providers can have a valid appeal from an untimely final determination. Further, as QRS requested a withdrawal of Toppenish Community Hospital, the Board need not address the timeliness issue raised by WPS. The Board finds that Toppenish Community Hospital was withdrawn from this appeal.

In addition to the previously raised challenges, WPS's Second Jurisdictional Challenge added that the lack of final determination should be considered under a separate appeal request. WPS maintains that the Board lacks jurisdiction over LDR days, but if the group " . . . wishes to pursue a CIRP group for failure to issue final determination[s], then they need to do so under a separate appeal request."[20] The Board finds that WPS' reasoning is incorrect. The lack of final determinations is the jurisdictional basis for filing the appeal, not the issue on appeal. In other words, the untimely final determination is a jurisdictional component just like the amount in controversy and the timeliness requirements as outlined in 42 U.S.C. § 1395*oo*(a). Therefore, the Board should find that the LDR issue need not be considered separate and apart from the lack of final determinations.

*CMS Ruling 1498-R*

CMS issued CMS Ruling 1498-R—which covers LDR days—on April 28, 2010 (after this appeal was pending before the Board). CMS 1498-R provides the following:

> . . . CMS and the Medicare contractors will resolve each properly pending claim, in a DSH appeal for a cost reporting period beginning before October 1, 2009, in which the hospital seeks inclusion in the [Disproportionate Patient Percentage ("DPP")] of LDR inpatient days. For such properly pending appeals, CMS and the contractors will recalculate the hospital's DSH payment adjustment for the period at issue by including the LDR days in the Medicaid fraction or the SSI fraction (whichever proves to be

[18] 42 C.F.R. § 405.1835(a)(3)(ii) (2009).
[19] *Id.*
[20] WPS's Second Jurisdictional Challenge.

> applicable), regardless of whether the LDR patient had occupied a routine care bed prior to occupying an ancillary LDR bed before the census-taking hour. . . . CMS' action eliminates any actual case or controversy regarding the hospital's previously calculated DSH payment adjustment and thereby renders moot each properly pending claim in a DSH appeal . . . [provided that] the claim satisfies the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines. Accordingly, it is hereby held that the [Board] and the other administrative tribunals lack jurisdiction over each properly pending claim on the LDR inpatient day issue for a cost reporting period beginning before October 1, 2009, provided that such claim otherwise satisfies the applicable jurisdictional and procedural requirements for appeal,[21]

Therefore, according to CMS 1489-R, pending cases for LDR days for cost reporting periods prior to October 1, 2009 should be remanded to the Medicare contractor if jurisdictional and procedural requirements are met.[22]

In this case, the cost reporting periods in question for each of the providers began prior to October 1, 2009. Therefore, the Board must determine if the requirements are met in order for a proper remand. The Board finds that the group meets the amount in controversy (the total estimated appeal is worth $222,079); however, some providers did not meet other jurisdictional requirements.

At the time when QRS submitted the Schedule of Providers on September 17, 2015, Board Rule 21 required a copy of the following items behind Tab A:

- the certification page of the perfected cost report,
- the certified mail receipt evidencing the Intermediary's receipt of the as-filed and any amended cost reports,
- the Intermediary's letter/e-mail acknowledging receipt of the as-filed and any amended cost reports,
- evidence of the Intermediary's acceptance or rejection of the as-filed and any amended cost reports, and
- the documentation described in Rule 7.2, as relevant, if the issue(s) being appealed involves one or more self-disallowed items.[23]

For a majority of the providers, QRS attached a printout from the STAR system showing the dates that cost reports were "received," along with a printout of the certification page. QRS notes that:

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[21] CMS Ruling 1498-R at 15-16, Apr. 28, 2010.
[22] *Id.* at 16.
[23] Board Rule 21(A)(2) at 17, Jul. 1, 2015.

> . . . Worksheet S, Parts I & II were taken from the CMS HCRIS data file and these copies are not signed by the Provider. However, QRS is enclosing print screens from the [Medicare contractor] of their "STAR's" system for [a] majority of the Providers which tracks all relevant dates with respect to the submitted cost report.[24]

For some of the providers that do not have the STAR printout, QRS enclosed a copy of its e-mail requesting the STAR printouts from the Medicare contractor.[25] The providers that are missing the STAR printout are:

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|---|---|
| Participant 14 | Seven Rivers Regional Medical Center |
| Participant 15 | Barrow Regional Medical Center |
| Participant 23 | Central Mississippi Medical Center |
| Participant 32 | Lake Norman Regional Medical Center |
| Participant 41 | Jamestown Regional Medical Center |

The Board hereby dismisses these providers (Participants 14, 15, 23, 32, and 41) for failure to follow Board Rules. The Board has no way of confirming the dates that are essential to jurisdiction without the required documentation.

*Premature Appeal*

The Medicare contractor is supposed to issue final determinations within 12 months of the date of receipt of a provider's cost report. If the providers do not have their NPRs issued timely, they can appeal to the Board within 180 days. Some of the providers appealed to the Board (April 19, 2010) *prior* to their final determination deadlines. The NPR due date was 12 months from the cost report receipt date for the following providers:

| **Participant No.** | **Provider Name** | **Cost Report Receipt** |
|---|---|---|
| Participant 3 | Summit Medical Center | 06/01/2009 |
| Participant 7 | Peace River Regional Medical Center | 05/28/2009 |
| Participant 8 | Lehigh Regional Medical Center | 05/29/2009 |
| Participant 15 | Barrow Regional Medical Center | 06/02/2009[26] |
| Participant 20 | Gilmore Memorial Regional Medical Center | 06/01/2009 |
| Participant 21 | Madison River Oaks Hospital | 05/29/2009 |
| Participant 22 | Northwest Mississippi Reg'l Medical Center | 06/02/2009 |
| Participant 23 | Central Mississippi Medical Center | 08/01/2009[27] |
| Participant 24 | Riley Hospital | 06/01/2009 |
| Participant 25 | Rankin Medical Center | 05/28/2009 |
| Participant 27 | Women's Hospital | 05/29/2009 |

[24] *See* Schedule of Providers footnotes, Sep. 17, 2015.
[25] *Id.*
[26] Participant 15, Barrow Regional Medical Center, was already dismissed for failing to have a STAR report.
[27] Participant 23, Central Mississippi Medical Center, was already dismissed for failing to have a STAR report.

| | | |
|---|---|---|
| Participant 28 | River Oaks Hospital | 05/29/2009 |
| Participant 29 | Twin Rivers Regional Medical Center | 05/28/2009 |
| Participant 30 | Poplar Bluff Regional Medical Center | 05/28/2009 |
| Participant 33 | Davis Regional Medical Center | 10/30/2009 |
| Participant 34 | Davis Regional Medical Center | 10/30/2009 |
| Participant 40 | Chester Regional Medical Center | 10/18/2010[28] |
| Participant 41 | Jamestown Regional Medical Center | 06/01/2009[29] |
| Participant 43 | Mesquite Regional Medical Center | 06/01/2009 |

Since all of the NPR due dates occurred *after* the appeal date for the above listed providers, the Board finds that these providers filed premature appeals. The Board hereby dismisses Participants 3, 7, 8, 20, 21, 22, 24, 25, 27, 28, 29, 30, 33, 34, 40, and 43. Providers must have an untimely determination prior to filing an appeal with the Board. Although Participants 15, 23, and 41 also filed premature appeals, they were already dismissed for failing to provide essential jurisdictional documentation.

The Board has found that it has jurisdiction over the remaining providers and will issue a remand under separate cover. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 1877.

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

FOR THE BOARD

L. Sue Andersen, Esq.
Chairperson

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

[28] QRS noted the cost report submission date on the Schedule of Provider as 02/27/2009; however, this must be a typo. The STAR report indicates the correct date was 10/18/2010.
[29] Participant 41, Jamestown Regional Medical Center, was already dismissed for failing to have a STAR report.

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MAY 19 2017

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RE: Southwest Consulting DSH Part C Days Groups
FYEs Various
PRRB Case Nos.
13-0630GC Memorial Herman Health Systems 2008 DSH Medicare Advantage Days Group
13-0736GC Memorial Herman Health Systems 2008 DSH SSI Fraction Denominator/Part C Days Group
13-2449GC Covenant Health 2008 DSH SSI Fraction Part C days Group
13-2450GC Covenant Health 2008 DSH Medicaid Fraction Part C days Group
13-2631GC Regional Care DSH SSI Fraction Part C Days Group
13-2633GC Regional Care DSH Medicaid Fraction Part C Days Group

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' May 1, 2017 request for expedited judicial review (EJR) (received May 2, 2017) for the above-referenced appeals. The Board's determination is set forth below.

The issue in these cases is:

> Whether the Medicare Part C patients are 'entitled to benefits' under Part A, such that they should be counted in the Medicare Part A/SSI fraction and excluded from the Medicaid fraction numerator [of the disproportionate share hospital (DSH) adjustment] or vice-versa.[1]

**Statutory and Regulatory Background: Medicare DSH Payment**

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system (PPS).[2] Under PPS,

[1] Providers' May 1, 2017 EJR Request at 4.
[2] *See* 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[3]

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

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

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

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

The Medicare/SSI fraction is computed annually by CMS, and the Medicare Administrative Contractors (MACs) use CMS' calculation to compute a hospital's DSH payment adjustment.[9]

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

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

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[3] *Id.*
[4] *See* 42 U.S.C. § 1395ww(d)(5).
[5] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] 42 C.F.R. § 412.106(b)(2)-(3).

> *part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period. (emphasis added)

The MAC 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.[10]

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[11] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[12]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[13]

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[10] 42 C.F.R. § 412.106(b)(4).
[11] of Health and Human Services
[12] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).
[13] *Id.*

With the creation of Medicare Part C in 1997,[14] 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 intermediaries to calculate DSH payments for the FY 2001-2004.[15]

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 Medicare fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction* . . . (emphasis added)[16]

The Secretary purportedly changed her position in the 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."[17] In response to a comment regarding this change, the Secretary explained that:

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A.* We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C*

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[14] 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.

[15] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).

[16] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).

[17] 69 Fed. Reg. at 49,099.

> *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.[18] (emphasis added)

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

Although the change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the Federal fiscal year (FFY) 2008 final rule was issued.[19] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule. As a result, Part C days were required to be included in the Medicare fraction as of October 1, 2004.

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius,*[20] vacated the FFY 2005 IPPS rule. However, the Providers point out, the decision is not binding in actions by other hospitals. Further, the Secretary has not acquiesced to that decision.[21]

**Providers' Request for EJR**

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

Prior to 2004, the Secretary treated Part C patients as not entitled to benefits under Part A. From 1986-2004, the Secretary interpreted the term "entitled to benefits under Part A" to mean covered or paid by Medicare Part A. In the final rule for the FFY 2005, the Secretary reversed course and announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective October 1, 2004.[22]

In *Allina*, the Court affirmed the district court's decision "that the Secretary's final rule was not a logical outgrowth of the proposed rule."[23] Because the Secretary has not acquiesced to the decision, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

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[18] *Id.*
[19] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[20] 746 F. 3d 1102 (D.C. Cir. 2014).
[21] Providers' EJR request at 1.
[22] 69 Fed. Reg. at 49,099.
[23] *Allina* at 1109.

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

**Decision of the Board**

The Board has reviewed the submissions of the Providers pertaining to the requests for hearing and expedited judicial review. This set of six group cases contain Providers with cost reporting periods ending 6/30/2008, 9/30/2008 or 12/30/2008. The Providers with 6/30/2008 and 9/30/2008 cost reporting periods could claim the Part C days issue as a self-disallowed cost under *Bethesda Hospital Association. Bowen.*[24] The 12/31/2008 cost report periods required either an adjustment to SSI or a protested amount. *See* 42 C.F.R. § 405.1835 (2008). In these cases all of the Providers, regardless of the cost reporting period, had an SSI adjustment. SSI percentages were adjusted as a result of the decision in *Baystate Medical Center v. Leavitt*[25] (*Baystate*) and the notice published in the August 16, 2010 Federal Register[26] stating that SSI percentages would be updated and applied to the cost reporting periods under appeal. Most of these Providers' NPRs were held during the course of the *Baystate litigation* and the new SSI percentages were used to calculate their DSH adjustments. This is reflected in their audit adjustment reports. In addition to the SSI adjustment, some Providers also protested the Part C issue. The documentation shows that the estimated amount in controversy for each group appeal exceeds $50,000, as required for a group appeal[27] and the appeals were timely filed from the issuance of the Providers' original Notices of Program Reimbursement. The estimated amount in controversy is subject to recalculation by the Medicare Administrative Contractor for the actual final amount in each case.

The Board finds that:

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

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

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[24] 108 S.Ct. 1255 (1988).
[25] 545 F. Supp. 2d 20 (D.D.C. 2008) modified 587 F.Supp. 2d 37 and 587 F.Supp. 2d 44.
[26] 76 Fed. Reg. 50042, 50275-50,286.
[27] *See* 42 C.F.R. § 405.1837.

3) it is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867);[28] and

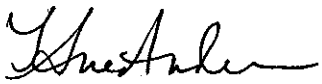
4) it is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), are valid.

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

Board Members Participating

L. Sue Andersen, Esq.
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA, CHFP
Gregory H. Ziegler

FOR THE BOARD:



L. Sue Andersen, Esq.
Chairperson

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

cc: Bill Tisdale, Novitas Solutions (Certified Mail w/Schedules of Providers)
Barb Hinkle, Cahaba GBA c/o NGS (Certified Mail w/Schedules of Providers)
Wilson Leong, (w/Schedules of Providers)

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Certified Mail

MAY 19 2017

Christopher L. Keough, Esq.
Akin, Gump, Strauss, Hauer & Feld, LLP
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1333 New Hampshire Avenue, N.W.
Washington, D.C. 20036-1564

RE: Southwest Consulting DSH Part C Days Groups
FYEs Various
PRRB Case Nos.
13-2620GC, 13-2621GC, 13-3397GC, 13-3436GC,
13-3685GC, 14-0196GC, 14-0197GC,14-0491GC,
14-0492GC, 14-0698GC, 14-0975GC,14-0978GC,
14-1042GC,14-0043GC, 14-1338GC, 14-1339GC,
14-1354GC, 14-1424GC, 14-1427GC,14-1542GC,
14-1553GC, 14-2364GC, 14-2425GC, 14-2428GC,
14-2613GC, 14-3651GC, 14-3652GC

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' May 1, 2017 request for expedited judicial review (EJR) (received May 2, 2017) for the above-referenced appeals. The Board's determination is set forth below.

The issue in these cases is:

> Whether the Medicare Part C patients are 'entitled to benefits' under Part A, such that they should be counted in the Medicare Part A/SSI fraction and excluded from the Medicaid fraction numerator [of the disproportionate share hospital (DSH) adjustment] or vice-versa.[1]

**Statutory and Regulatory Background: Medicare DSH Payment**

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the

[1] Providers' May 1, 2017 EJR Request at 4.

prospective payment system (PPS).[2] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[3]

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

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

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

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

The Medicare/SSI fraction is computed annually by CMS, and the Medicare Administrative Contractors (MACs) use CMS' calculation to compute a hospital's DSH payment adjustment.[9]

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the

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[2] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[3] *Id.*
[4] *See* 42 U.S.C. § 1395ww(d)(5).
[5] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(l).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] 42 C.F.R. § 412.106(b)(2)-(3).

> Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period. (emphasis added)

The MAC 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.[10]

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[11] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[12]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[13]

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[10] 42 C.F.R. § 412.106(b)(4).
[11] of Health and Human Services
[12] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).
[13] *Id.*

With the creation of Medicare Part C in 1997,[14] 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 intermediaries to calculate DSH payments for the FY 2001-2004.[15]

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 Medicare fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction* . . . (emphasis added)[16]

The Secretary purportedly changed her position in the 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."[17] In response to a comment regarding this change, the Secretary explained that:

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A.* We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C*

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[14] 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.

[15] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).

[16] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).

[17] 69 Fed. Reg. at 49,099.

> *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.[18] (emphasis added)

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

Although the change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the Federal fiscal year (FFY) 2008 final rule was issued.[19] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule. As a result, Part C days were required to be included in the Medicare fraction as of October 1, 2004.

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius,*[20] vacated the FFY 2005 IPPS rule. However, the Providers point out, the decision is not binding in actions by other hospitals. Further, the Secretary has not acquiesced to that decision.[21]

**Providers' Request for EJR**

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

Prior to 2004, the Secretary treated Part C patients as not entitled to benefits under Part A. From 1986-2004, the Secretary interpreted the term "entitled to benefits under Part A" to mean covered or paid by Medicare Part A. In the final rule for the FFY 2005, the Secretary reversed course and announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective October 1, 2004.[22]

In *Allina*, the Court affirmed the district court's decision "that the Secretary's final rule was not a logical outgrowth of the proposed rule."[23] Because the Secretary has not acquiesced to the decision, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

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[18] *Id.*
[19] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[20] 746 F. 3d 1102 (D.C. Cir. 2014).
[21] Providers' EJR request at 1.
[22] 69 Fed. Reg. at 49,099.
[23] *Allina* at 1109.

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

**Decision of the Board**

The Board has reviewed the submissions of the Providers pertaining to the requests for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy for each group appeal exceeds $50,000, as required for a group appeal and the appeals were timely filed from the issuance of the Providers' original Notices of Program Reimbursement. In these cases, the Providers protested the Medicare Part C day issue as required by the regulation, 42 C.F.R. § 405.1835(a)(1)(iii) and/or the Providers have an adjustment to the Supplement Security Income calculation which is reflected on their audit adjustment report. The estimated amount in controversy is subject to recalculation by the Medicare Administrative Contractor for the actual final amount in each case.

The Board finds that:

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

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

3) it is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867);[24] and

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

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

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

Board Members Participating

L. Sue Andersen, Esq.
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA, CHFP
Gregory H. Ziegler

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

cc: Pam Van Arsdale, NGS (Certified Mail w/Schedules of Providers)
Bruce Snyder, Novitas Solutions (Certified Mail w/Schedules of Providers)
Barb Hinkle, Cahaba GBA c/o NGS (Certified Mail w/Schedules of Providers)
Geoff Pike, First Coast Service Options (Certified Mail w/Schedules of Providers)
Laurie Polson, Palmetto GBS c/o NGS (Certified Mail w/Schedules of Providers)
Judith Cummings, CGS Administrators (Certified Mail w/Schedules of Providers)
Bill Tisdale, Novitas Solutions (Certified Mail w/Schedules of Providers)
Wilson Leong, (w/Schedules of Providers)

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MAY 19 2017

Christopher L. Keough, Esq.
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Robert S. Strauss Building
1333 New Hampshire Avenue, N.W.
Washington, D.C. 20036-1564

RE: Southwest Consulting DSH Part C Days Groups
FYEs Various
PRRB Case Nos.
13-1784GC, 13-1785GC, 13-2857GC, 13-2859GC,
13-3877GC, 13-3885GC, 14-0783GC, 14-0787GC,
14-1620GC, 14-1621GC, 14-1644GC, 14-1645GC,
14-1688GC, 14-1689GC, 14-2021GC, 14-2022GC,
14-3485GC, 14-3486GC, 14-3766GC, 14-3767GC,
14-3857GC, 14-3858GC, 14-4209GC, 14-4210GC

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' May 1, 2017 request for expedited judicial review (EJR) (received May 2, 2017) for the above-referenced appeals. The Board's determination is set forth below.

The issue in these cases is:

> Whether the Medicare Part C patients are 'entitled to benefits' under Part A, such that they should be counted in the Medicare Part A/SSI fraction and excluded from the Medicaid fraction numerator [of the disproportionate share hospital (DSH) adjustment] or vice-versa.[1]

**Statutory and Regulatory Background: Medicare DSH Payment**

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

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

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

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

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

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

The Medicare/SSI fraction is computed annually by CMS, and the Medicare Administrative Contractors (MACs) use CMS' calculation to compute a hospital's DSH payment adjustment.[9]

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

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

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

The MAC 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.[10]

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[11] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[12]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[13]

With the creation of Medicare Part C in 1997,[14] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their

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[10] 42 C.F.R. § 412.106(b)(4).
[11] of Health and Human Services
[12] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).
[13] *Id.*
[14] 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

care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the intermediaries to calculate DSH payments for the FY 2001-2004. [15]

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 Medicare fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction* . . . (emphasis added)[16]

The Secretary purportedly changed her position in the 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."[17] In response to a comment regarding this change, the Secretary explained that:

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

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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.

[15] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).

[16] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).

[17] 69 Fed. Reg. at 49,099.

> regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[18] (emphasis added)

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

Although the change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the Federal fiscal year (FFY) 2008 final rule was issued.[19] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule. As a result, Part C days were required to be included in the Medicare fraction as of October 1, 2004.

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius,*[20] vacated the FFY 2005 IPPS rule. However, the Providers point out, the decision is not binding in actions by other hospitals. Further, the Secretary has not acquiesced to that decision.[21]

**Providers' Request for EJR**

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

Prior to 2004, the Secretary treated Part C patients as not entitled to benefits under Part A. From 1986-2004, the Secretary interpreted the term "entitled to benefits under Part A" to mean covered or paid by Medicare Part A. In the final rule for the FFY 2005, the Secretary reversed course and announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective October 1, 2004.[22]

In *Allina*, the Court affirmed the district court's decision "that the Secretary's final rule was not a logical outgrowth of the proposed rule."[23] Because the Secretary has not acquiesced to the decision, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

In these cases, the Providers contend that all Part C days should be excluded from the Part A/SSI fraction and the Medicaid-eligible Part C days should be included in the numerator of the

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[18] *Id.*
[19] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[20] 746 F. 3d 1102 (D.C. Cir. 2014).
[21] Providers' EJR request at 1.
[22] 69 Fed. Reg. at 49,099.
[23] *Allina* at 1109.

Medicaid fraction. To obtain relief, the Providers seek a ruling on the procedural and substantive validity of the 2004 rule that the Board lacks the authority to grant. Since the Secretary has not acquiesced to the decision in *Allina*, the Board remains bound by the regulation. Hence, EJR is appropriate.

**Decision of the Board**

The Board has reviewed the submissions of the Providers pertaining to the requests for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy for each group appeal exceeds $50,000, as required for a group appeal and the appeals were timely filed from the issuance of the Providers' original Notices of Program Reimbursement. In these cases, the Providers protested the Medicare Part C day issue as required by the regulation, 42 C.F.R. § 405.1835(a)(1)(iii) and/or the Providers have an adjustment to the Supplement Security Income calculation which is reflected on their audit adjustment report. The estimated amount in controversy is subject to recalculation by the Medicare Administrative Contractor for the actual final amount in each case.

The Board finds that:

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

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

3) it is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867);[24] and

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for expedited judicial review for the issue and the subject year. The

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

Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the cases.

Board Members Participating

L. Sue Andersen, Esq.
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA, CHFP
Gregory H. Ziegler

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

cc: Pam Van Arsdale, NGS (Certified Mail w/Schedules of Providers)
Bruce Snyder, Novitas Solutions (Certified Mail w/Schedules of Providers)
Wilson Leong, (w/Schedules of Providers)

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

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

Refer to:

CERTIFIED MAIL MAY 2 4 2017

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

RE: Rapid City Regional Hospital (43-0077), FYE 6/30/2009, Case No. 14-1297

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the Board) recently began a review of the above-captioned appeal in order to schedule the case for a hearing date. Upon review, the Board noted a problem with jurisdiction. The pertinent facts of the case and the Board's determination are set forth below.

**Pertinent Facts:**

Rapid City Regional Hospital was issued an original Notice of Program Reimbursement (NPR) for FYE 06/30/2009 on June 5, 2013.

Quality Reimbursement Services, Inc. (QRS) filed an individual appeal on behalf of the Provider on December 11, 2013. The appeal included nine issues:

1. Supplemental Security Income (SSI) Percentage (Provider Specific)
2. SSI (Systemic)
3. SSI Fraction/Medicare Managed Care Part C Days
4. SSI Fraction/Dual Eligible Days
5. Medicaid Eligible Days
6. Medicaid Fraction/ Medicare Managed Care Part C Days
7. Medicaid Fraction/Dual Eligible Days
8. Medicaid Eligible Labor Room Days
9. Outlier Payments – Fixed Loss Threshold

On August 20, 2014, QRS transferred issues 2, 3, 4, 6, 7 and 9 to group appeals.[1]

The Medicaid Eligible Labor Room Days issue was subsequently withdrawn by QRS on August 19, 2014.

[1] Case nos. 13-3931G, 13-3928G, 13-3944G, 13-3941G, 13-3942G and 14-0728G, respectively.

On January 7, 2015 the Board received the Medicare Contractor's challenge to jurisdiction over the appeal. The Medicare Contractor contends that the appeal was not filed timely as it was received by the Board 189 days after the issuance of the NPR.

**Board Determination:**

Pursuant to 42 C.F.R. § 405.1835(a)(3), unless the Provider qualifies for a good cause extension, the Board must receive a Provider's hearing request no later than 180 days after the date of receipt of the final determination, with a five-day presumption for mailing. Pursuant to 42 C.F.R. § 405.1801(a) and PRRB Rule 21, for appeal requests filed after August 21, 2008, the date of filing is the date of receipt by the Board, or the date of delivery by a nationally-recognized next-day courier.

The Medicare Contractor issued the Provider's NPR on June 5, 2013. The 185th day fell on Saturday, December 7th, 2013. The Federal Rules of Civil Procedure state that "if the last day is a Saturday, Sunday, or legal holiday, the period continues to run until the end of the next day that is not a Saturday, Sunday, or legal holiday."[2] Based on this procedure, the appeal was due to the Board on Monday, December 9, 2013. The appeal was not filed until December 11, 2013.[3] This is 189 days after issuance of the NPR.

Because the appeal was not timely filed, the Board finds that it does not meet the regulatory filing requirements and hereby dismisses Case No. 14-1297. In addition, the Board denies the transfer of this Provider into group case numbers 13-3931G, 13-3928G, 13-3944G, 13-3941G, 13-3942G and 14-0728G.

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

Board Members Participating:
L. Sue Andersen, Esq.
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA, CHFP
Gregory F. Ziegler

For the Board:

L. Sue Andersen, Esq.
Chairperson

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

cc: James R. Ward, Noridian Healthcare Solutions, LLC (J-F)
Wilson C. Leong, Esq., CPA, Federal Specialized Services

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[2] Fed.R.Civ.P. 12(b)(6).
[3] The Board's offices were closed on December 10th due to snow.

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Refer to:

17-0770 **CERTIFIED MAIL** MAY 2 6 2017

Nicholas Weston
Chief Nursing Officer
Latimer County General Hospital
806 Hwy 2 North
Wilburton, OK 74578

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

RE: Jurisdictional Determination
Latimer County General Hospital
Provider Nos.: 37-0072
FYE: 09/30/2017
PRRB Case No.: 17-0770

Dear Mr. Weston and Mr. Tisdale:

This case involves Latimer County General Hospital's ("Latimer's") appeal of its reconsideration determination regarding the Centers for Medicare & Medicaid Services' ("CMS") decision to reduce Latimer's fiscal year ("FY") 2017 Annual Payment Update ("APU"). Following review of the Medicare contractor's March 15, 2017 jurisdictional challenge, the Board finds that Latimer failed to file its request for hearing ("RFH") in a timely manner and must dismiss Latimer's RFH, as explained below.

## BACKGROUND

On July 8, 2016, CMS issued Latimer's reconsideration letter regarding its March 23, 2016 decision to reduce Latimer's FY 2017 APU. CMS reports that its decision to reduce Latimer's APU is based upon Latimer's failure to meet the requirements of the Hospital Inpatient Quality Reporting ("IQR") Program for the FY under review. CMS' reconsideration letter specifically warns that Latimer "may appeal this decision through the [Board] within 180 days of the date of this letter."

The Board received Latimer's RFH on January 10, 2017. Subsequently, the Medicare contractor filed a March 15, 2017 jurisdictional challenge in which it argues that Latimer filed an untimely RFH, thus the Board lacks jurisdiction to hear Latimer's appeal. To date, Latimer has not responded to the contractor's jurisdictional challenge.

## BOARD'S ANALYSIS AND DECISION

### APPLICABLE REGULATIONS AND AUTHORITY

Under 42 C.F.R. § 405.1835(a) (2015), a provider has a right to a Board hearing for specific items claimed for a cost reporting period covered by a final contractor or Secretary determination as long as the provider meets certain jurisdictional requirements. One of the requirements is that the Board must receive the provider's RFH within 180 days of the date of receipt of the provider's final determination.[1] With respect to the provider, the applicable regulation defines the phrase "date of receipt" as the date a document or other material is received by the provider. More specifically, the regulatory definition states that the date of receipt of documents in proceedings before a reviewing entity (such as the Board) is presumed to be 5 days after the date of issuance of a contractor notice or a reviewing entity notice. This presumption, which is otherwise conclusive, is rebuttable if the provider can show by a preponderance of the evidence that the documents were received on a later date.[2] With respect to the Board, the date of receipt is defined as the date of delivery to the Board for documents transmitted by a nationally-recognized next-day courier, as evidenced by the courier's tracking bill, or date stamped "received" if submitted by regular mail, hand or non-nationally recognized next-day courier.[3]

In addition, the regulations permit that the Board may grant a provider a good cause extension of the time limit for requesting a Board hearing if the provider can demonstrate in writing that it could not reasonably be expected to file timely due to circumstances beyond its control.[4] Otherwise, the regulations specifically state that a provider's RFH that the Board receives after the applicable 180-day time limit must be dismissed by the Board.[5]

Lastly, under Board Rule 44.4, a responding party must file a response within 30 days of the Medicare contractor's jurisdictional challenge. A responding party's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record.

### ANALYSIS AND JURISDICTIONAL DETERMINATION

As noted prior, on July 8, 2016, CMS issued its reconsideration letter to Latimer regarding CMS' decision to reduce Latimer's FY 2017 APU based upon Latimer's purported failure to meet the requirements of the Hospital IQR Program for the FY under review. The Board received Latimer's RFH on January 10, 2017, 186 days after the date of issuance of CMS' reconsideration determination. To date, Latimer has not filed a response with the Board regarding its untimely submission. Latimer has not argued for a good cause extension of the time limit for requesting a Board hearing, nor has it presented evidence to rebut the date of receipt presumption with respect

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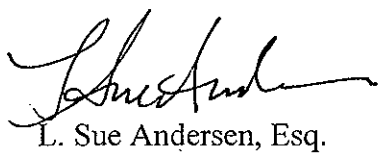
[1] 42 C.F.R. § 405.1835(a)(3) (2015).
[2] 42 C.F.R. § 405.1801(a) (2015).
[3] 42 C.F.R. § 405.1801(b) (2015).
[4] 42 C.F.R. § 405.1836(b) (2015).
[5] 42 C.F.R. § 405.1836(a) (2015).

to CMS' reconsideration determination. Accordingly, as the Board received Latimer's RFH after the applicable 180-day time limit, the Board must dismiss Latimer's RFH as untimely pursuant to 42 C.F.R. § 405.1836(a) (2015).

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:
L. Sue Andersen, Esq.
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler

For the Board:



L. Sue Andersen, Esq.
Chairperson

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

cc: Wilson Leong, Federal Specialized Services

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MAY 2 6 2017

Christopher L. Keough, Esq.
Akin, Gump, Strauss, Hauer & Feld, LLP
Robert S. Strauss Building
1333 New Hampshire Avenue, N.W.
Washington, D.C. 20036-1564

RE: Southwest Consulting DSH Part C Days Groups
FYEs Various
PRRB Case Nos.
Southwest Consulting Christus 2008 DSH Medicare Advantage Days Group, PRRB Case No.13-0538GC
Southwest Consulting Christus 2008 DSH SSI Fraction Denominator/Part C Days Group, PRRB Case No.13-0732GC
Southwest Consulting Carilion Clinic 2007 DSH Medicare Advantage Days Group, PRRB Case No.13-1059GC
Southwest Consulting Christus 2009 DSH SSI Fraction Part C Days Group, PRRB Case No.14-0704GC
Southwest Consulting Christus 2009 DSH Medicaid Fraction Part C Group, PRRB Case No.14-0706GC

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' May 1, 2017 request for expedited judicial review (EJR) (received May 2, 2017) for the above-referenced appeals. The Board's determination is set forth below.

The issue in these cases is:

> Whether the Medicare Part C patients are 'entitled to benefits' under Part A, such that they should be counted in the Medicare Part A/SSI fraction and excluded from the Medicaid fraction numerator [of the disproportionate share hospital (DSH) adjustment] or vice-versa.[1]

**Statutory and Regulatory Background: Medicare DSH Payment**

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system (PPS).[2] Under PPS,

[1] Providers' May 1, 2017 EJR Request at 4.
[2] *See* 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[3]

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

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

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

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

The Medicare/SSI fraction is computed annually by CMS, and the Medicare Administrative Contractors (MACs) use CMS' calculation to compute a hospital's DSH payment adjustment.[9]

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the

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[3] *Id.*
[4] *See* 42 U.S.C. § 1395ww(d)(5).
[5] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] 42 C.F.R. § 412.106(b)(2)-(3).

> Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period. (emphasis added)

The MAC 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.[10]

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[11] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[12]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[13]

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[10] 42 C.F.R. § 412.106(b)(4).
[11] of Health and Human Services
[12] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).
[13] *Id.*

With the creation of Medicare Part C in 1997,[14] 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 intermediaries to calculate DSH payments for the FY 2001-2004.[15]

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 Medicare fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction* . . . (emphasis added)[16]

The Secretary purportedly changed her position in the 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."[17] In response to a comment regarding this change, the Secretary explained that:

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A.* We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C*

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[14] 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.

[15] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).

[16] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).

[17] 69 Fed. Reg. at 49,099.

> *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.[18] (emphasis added)

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

Although the change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the Federal fiscal year (FFY) 2008 final rule was issued.[19] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule. As a result, Part C days were required to be included in the Medicare fraction as of October 1, 2004.

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius,*[20] vacated the FFY 2005 IPPS rule. However, the Providers point out, the decision is not binding in actions by other hospitals. Further, the Secretary has not acquiesced to that decision.[21]

**Providers' Request for EJR**

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

Prior to 2004, the Secretary treated Part C patients as not entitled to benefits under Part A. From 1986-2004, the Secretary interpreted the term "entitled to benefits under Part A" to mean covered or paid by Medicare Part A. In the final rule for the FFY 2005, the Secretary reversed course and announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective October 1, 2004.[22]

In *Allina*, the Court affirmed the district court's decision "that the Secretary's final rule was not a logical outgrowth of the proposed rule."[23] Because the Secretary has not acquiesced to the

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[18] *Id.*
[19] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[20] 746 F. 3d 1102 (D.C. Cir. 2014).
[21] Providers' EJR request at 1.
[22] 69 Fed. Reg. at 49,099.
[23] *Allina* at 1109.

decision, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

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

**Decision of the Board**

The Board has reviewed the submissions of the Providers pertaining to the requests for hearing and expedited judicial review. This set of five group cases contain Providers with cost reporting periods ending 9/30/2007, 6/30/2008 and 6/30/2009. The Providers with 9/30/2007 and 6/30/2008 cost reporting periods could claim the Part C days issue as a self-disallowed cost under *Bethesda Hospital Association. Bowen.*[24] The 6/30/2009 cost report periods required either an adjustment to SSI or a protested amount. *See* 42 C.F.R. § 405.1835 (2008). In these cases all of the Providers, regardless of the cost reporting period, had an SSI adjustment. SSI percentages were adjusted as a result of the decision in *Baystate Medical Center v. Leavitt*[25] (*Baystate*) and the notice published in the August 16, 2010 Federal Register[26] stating that SSI percentages would be updated and applied to the cost reporting periods under appeal. Most of these Providers' NPRs were held during the course of the *Baystate litigation* and the new SSI percentages were used to calculate their DSH adjustments. This is reflected in their audit adjustment reports. The documentation shows that the estimated amount in controversy for each group appeal exceeds $50,000, as required for a group appeal[27] and the appeals were timely filed from the issuance of the Providers' original Notices of Program Reimbursement. The estimated amount in controversy is subject to recalculation by the Medicare Administrative Contractor for the actual final amount in each case.

The Board finds that:

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

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

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[24] 108 S.Ct. 1255 (1988).
[25] 545 F. Supp. 2d 20 (D.D.C. 2008) modified 587 F.Supp. 2d 37 and 587 F.Supp. 2d 44.
[26] 76 Fed. Reg. 50042, 50275-50,286.
[27] *See* 42 C.F.R. § 405.1837.

3) it is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867);[28] and

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

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

Board Members Participating

L. Sue Andersen, Esq.
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA, CHFP
Gregory H. Ziegler

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

cc: Bill Tisdale, Novitas Solutions (Certified Mail w/Schedules of Providers)
Barb Hinkle, Cahaba GBA c/o NGS (Certified Mail w/Schedules of Providers)
Wilson Leong, (w/Schedules of Providers)

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
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Baltimore MD 21244-2670

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Certified Mail

MAY 2 6 2017

Christopher L. Keough, Esq.
Akin, Gump, Strauss, Hauer & Feld, LLP
Robert S. Strauss Building
1333 New Hampshire Avenue, N.W.
Washington, D.C. 20036-1564

RE: Southwest Consulting DSH Part C Days Groups
FYEs Various
PRRB Case Nos. 13-0493GC, 13-0730GC, 13-1057GC,
13-1208GC, 13-1478GC, 13-1481GC, 13-2720GC,
13-2736GC, 13-2876GC, 13-2877GC,
13-3334GC, 13-3340GC, 13-3750GC, 13-3752GC

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' May 16, 2017 request for expedited judicial review (EJR) (received May 17, 2017) for the above-referenced appeals. The Board's determination is set forth below.

The issue in these cases is:

> Whether the Medicare Part C patients are 'entitled to benefits' under Part A, such that they should be counted in the Medicare Part A/SSI fraction and excluded from the Medicaid fraction numerator [of the disproportionate share hospital (DSH) adjustment] or vice-versa.[1]

**Statutory and Regulatory Background: Medicare DSH Payment**

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

[1] Providers' May 16, 2017 EJR Request at 4.
[2] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[3] *Id.*

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

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

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

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

The Medicare/SSI fraction is computed annually by CMS, and the Medicare Administrative Contractors (MACs) use CMS' calculation to compute a hospital's DSH payment adjustment.[9]

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

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

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

The MAC 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.[10]

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[11] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[12]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[13]

With the creation of Medicare Part C in 1997,[14] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their

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[10] 42 C.F.R. § 412.106(b)(4).
[11] of Health and Human Services
[12] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).
[13] *Id.*
[14] 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

care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the intermediaries to calculate DSH payments for the FY 2001-2004.[15]

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 Medicare fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction* . . . (emphasis added)[16]

The Secretary purportedly changed her position in the 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."[17] In response to a comment regarding this change, the Secretary explained that:

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

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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.

[15] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).

[16] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).

[17] 69 Fed. Reg. at 49,099.

> associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[18] (emphasis added)

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

Although the change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the Federal fiscal year (FFY) 2008 final rule was issued.[19] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule. As a result, Part C days were required to be included in the Medicare fraction as of October 1, 2004.

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius,*[20] vacated the FFY 2005 IPPS rule. However, the Providers point out, the decision is not binding in actions by other hospitals. Further, the Secretary has not acquiesced to that decision.[21]

**Providers' Request for EJR**

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

Prior to 2004, the Secretary treated Part C patients as not entitled to benefits under Part A. From 1986-2004, the Secretary interpreted the term "entitled to benefits under Part A" to mean covered or paid by Medicare Part A. In the final rule for the FFY 2005, the Secretary reversed course and announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective October 1, 2004.[22]

In *Allina*, the Court affirmed the district court's decision "that the Secretary's final rule was not a logical outgrowth of the proposed rule."[23] Because the Secretary has not acquiesced to the decision, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

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

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[18] *Id.*
[19] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[20] 746 F. 3d 1102 (D.C. Cir. 2014).
[21] Providers' EJR request at 1.
[22] 69 Fed. Reg. at 49,099.
[23] *Allina* at 1109.

validity of the 2004 rule that the Board lacks the authority to grant. Since the Secretary has not acquiesced to the decision in *Allina*, the Board remains bound by the regulation. Hence, EJR is appropriate.

**Decision of the Board**

The Board has reviewed the submissions of the Providers pertaining to the requests for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy for each group appeal exceeds $50,000, as required for a group appeal. The some of were timely filed from the issuance of the Providers' original Notices of Program Reimbursement (NPRs) for fiscal years 2006 and 2007. For those fiscal years, the Providers could claim the Part C Days issue as a self-disallowed cost under *Bethesda Hospital Association v. Bowen.*[24] All of the appeals of revised NPRs have audit adjustments of the SSI percentage as required by 42 C.F.R. § 405.1889 (where a revision is made to an intermediary determination, only those matters that are specifically revised are within the scope of any appeal of the revised determination) for jurisdiction over an appeal. The estimated amount in controversy is subject to recalculation by the Medicare Administrative Contractor for the actual final amount in each case.

The Board finds that:

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

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

3) it is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867);[25] and

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for expedited judicial review for the issue and the subject year. The

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[24] 108 S.Ct. 1255 (1988)

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

Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the cases.

Board Members Participating

L. Sue Andersen, Esq.
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA, CHFP
Gregory H. Ziegler

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

cc: Pam Van Arsdale, NGS (Certified Mail w/Schedules of Providers)
Bruce Snyder, Novitas Solutions (Certified Mail w/Schedules of Providers)
Barb Hinkle, Cahaba GBA c/o NGS (Certified Mail w/Schedules of Providers)
Laurie Polson, Palmetto GBS c/o NGS (Certified Mail w/Schedules of Providers)
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MAY 30 2017

Michael G. Newell
Southwest Consulting Associates
2805 Dallas Parkway
Suite 620
Dallas, TX 75093-8724

RE: Southwest Consulting DSH Part C Days Groups
FYEs Various
PRRB Case Nos.
14-4334GC, 14-4337GC, 15-0113GC, 15-0116GC, 15-0120GC, 15-0123GC, 15-0127GC, 15-0130GC, 15-0169GC, 15-0170GC, 15-0175GC, 15-0176GC, 15-0293GC, 15-0322GC, 15-0323GC, 15-0532GC, 15-0533GC, 15-0537GC, 15-0538GC, 15-0574GC, 15-0575GC, 15-0631GC, 15-0633GC, 15-0709GC, 15-0713GC, 15-0864GC, 15-0865GC, 15-1053GC, 15-1055GC, 15-1341GC, 15-1342GC, 15-1513GC, 15-1514GC, 15-2286GC, 15-2288GC, 15-2773GC, 15-2775GC, 15-2838GC, 15-2840GC, 15-3101GC

Dear Mr. Newell:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' May 17, 2017 request for expedited judicial review (EJR) (received May 18, 2017) for the above-referenced appeals. The Board's determination is set forth below.

The issue in these cases is:

> Whether the Medicare Part C patients are 'entitled to benefits' under Part A, such that they should be counted in the Medicare Part A/SSI fraction and excluded from the Medicaid fraction numerator [of the disproportionate share hospital (DSH) adjustment] or vice-versa.[1]

**Statutory and Regulatory Background: Medicare DSH Payment**

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the

[1] Providers' May 17, 2017 EJR Request at 4.

prospective payment system (PPS).[2] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[3]

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

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

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

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

The Medicare/SSI fraction is computed annually by CMS, and the Medicare Administrative Contractors (MACs) use CMS' calculation to compute a hospital's DSH payment adjustment.[9]

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the

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[2] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[3] *Id.*
[4] *See* 42 U.S.C. § 1395ww(d)(5).
[5] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(l).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] 42 C.F.R. § 412.106(b)(2)-(3).

> Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period. (emphasis added)

The MAC 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.[10]

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[11] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[12]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[13]

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[10] 42 C.F.R. § 412.106(b)(4).
[11] of Health and Human Services
[12] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).
[13] *Id.*

With the creation of Medicare Part C in 1997,[14] 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 intermediaries to calculate DSH payments for the FY 2001-2004.[15]

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 Medicare fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction* . . . (emphasis added)[16]

The Secretary purportedly changed her position in the 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."[17] In response to a comment regarding this change, the Secretary explained that:

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A.* We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C*

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[14] 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.

[15] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).

[16] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).

[17] 69 Fed. Reg. at 49,099.

> *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.[18] (emphasis added)

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

Although the change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the Federal fiscal year (FFY) 2008 final rule was issued.[19] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule. As a result, Part C days were required to be included in the Medicare fraction as of October 1, 2004.

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius,*[20] vacated the FFY 2005 IPPS rule. However, the Providers point out, the decision is not binding in actions by other hospitals. Further, the Secretary has not acquiesced to that decision.[21]

**Providers' Request for EJR**

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

Prior to 2004, the Secretary treated Part C patients as not entitled to benefits under Part A. From 1986-2004, the Secretary interpreted the term "entitled to benefits under Part A" to mean covered or paid by Medicare Part A. In the final rule for the FFY 2005, the Secretary reversed course and announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective October 1, 2004.[22]

In *Allina*, the Court affirmed the district court's decision "that the Secretary's final rule was not a logical outgrowth of the proposed rule."[23] Because the Secretary has not acquiesced to the decision, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

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[18] *Id.*
[19] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[20] 746 F. 3d 1102 (D.C. Cir. 2014).
[21] Providers' EJR request at 1.
[22] 69 Fed. Reg. at 49,099.
[23] *Allina* at 1109.

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

**Decision of the Board**

The Board has reviewed the submissions of the Providers pertaining to the requests for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy for each group appeal exceeds $50,000, as required for a group appeal and the appeals were timely filed from the issuance of the Providers' original Notices of Program Reimbursement. In these cases, the Providers protested the Medicare Part C day issue as required by the regulation, 42 C.F.R. § 405.1835(a)(1)(iii) and/or the Providers have an adjustment to the Supplement Security Income calculation which is reflected on their audit adjustment report. The estimated amount in controversy is subject to recalculation by the Medicare Administrative Contractor for the actual final amount in each case.

The Board finds that:

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

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

3) it is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867);[24] and

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

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

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

Board Members Participating

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FOR THE BOARD:

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

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Bruce Snyder, Novitas Solutions (Certified Mail w/Schedules of Providers)
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RE: French Hospital Medical Center
Provider No.: 05-0232
FYE: 6/30/09
PRRB Case No.: 13-2597

Dear Ms. Bhatnagar and Ms. Alcantara,

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

**Background**

The Provider submitted a request for hearing on August 1, 2013, based on a Notice of Program Reimbursement ("NPR") dated February 22, 2013. The hearing request included nine issues. One additional issue was added via a Provider request dated September 12, 2013, bringing the total number of issues to ten. Seven issues were subsequently transferred to group appeals via Provider requests dated March 19, 2014 and March 21, 2014. Three issues remain in the appeal as follows: 1) Issue No. 1 – Medicare Settlement Data, 2) Issue No. 2 – Medicare Disproportionate Share Hospital (DSH) – Additional Medicaid Eligible Days, and 3) Issue No. 6 – Medicare Disproportionate Share Hospital (DSH) – SSI Ratio Alignment to Provider's Cost Reporting Year. The Medicare Contractor submitted a jurisdictional challenge on Issue No. 2 and Issue No. 6 on May 19, 2014. The Provider filed a responsive brief on June 6, 2014.

**Medicare Contractor's Position**

*Issue No. 2 – Medicare Disproportionate Share Hospital (DSH) – Additional Medicaid Eligible Days*

The Medicare Contractor explains that the Provider is contesting the Medicaid ratio utilized in the calculation of the disproportionate share payment. The Provider contends that DSH Medicaid ratio is understated due to the exclusion of 29 additional Medicaid eligible days. The Medicare Contractor contends that it did not render a final determination over the additional Medicaid days, and there was no adverse finding meeting the requirements of 42 C.F.R. § 405.1801(a).[1]

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

The Medicare Contractor explains that the Provider filed its cost report with 2,356 Medicaid Days and 17,860 Total Patient Days, resulting in a reported DSH Medicaid ratio of 13.19. The Medicare Contractor goes on to explain that it proposed adjustment number 6 to include 283 total labor and delivery room days. Of this number, 128 were related to Medicaid. The implementation of adjustment 6 resulted in increasing the DSH Medicaid ratio from 13.19 to 13.69. This is based on a numerator of 2,484 Medicaid Days and a denominator of 18,143 Total Patient Days.[2]

The Medicare Contractor states that the Provider filed its Medicare cost report identifying $169, 187 of protested amounts. The Medicare Contractor explains that it removed this amount via adjustment 12. The Provider did not include adjustment 12 as a basis for the appeal of the additional eligible days. The Medicare Contractor argues that a review of the protested items identified in the Provider's appeal request shows that the Provider did not claim a protested amount in controversy for the issue of additional Medicaid days.[3]

The Medicare Contractor contends that the Provider's dissatisfaction stems from its failure to claim the additional 50 days per their original appeal (revised to 29 days in their preliminary position paper) on its as-filed Medicare cost report. The Provider is dissatisfied with its own reporting of Medicaid days.[4]

The Medicare Contractor contends that in the instant case, the additional Medicaid days were omitted from its as-filed cost report. The Provider's dissatisfaction stems from its failure to claim the additional days. Logically, because the additional days were not claimed by the Provider, the Medicare Contractor did not render a final determination over them or the associated reimbursement. The Medicare Contractor requests that the Board exercise its discretion under 42 U.S.C. § 1395oo(d) and dismiss this issue consistent with its decision in *St. Vincent Hospital & Medical Center.*[5]

*Issue No. 6 – Medicare Disproportionate Share Hospital (DSH) – SSI Ratio Alignment to Provider's Cost Reporting Year*

The Medicare Contractor explains that the Provider is contesting the Medicaid ratio utilized in the calculation of the disproportionate share payment. The Provider contends calculation of the Medicare ratio should be realigned with the Provider's fiscal year versus the federal fiscal year. The Medicare Contractor contends that it did not render a final determination regarding realignment of the Medicare ratio to the Provider's fiscal year end.[6]

The Medicare Contractor explains that in the instant case, the Provider submitted an SSI Ratio realignment request to the Medicare Contractor on March 28, 2013. The Medicare Contractor forwarded the Provider's request to CMS on April 10, 2013. CMS has not completed a recalculation of the Provider's SSI Ratio based on the Provider's fiscal year end. As a result there has been no final determination of the SSI Ratio to be used on the Provider's FYE 6/30/09 cost report. Therefore, the

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[2] Medicare Contractor's jurisdictional challenge at 1-2.
[3] Medicare Contractor's jurisdictional challenge at 2.
[4] Medicare Contractor's jurisdictional challenge at 2.
[5] Medicare Contractor's jurisdictional challenge at 5.
[6] Medicare Contractor's jurisdictional challenge at 6.

Medicare Contractor contends, the Provider's appeal of this issue is premature and the Board lacks jurisdiction over the issue.[7]

**Provider's Position**

*Issue No. 2 – Medicare Disproportionate Share Hospital (DSH) – Additional Medicaid Eligible Days*

The Provider explains that a review of the Medicare Contractor's audit adjustment report shows the Provider reported 2,044 Medicaid eligible days on Worksheet S-3, Part I, Column 5, Line 1. The Medicare Contractor implemented a 128 Medicaid eligible day adjustment via Audit Adjustment No. 6. The Provider contends the Medicare Contractor's adjustment should have been 157 Medicaid eligible days, not the 128 Medicaid eligible days the Medicare Contractor adjusted.[8]

The Provider contends 42 C.F.R. § 405.1835(a)(1)(i) supports the Board's jurisdiction over this matter because the Provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item (i.e. Medicaid eligible days used in the DSH payment calculation) at issue by including a claim for specific item (i.e. Medicaid eligible days) on its cot report for the period where the Provider seeks payment that it believes to be in accordance with Medicare policy. The Medicare Contractor implemented an adjustment to the Provider's Medicaid eligible days which is inaccurate and which created dissatisfaction with the NPR and the final Medicare payment received.[9]

The Provider argues that it is also important to note the State of California's verification of Medicaid eligibility, as required at 42 C.F.R. § 412.106(b)(4)(iii), cannot occur in its entirety prior to the Provider's cost report filing deadline (five months after fiscal year end) because the State of California's Medicaid Eligibility Branch will not provide eligibility verification for all patients immediately after the close of the Provider's fiscal year end. Specifically, the State of California will provide patient Medicaid eligibility verification after thirteen months from the patient's date of service. CMS is not enforcing State Medicaid agency compliance with the state verification component of 42 C.F.R. § 412.106(b)(4)(iii), therefore CMS is leaving Providers vulnerable as it relates to the filing of Medicaid eligible days on their Medicare cost report. In short, the data necessary for a Provider to comply with 42 C.F.R. § 412.106(b)(4)(iii) in its entirety is not available from the State of California's Medicaid Eligibility Branch at the time the Provider's Medicare cot report is due to be filed with the Medicare Contractor.[10]

*Issue No. 6 – Medicare Disproportionate Share Hospital (DSH) – SSI Ratio Alignment to Provider's Cost Reporting Year*

The Provider contends that the NPR and all audit adjustments within meet the criteria of a final determination by the Medicare Contractor. Specifically, audit adjustment numbers 11, 13, 20 and 21 were implemented in the Medicare Contractor's own words "To adjust SSI percentage and allowable DSH percentage" and "To update the SSI ratio to CMS data..".[11]

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[7] Medicare Contractor's jurisdictional challenge at 1.
[8] Provider's jurisdictional response at 2.
[9] Provider's jurisdictional response at 2.
[10] Provider's jurisdictional response at 3.
[11] Provider's jurisdictional response at 3.

The Provider explains that the SSI ratio was adjusted by the Medicare Contractor from 2.51% to a value of 2.20% that is developed by CMS on a federal fiscal year basis. The Provider contends the final SSI ratio value of 2.20% should be higher. The Provider argues that it has a right to be dissatisfied with any aspect of the Medicare Contractor's audit adjustments, including the aspect of the Medicare Contractor's adjustment implementing a SSI ratio that has been developed on a federal fiscal year basis because all other DSH payment elements for this Provider are developed upon a cost reporting period basis. There is nothing in the DSH statute or the Medicare regulations that preclude an appeal of this nature.[12]

The Provider contends that the regulation concerning the "Contents of Request for a Board Hearing"[13] requires the Provider to describe their dispute[14] and provide a remedy describing how and why the Provider believes Medicare payment must be determined differently.[15] The Provider contends that it performed both of these tasks, including identifying two remedies: 1) Request CMS to realign the Provider's SSI percentage to the Provider's cost reporting year, or 2) Use the Provider's own data to seek a resolution to the issue. The Provider explains that it sought a remedy to the issue by submitting a DSH Ratio Realignment Request to the Contractor on March 28, 2013.[16]

**Board's Decision**

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination. The jurisdictional issue presented here is whether or not this hospital has preserved its right to claim dissatisfaction with the amount of Medicare payment. "A provider. . . has a right to a Board hearing . . . only if – (1) the provider has preserved its right to claim dissatisfaction.....by.....[i]ncluding a claim for specific item(s) on its cost report...or...self-disallowing the specific item(s) by.....filing a cost report under protest.....[17]

*Issue No. 2 – Medicare Disproportionate Share Hospital (DSH) – Additional Medicaid Eligible Days*

The Provider is appealing from a 6/30/2009 cost report, which means that it either had to claim the cost at issue or it is subject to the protest requirement in order for the Board to have jurisdiction.
The Board finds that it does not have jurisdiction over the DSH - Medicaid eligible days issue in this appeal. The Provider did not protest the Medicaid eligible days currently under appeal on its cost report notwithstanding the fact that it knew California would have additional days at a later point in time. Therefore, the Board could only have jurisdiction over those days if the Provider included a claim for the specific items on its cost report, as required by 42 C.F.R. § 405.1835(a).

The Board finds that the Provider did not include a claim for the specific days at issue in this appeal on its cost report. Therefore, the Board finds that French Hospital Medical Center has not met the

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[12] Provider's jurisdictional response at 3 (Emphasis included).
[13] 42 C.F.R. § 45.1835(b).
[14] 42 C.F.R. § 45.1835(b) (2)(i).
[15] 42 C.F.R. § 45.1835(b) (2)(ii).
[16] Provider's jurisdictional response at 4-5.
[17] 42 C.F.R. § 405.1835(a).

dissatisfaction requirement of including a specific claim on the cost report, or protesting the specific Medicaid eligible days at issue, and concludes that it does not have jurisdiction over the issue, and dismisses the issue from the appeal.

*Issue No. 6 – Medicare Disproportionate Share Hospital (DSH) – SSI Ratio Alignment to Provider's Cost Reporting Year*

The Board finds that it does not have jurisdiction over the SSI Ratio Realignment issue in the appeal because there is no final determination from which the Provider is appealing, and dismisses the issue from the appeal. Under 42 C.F.R. § 412.106(b)(3) a hospital can, if it prefers, use its cost reporting period data instead of the federal fiscal year data in determining the DSH Medicare fraction. The decision to use its own cost reporting period is the hospitals alone, which then must submit a written request to the Medicare Contractor. Without this request it is not possible for the Medicare Contractor to have issued a final determination from which the Provider could appeal. Furthermore, even if a Provider had requested a realignment from the federal fiscal year to its cost reporting year, 42 C.F.R. § 412.106(b)(3) makes clear that the Provider must use the data from its cost reporting year; there is no appeal right that stems from a realignment request.

Issue No. 1 – Medicare Settlement Data remains in the appeal. This case is scheduled for a live hearing on October 10, 2017. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

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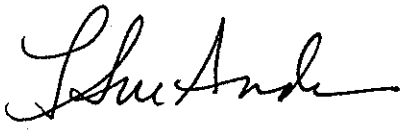

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Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

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