DEPARTMENT OF HEALTH & HUMAN SERVICES

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

CERTIFIED MAIL

JUL 13 2017

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

RE: Request for Rescission of Remand and Bifurcation of Individual Appeal
Regarding DSH Part C Days issue
Simi Valley Hospital
Provider no.: 05-0236
FYE: 12/31/02
PRRB Case No.: 07-1463

Dear Mr. Blumberg:

The Provider Reimbursement Review Board (PRRB or Board) has reviewed your June 6, 2016 Request for Rescission of Remand and Bifurcation of Individual Appeal Regarding DSH Part C Days Issue for Simi Valley Hospital (Simi). The Board denies Simi's Request for Rescission of Remand and Reinstatement of the dual eligible Part A days issue. The Board grants Simi's Request for Bifurcation of the Individual Appeal Regarding the DSH Part C Days issue.

Background

On October 21, 2014, the supplemental security income (SSI) percentage and dual eligible Part A days issues were remanded to the Medicare Contractor in case number 07-1463, Simi Valley Hospital, pursuant to the Centers for Medicare & Medicaid Services (CMS) Ruling 1498-R[1] and the case was closed. On June 6, 2016, Simi filed a Request for Rescission of Remand and Bifurcation of Individual Appeal Regarding Disproportionate Share Hospital (DSH) Part C Days Issue for the dual eligible days issue. Simi argued that its appeal of the dual eligible days issue was intended to refer to persons eligible for Medicare Parts A and C; based on numerous decisions of the Board, the dual eligible days issue did not come within the scope of Ruling 1498-R. Simi requested that the Board rescind its remand and reinstate its appeal of the dual eligible days issue.[2]

[1] Ruling 1498-R was issued on April 28, 2010, by the CMS Administrator to address three specific issues regarding the calculation of the Medicare disproportionate share hospital (DSH) payment adjustment: (1) the Medicare SSI fraction data matching process issue and the method for recalculating the hospital's Medicare SSI fraction, (2) the exclusion from the DSH calculation of non-covered patient hospital days for patients entitled to Medicare Part A including days for which the patient's Part A inpatient hospital benefits were exhausted for cost reporting periods before October 1, 2004, and (3) the exclusion from the DSH calculation of the labor/delivery room (LDR) inpatient days.

[2] Provider's Request for Rescission of Remand and Bifurcation of Individual Appeal Regarding DSH Part C Days

On August 15, 2016, Simi filed a Request for Reconsideration and Rescission of Remand Pursuant to CMS Ruling 1498-R and a Request for Expedited Judicial Review (EJR) for the SSI percentage issue. On February 8, 2017, the Board denied Simi's Request for Reconsideration and Rescission of Remand and EJR for the SSI percentage issue finding that it lacked jurisdiction to review the SSI percentage issue under the terms of CMS Ruling 1498-R.

Decision of the Board

PRRB Rule 46.1 (effective July 1, 2015), provides "[a] Provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case . . . if an issue(s)/case was remanded pursuant to a CMS ruling (e.g., CMS Ruling 1498-R), the Provider must address whether the CMS ruling permits reinstatement of such issue(s)/case." Simi has not addressed whether Ruling 1498-R permits reinstatement of the dual eligible Part A days issue and thus, has failed to comply with this requirement. Nevertheless, the Board concludes CMS Ruling 1498-R does not permit reinstatement of this issue.

CMS Rulings are published under the authority of the CMS Administrator and serve as precedent final opinions and orders or statements of policy or interpretation. CMS Rulings are binding on all CMS components, on all Department of Health and Human Services components that adjudicate matters under the jurisdiction of CMS, and on the Social Security Administration (SSA) to the extent that components of the SSA adjudicate matters under the jurisdiction of CMS.[3] The Board is a CMS component that adjudicates matters under the jurisdiction of CMS, as such, is bound by CMS Rulings. The Board must comply with all of the provisions of Title XVIII of the Social Security Act (Act) and regulations issued thereunder, as well as CMS Rulings issued under the authority of the Administrator.

On April 28, 2010, the CMS Administrator issued CMS Ruling 1498-R to address three specific Medicare disproportionate share hospital issues. One of these issues involves the exclusion from the DSH calculation of non-covered inpatient hospital days for patients entitled to Medicare Part A, including days for which the patient's Part A inpatient hospital benefits were exhausted (dual eligible days). With respect to this issue, the Ruling requires the Board to remand each qualifying appeal of the dual eligible days issue for cost reports with pre-October 1, 2004 discharges to the appropriate Medicare Contractor.[4] Upon remand, CMS and the Medicare Contractor will recalculate the hospital's SSI fraction and DSH payment adjustment for the period at issue by including the inpatient days of a person entitled to Medicare Part A in the numerator of the hospital's SSI fraction (provided that the person was also entitled to SSI) and in that fraction's denominator, even if the inpatient stay was not covered under Part A or the patient's Part A hospital benefits were exhausted.

The Ruling provides:

> CMS' action eliminates any actual case or controversy regarding

---

Issue at 1.
[3] CMS Ruling 1498-R at 1.
[4] *Id.* at 17.

> the hospital's previously calculated DSH payment adjustment and thereby renders moot each properly pending claims in a DSH appeal, for cost reports with pre-October 1, 2004 discharges, in which the hospital seeks inclusion in the DPP of the non-covered inpatient hospital days (for example, MSP days) or exhausted benefit inpatient hospital days of a person entitled to Part A. . . . *Accordingly, it is hereby held that the PRRB and the other Medicare administrative tribunals lack jurisdiction over each properly pending claim on the non-covered or exhausted benefit inpatient hospital day issue for a cost report with discharges before October 1, 2004.*[5] (Emphasis added).

Here, within CMS Ruling 1498-R, the CMS Administrator has spoken directly on the issue of the Board's jurisdiction over the dual eligible Part A days issue for cost reports with discharges before October 1, 2004, that is subject to the mandatory remand. In the instant appeal, once the Board determined that the dual eligible Part A days issue was within CMS Ruling 1498-R's mandates, the Board no longer had jurisdiction over the issue and was required to remand the issue to the Medicare Contractor.[6] Nothing within CMS Ruling 1498-R indicates that the Board may reassume jurisdiction over this issue once it has been remanded.

In fact, CMS Ruling 1498-R states that upon remand, "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, for cost reports with pre-October 1, 2004, discharges in which the hospital seeks inclusion in the disproportionate patient percentage (DPP) of the non-covered inpatient hospital days (for example, MSP days) or exhausted benefit inpatient hospital days of a person entitled to Part A."[7] Once Simi's dual eligible Part A days claim was remanded to the Medicare Contractor, any actual case or controversy in the appeal was eliminated and the claim was rendered moot. Accordingly, the Board may not rescind the dual eligible Part A days remand and reinstate the dual eligible Part A days issue because, in accordance with CMS Ruling 1498-R, the Board lacks jurisdiction over the issue.

The Board does however agree to reopen case number 07-1463 and hereby grants Simi's Request for Bifurcation of the Individual Appeal Regarding the DSH Part C Days issue. The Board acknowledges that at the time that Simi's individual appeal was filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or Part C days. Federal courts later ruled differently on the dual eligibility related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that Simi's individual appeal added the dual eligible days issue using a broad issue statement that encompassed both dual eligible Part A days and Part C days. Therefore, the Board bifurcates the dual eligible Part A days and Part C days issues. As the Board remanded the dual eligible Part A days issue on October 21, 2014, and closed the case, the Board hereby reopens case number 07-1463 and reinstates the dual eligible Medicare/Medicaid

---

[5] *Id.* at 11.
[6] *Id.* at 13, 17-18.
[7] *Id.* at 11.

Part C days issue into case number 07-1463. The parties will receive a Notice of Hearing under separate cover for the Part C days issue only.

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

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

For the Board

L. Sue Andersen
Chairperson

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

cc: Evaline Alcantara, Noridian Healthcare Solutions
Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Refer to: 13-0582GC

JUL 19 2017

CERTIFIED MAIL

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

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

RE: Jurisdictional Challenge
PRRB Case Number: 13-0582GC
Memorial Hermann 2008 Indigent Bad Debt Group
Provider Numbers: Various
FYE: 06/30/2008

Dear Ms. Webster and Mr. Tisdale,

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

Background:

The Board established a group appeal on January 30, 2013 for the Memorial Hermann 2008 Indigent Bad Debt Group. The group issue statement reads, in part, as follows:

> "The common issue in this group appeal concerns the Medicare Administrative Contractor's ("MAC's") improper treatment of the Providers' bad debts. The Providers contend that the MAC incorrectly disallowed bad debts attributable to indigent Medicare beneficiaries who were not eligible for Medicaid (*i.e.*, so-called "dual eligible") ..."[1]

Pertinent Facts:

All of the participants[2] filed the cost reporting periods in dispute under protest which included non-Medicaid and Medicaid indigent bad debt amounts.[3] The Medicare

[1] Providers' appeal request at Tab 2 (January 29, 2013).
[2] Participant #4 was withdrawn on January 6, 2017.
[3] *See* Schedule of Providers under tab D (June 21, 2016)

Contractor made adjustments to remove the protested amounts on the Providers' cost reports. The participants were directly added to Case No. 13-0582GC.

The Medicare Contractor filed a jurisdiction challenge on May 8, 2017 arguing that the Providers are expanding the scope of the stated issue by including Medicaid indigent bad debts. The Providers filed a Response to Jurisdictional Challenge on June 2, 2017.

Medicare Contractor's Position

The Medicare Contractor contends that the issue as stated in the January 29, 2013 appeal request is:

> "The common issue in this group appeal concerns the Medicare Administrative Contractor's ("MAC's") improper treatment of the Providers' bad debts. The Providers contend that the MAC incorrectly disallowed **bad debts attributable to indigent Medicare beneficiaries who were not eligible for Medicaid** (*i.e.*, so-called "dual eligible"), resulting in a reduction in Medicare reimbursement owed to the Providers. (emphasis added)[4]

Also, the issue is stated on the Schedule of Providers dated June 21, 2016 as "Disallowance of Bad Debt for Indigent Non-Medicaid Beneficiaries". The Medicare Contractor determined that the issue was resolvable with the proper supporting documentation. During the Medicare Contractor's review of the Providers' bad debt listings, it determined that the Provider was also requesting reimbursement as part of the appeal for bad debts relating to Medicaid eligible patients. The Medicare Contractor considered these bad debts to be outside the scope of the appeal issue and disallowed these from a proposed administrative resolution.

The Medicare Contractor proposed adjustments that included the properly supported non-Medicaid indigent bad debt accounts. The Provider Representative lodged its objection to the exclusion of the Medicaid crossover bad debts stating:

> Even though the Providers' statement of the issue may not have used the particular language that the MAC would prefer, the Providers' intent was to include all indigent bad debt, including both the Medicaid cross-over and bankrupt accounts as part of their appeal. ...[5]

The Medicare Contractor asserts that PRRB Rule 8.1 states "To comply with regulatory requirements to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible". Regarding bad debt cases, Section 8.3 provides examples of **crossover**, use of collection agency, 120-day presumption, **indigence determination**. Per PRRB Rule 13, the matter at issue must

---

[4] Medicare Contractor's Jurisdictional Challenge at 2. (May 8, 2017)
[5] Medicare Contractor's Jurisdictional Challenge at Exhibit I-2. (May 8, 2017)

involve a **single common question** of fact or interpretation of law, regulation or CMS policy or ruling.[6]

The Medicare Contractor maintains that regardless of the Providers' intent, the inclusion of Medicaid cross-over bad debts with the non-Medicaid indigent bad debts, expands the scope of the stated common issue. This expansion is contrary to Board Rules 8 and 13 because it creates a group appeal that contains two separate issues.

Providers' Position

The Providers have made their dissatisfaction well-known to the Medicare Contractor regarding indigent bad debt allowances. The protested amounts were removed for all Providers in the group for both bad debt accounts for patients that the hospital had determined to be indigent under their customary methods as well as indigent bad debt for patients determined to be Medicaid recipients.

The Providers argue that the Medicare Contractor is wrong to object to jurisdiction on the grounds that Medicaid eligible bad debts are "outside the scope of the as-stated appeal issue."[7] Each of the Providers protested all indigent bad debts including the Medicaid eligible ones and the Medicare Contractor made audit adjustments disallowing the protested indigent bad debts. The Providers then appealed the Medicare Contractor's adjustments.

The Providers state that it is undisputed that the Board has jurisdiction over the indigent non-Medicaid bad debts. Therefore, the Board has jurisdiction to review all aspects of the bad debt payment determination in accordance with section 1878(a) of the Act, 42 U.S.C. § 1395oo(a), and implementing regulations.[8]

Finally, the Providers assert that since the Board's jurisdiction has been invoked in this case regarding other issues arising from the NPR, including the calculation of bad debt reimbursement, the Board has jurisdiction under 42 U.S.C. § 1395oo(d).

Broad Decision:

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

The Board finds the participants in Case No. 13-0582GC **do have** a right under 42 U.S.C. § 1395oo(a) to a hearing on the **non-Medicaid indigent bad debt issue**. However, the Providers do not have a right under 42 U.S.C. § 1395oo(a) to a hearing on the Medicaid indigent bad debt

[6] Medicare Contractor's Jurisdictional Challenge at 3. (May 8, 2017)
[7] Providers' Response to Jurisdiction at 9. (June 2, 2017)
[8] Providers' Response to Jurisdiction at 10. (June 2, 2017)

issue. The group appeal issue statement clearly only refers to "non-Medicaid" indigent bad debts. All of the Provider's directly filed into the group taking on the issue statement of the group appeal. Even up to the date of the Providers final position paper submission in January of 2017, only arguments related to non-Medicaid indigent patients only were briefed.[9] Accordingly, the Board concludes that it does not have jurisdiction under 1395(a) to hear the Medicaid indigent bad debt issue that the Provider only now claims is part of the single legal issue group appeal. The providers' are now attempting to expand the issue in a group appeal to include a separate legal issue,[10] and are doing it long passed the timeframe in which a provider can file a timely appeal.

The following is the breakout of non-Medicaid and Medicaid indigent bad debts.[11]

Participant	Bad Debt Amount	Medicaid Bad Debt	Non-Medicaid bad debt amount
1	191978	32908	159070
2	210406	157586	52820
3	66633	20049	46584
5	19121	13248	5873
6	13918	12608	1310
Totals	502056	236399	265657

The Board also finds that since the Providers failed to established a jurisdictionally valid appeal under § 1395oo(a) on the Medicaid indigent bad debt issue, (these providers were all direct adds into this group appeal, they did not file into individual appeals with "other" issues, to which the Board has jurisdiction under § 1395oo(a)) the Board cannot use its discretionary power to make a determination under 42 U.S.C. § 1395oo(d). Therefore, the Board dismisses the Medicaid bad debts from the subject appeal. Case No. 13-0582GC remains open for the non-Medicaid bad debt issued raised in the initial appeal request.

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

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

FOR THE BOARD

L. Sue Andersen, Esq.

---

[9] Providers' Final Position Paper at 6-7. (January 25, 2017)
[10] 42 C.F.R 405.1837 (a)(2) requires that a group appeal be limited to a single question of law, regulations, or CMS rulings that is common to each provider in the group.
[11] Providers' Response to Jurisdiction at 6-9. (June 2, 2017)

Chairperson

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

JUL 19 2017

Certified Mail

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

RE: Expedited Judicial Review Request
Southwest Consulting DSH[1] Part C Days Groups
FYE: 2005, 2010-2014
PRRB Case Nos.: 15-0032G, 15-0034G, 15-1131GC, 15-1133GC, 15-1545GC, 15-1546GC, 15-1561GC, 15-1563GC, 15-1567GC, 15-1569GC, 15-1703GC, 15-1704GC, 15-1749G, 15-1750G, 15-2076GC, 15-2078GC, 15-2194GC, 15-2195GC, 15-2895GC, 15-2897GC,15-2980GC, 15-2985GC, 15-3260G, 15-3331GC, 15-3371GC, 16-0171GC, 16-0172GC, 16-0176GC, 16-0178GC, 16-0236G, 16-0391GC, 16-0392GC, 16-0394GC, 16-0396GC, 16-0700GC, 16-0702GC, 16-0834GC, 16-0836GC, 16-1024GC, 16-1153GC, 16-1271GC, 16-1272GC, 16-1339GC, 16-1340GC, 16-1389GC, 16-1390GC, 16-2133GC, 16-2343GC, 16-2344GC, 16-2444GC, 16-2446GC, 17-0036GC, 17-0042GC, 17-0085GC, 17-0088GC, 17-0090GC, 17-0092GC

Dear Mr. Newell:

On June 26, 2017, the Provider Reimbursement Review Board ("PRRB" or "Board') received a request for expedited judicial review ("EJR") for the above-referenced appeals. The Board has reviewed the request and hereby grants the request for all group participants except three, as explained in the Board's determination below.

The issue in these appeals is:

> [W]hether Medicare Part C patients are 'entitled to benefits' under Part A, such that they should be counted in the Medicare Part A/SSI[2] fraction and excluded from the Medicaid fraction numerator or vice-versa.[3]

Individual Participant Jurisdiction

Each of the following participants appealed a cost reporting period ending on or after December 31, 2008. As such, the regulation at 42 C.F.R. § 405.1835(a)(1) (2011) governs the participants'

[1] The abbreviation "DSH" stands for "disproportionate share hospital."
[2] "SSI" stands for "Supplemental Security Income."
[3] June 26, 2017 EJR Request at 4.

dissatisfaction requirements with respect to Board jurisdiction. Under this regulation, a participant preserves its right to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either including a claim for the specific item on a cost report for the period where the participant seeks payment that it believes to be in accordance with Medicare policy, or self-disallowing the specific item by following the applicable procedures for filing a cost report under protest.

1. PRRB Case No. 15-1546GC, Participant 11, Holy Family Hospital (Provider No. 22-0080)

   This participant timely filed a direct-add appeal of its January 13, 2015 original notice of program reimbursement ("NPR") for the cost reporting period covering October 1, 2011-September 30, 2012. Within PRRB Case No. 15-1546GC's Schedule of Providers, Holy Family lists Audit Adjustment Numbers 4, 9, 14, 17 and 18 as the adjustments pertinent to the appeal. However, based on the jurisdictional documents submitted to the Board, the only adjustment that mentions the SSI % is Adjustment No. 4. Specifically, within the Holy Family's Audit Adjustment Report, the Medicare contractor states that, for Adjustment No. 4, "[w]e have adjusted the SSI % and DSH % to audited amounts in accordance with PRM-2, Section 4030.1 and 42 CFR 412.106 (d)." However, the Audit Adjustment Report reflects that the only value adjusted under Adjustment No. 4 is Worksheet S-2, Part I, Line 24.00, Column 2.00, In-State Medicaid eligible unpaid days.

   Within its "Statement of Jurisdiction," Holy Family Hospital states that the Medicare contractor adjusted its Medicaid eligible days and Medicaid fraction, but it does not point to an SSI fraction[4] adjustment. Holy Family also states that it protested the issue in its as-filed cost report but does not provide any documentation to support its assertion. In fact, in an October 16, 2013 letter addressed to the Medicare contractor, Holy Family requests to *revise* its "DSH-related protest amounts stated in the original filing to clarify Steward Holy Family's protests with respect to the SSI and Medicaid fractions used to calculate the DSH payment." Holy Family closes this October 13, 2013 letter by stating that it "would appreciate [the Medicare contractor's] written acknowledgment of this request . . ." However, Holy Family has not included any such acknowledgment in its jurisdictional documents to indicate whether the Medicare contractor accepted its "amended" protest items as it requested.

   Based on the submitted jurisdictional documents, the Board finds that Holy Family has not demonstrated that the Medicare contractor adjusted its SSI % within the NPR under appeal nor did it initially protest the Medicare Part C/SSI % issue on its as-filed cost report. As such, under the specific requirements set out in 42 C.F.R. § 405.1835(a)(1) (2011), Holy Family has not preserved its right to claim dissatisfaction with the appealed issue for this cost reporting period. The Board concludes, therefore, that it lacks the jurisdiction to hear Holy Family's appeal of this issue.

[4] The Board uses the terms "SSI %" and "SSI fraction" synonymously throughout this determination.

2. & 3. PRRB Case No. 15-1749G, Participant 24, The Christ Hospital (Provider No. 36-0163)
PRRB Case No. 15-1750G, Participant 22, The Christ Hospital (Provider No. 36-0163)

Participant 24 from PRRB Case No. 15-1749G and Participant 22 from PRRB Case No. 15-1750G are the same provider (The Christ Hospital—Provider No. 36-0163)/cost reporting period/NPR appeal, therefore, the Board's jurisdictional analysis for both participants is set forth in one determination below. [5]

The Christ Hospital timely filed a direct-add appeal of its November 19, 2014 original NPR for the cost reporting period ending on June 30, 2012. Within the Schedule of Providers for both group appeals, The Christ Hospital lists Audit Adjustment Numbers 5, 6, 17 and 18 as the adjustments pertinent to the appeal.

According to the Audit Adjustment Report, the Medicare contractor's purpose for Adjustment 17 is "[t]o adjust the SSI% to CMS' determination and adjust Federal Payments to the [Medicare contractor]'s determination." Despite the Medicare contractor's statement, the adjustment to Worksheet E, Part A, Line 30.00, Percentage of SSI recipient patient days to Medicare Part A patient days is recorded as "0." The columns under this adjustment list "Previous Value" as 6.06 and "New Value" as 6.06, with the "Difference" column at 0. Within its "Statement of Jurisdiction," The Christ Hospital states that the Medicare contractor adjusted its DSH SSI fraction but presents no documentation to support this assertion as the Audit Adjustment Report shows no change to the SSI %. The Christ Hospital also argues that the Board has jurisdiction over its appeal because the Medicare contractor adjusted its Medicaid eligible days and Medicaid fraction, but, ultimately, it does not point to an SSI fraction adjustment, nor does it demonstrate that it protested the appealed issue in its as-filed cost report.

Based on the submitted jurisdictional documents, the Board finds that The Christ Hospital has not demonstrated that the Medicare contractor adjusted its SSI % within the NPR under appeal, nor did it protest the Medicare Part C/SSI % issue on its as-filed cost report. As such, under the specific requirements set out in 42 C.F.R. § 405.1835(a)(1) (2011), The Christ Hospital has not preserved its right to claim dissatisfaction with the appealed issue for this cost reporting period. The Board concludes, therefore, that it lacks the jurisdiction to hear The Christ Hospital's appeal of this issue involved with the EJR request in both PRRB Case No. 15-1749G and PRRB Case No. 15-1750G.

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

[5] PRRB 15-1749G is the appeal for the Part C SSI fraction, whereas PRRB 15-1750G is the appeal for the Medicaid fraction.

prospective payment system ("PPS").[6] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[7]

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[8] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[9]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[10] 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.[11] The DPP is defined as the sum of two fractions expressed as percentages.[12] 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 the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[13]

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

---

[6] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[7] *Id.*
[8] *See* 42 U.S.C. § 1395ww(d)(5).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[10] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).
[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[12] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[13] 42 C.F.R. § 412.106(b)(2)-(3).

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

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

Medicare Advantage Program

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

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

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[16]

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

---

[14] 42 C.F.R. § 412.106(b)(4).
[15] of Health and Human Services
[16] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).
[17] *Id.*

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

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

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

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

> . . . *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*

---

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

[19] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).

[20] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).

[21] 69 Fed. Reg. at 49,099.

> *adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[22] (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 FFY 2008 final rule was issued.[23] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change 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,*[24] 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.[25]

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.[26]

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."[27] 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.

---

[22] *Id.*
[23] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[24] 746 F. 3d 1102 (D.C. Cir. 2014).
[25] EJR Request at 1.
[26] 69 Fed. Reg. at 49,099.
[27] *Allina* at 1109.

§§ 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

Under the Medicare statute codified at 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1) (2017), the Board is required to grant an EJR request if it determines that (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

Jurisdictional Determination for the Participants

For the three participants discussed above—Participant 11, Holy Family Hospital (Provider No. 22-0080) in PRRB Case No. 15-1546GC; Participant 24, The Christ Hospital (Provider No. 36-0163) in PRRB Case No. 15-1749G; and Participant 22, The Christ Hospital (Provider No. 36-0163) in PRRB Case No. 15-1750G—the Board has determined that it lacks jurisdiction over these participants' appeals, therefore, the Board must deny their respective EJR requests with respect to the Medicare Part C/SSI issue that the participants are challenging.

The participants in PRRB Case No. 16-1153GC filed their respective appeals from original NPRs for the cost reporting period ending on December 31, 2005. Therefore, these participants may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the Part C days issue as a "self-disallowed cost" pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[28] The Board, therefore, finds that it has jurisdiction to hear the appeals for the participants in PRRB Case No. 16-1153GC.

The remaining group appeals involve cost reporting periods that end on or after December 31, 2008, thus, in order to demonstrate dissatisfaction with the amount of Medicare payment for the appealed issue, the participants filing appeals from an original NPR must show that the Medicare contractor adjusted their respective SSI fractions when each participant's cost report was settled or the participant must have self-disallowed the appealed issue by filing its cost report under protest. *See* 42 C.F.R. § 405.1835 (2008). For participants filing appeals from revised NPRs ("RNPRs"), the Board only has jurisdiction to hear a participant's appeal of matters that the Medicare contractor specifically revised within the RNPR.

---

[28] 108 S.Ct. 1255 (1988).

The Board has determined that the remaining participants have either a specific adjustment to the SSI fraction or have properly protested the issue where appropriate such that the Board has jurisdiction to hear their respective appeals. In addition, the participants' documentation shows that the estimated amount in controversy for each group appeal exceeds $50,000, as required for a group appeal[29] and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board Jurisdiction Regarding the Appealed Issue

The group appeals in this EJR request span fiscal years 2005 and 2010-2014. However, the participants with fiscal years ending in 2014, all report a fiscal year end on or before August 31, 2014. Therefore, pursuant to 42 C.F.R. § 412.106(b)(2) (2013),[30] CMS calculated the EJR participants' SSI percentages using the first month of each participants' fiscal year, i.e., 2013 or earlier. As such, the Board concludes that the Secretary's final rule, as set out in 78 Fed. Reg. 50496, 50615 (August 19, 2013), concerning CMS' placement of Medicare Advantage-covered inpatient days in the Medicare fraction of the Disproportionate Patient Percentage for fiscal years 2014 and later, does not apply to the participants' appeals involved in this EJR request.

As such, the Board recognizes that the D.C. Circuit vacated the regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only 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.[31]

Board's Decision Regarding the EJR Request

---

[29] *See* 42 C.F.R. § 405.1837.

[30] The regulation states that for each month of the federal fiscal year in which the hospital's cost reporting period *begins*, CMS (i) determines the number of patient days that (A) are associated with discharges occurring during each month; and (B) are furnished to patients who during that month were entitled to Medicare Part A (including Medicare Advantage (Part C)) and SSI, excluding those patients who received only state supplementation; (ii) adds the results for the whole period; and (iii) divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that (A) are associated with discharges that occur during that period; and are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)). Emphasis added.

[31] On July 10, 2017, one of Medicare contractors, Wisconsin Physicians Service ("WPS"), filed an objection to the EJR request in PRRB Case Nos. 15-1703GC and 15-1704GC. In its filing, WPS argues that the Board should deny the EJR request because the Board has the authority to decide the issue under appeal since it is not bound by the Secretary's regulation that the federal district court vacated in *Allina*. The Board's explanation of its authority regarding this issue addresses the arguments set out in WPS' challenge.

The Board finds that:

1) it has jurisdiction over the matter for the subject years and that the Providers in these group appeals are entitled to a hearing before the Board, except as otherwise noted above;

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

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

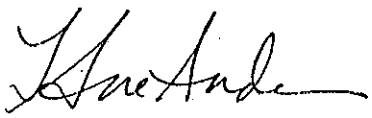
4) it is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), are valid.

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

Board Members Participating:

L. Sue Andersen, Esq.
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)
Judith E. Cummings, CGS Administrators, LLC (Certified Mail w/Schedules of Providers)
Laurie Polson, Palmetto GBA c/o NGS (Certified Mail w/Schedules of Providers)
Bruce Snyder, Novitas Solutions (Certified Mail w/Schedules of Providers)
Byron Lamprecht, Wisconsin Physician Service (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)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Certified Mail

JUL 25 2017

Christopher L. Keough
Alex J. Talley
Akin Gump Straus Hauer & Feld LLP
1333 New Hampshire Avenue, NW
Washington, DC 20036-1564

RE: Expedited Judicial Review Request
Southwest Consulting DSH[1] Part C Days Groups
FYE: 2004-2008
PRRB Case Nos.: 08-1774GC, 08-2922GC, 08-2934GC, 08-2937GC, 09-0308GC, 09-0413GC, 09-0657G, 09-1021GC, 09-1687GC, 09-1808G, 09-2142G, 09-2257GC, 09-2307GC, 10-1395G, 11-0599G, 13-0272GC, 13-0690G, 13-0713G, 13-0718GC, 13-0727GC, 13-0795G, 13-1275GC, 13-1365G, 13-1369GC, 13-1918GC, 13-1919GC, 13-2430GC, 13-2538GC, 13-2553GC, 13-2554GC, 13-2556GC, 13-2661GC, 13-2688GC, 13-2698GC, 13-2723GC, 13-2781GC, 13-2783GC, 13-3260GC, 13-3299GC, 13-3322GC, 13-3324GC, 13-3574GC, 13-3597GC, 13-3961GC, 14-0240GC, 14-0249GC, 14-0321GC, 14-0323GC, 14-3964G, 15-2567GC and 15-2592GC

Dear Mr. Keough and Mr. Talley:

On June 26, 2017, the Provider Reimbursement Review Board ("PRRB" or "Board') received a request for expedited judicial review ("EJR") for the above-referenced appeals. The Board has reviewed the request and hereby grants the request for all group participants, as explained below.

The issue in these appeals is:

> [W]hether Medicare Part C patients are 'entitled to benefits' under Part A, such that they should be counted in the Medicare Part A/SSI[2] fraction and excluded from the Medicaid fraction numerator or vice-versa.[3]

[1] The abbreviation "DSH" stands for "disproportionate share hospital."
[2] "SSI" stands for "Supplemental Security Income."
[3] June 26, 2017 EJR Request at 4.

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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

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

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

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[11]

---

[4] *See* 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.
[5] *Id.*
[6] *See* 42 U.S.C. § 1395ww(d)(5).
[7] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[11] 42 C.F.R. § 412.106(b)(2)-(3).

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

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

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[12]

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[13] 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

---

[12] 42 C.F.R. § 412.106(b)(4).
[13] of Health and Human Services

> including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[14]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[15]

With the creation of Medicare Part C in 1997,[16] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004. [17]

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)[18]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[19] In response to a comment regarding this change, the Secretary explained that:

---

[14] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).
[15] *Id.*
[16] 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.
[17] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).
[18] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).
[19] 69 Fed. Reg. at 49,099.

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A.* We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[20] (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 FFY 2008 final rule was issued.[21] 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,*[22] 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.[23]

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

---

[20] *Id.*
[21] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[22] 746 F. 3d 1102 (D.C. Cir. 2014).
[23] June 26, 2017 EJR Request at 1.

course and announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective October 1, 2004.[24]

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

In these cases, the Providers contend that all Part C days should be excluded from the Part A/SSI fraction and the Medicaid-eligible Part C days should be included in the numerator of the Medicaid fraction. To obtain relief, the Providers seek a ruling on the procedural and substantive validity of the 2004 rule that 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

Under the Medicare statute codified at 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1) (2017), the Board is required to grant an EJR request if it determines that (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

Jurisdictional Determination for the Providers

The providers that comprise the group appeals within this EJR request have filed appeals involving cost reporting periods between October 1, 2004, and September 30, 2008. With respect to Board jurisdiction over an issue for this cost reporting time period, any provider that files an appeal from an original NPR may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the Part C days issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[26] For any provider that files an appeal from a revised NPR ("RNPR") issued after August 21, 2008, the Board only has jurisdiction to hear that provider's appeal of matters that the Medicare contractor specifically revised within the RNPR. *See* 42 C.F.R. § 405.1889(b)(1) (2008). The Board notes that all provider RNPR appeals included within this EJR request were issued after August 21, 2008.

The Board has determined that the providers involved with the instant EJR request have either filed their respective appeal requests from original NPRs or, where applicable, had a specific adjustment to the SSI fraction. In addition, the providers' documentation shows that the

---

[24] 69 Fed. Reg. at 49,099.
[25] *Allina* at 1109.
[26] 108 S.Ct. 1255 (1988).

estimated amount in controversy for each group appeal exceeds $50,000, as required for a group appeal[27] and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

The Board concludes that it has jurisdiction to hear the providers' appeals of the SSI/Part C issue as set out within the group appeals involved with the instant EJR request.

Board's Analysis Regarding the Appealed Issue

The group appeals in this EJR request span fiscal years between October 1, 2004 and September 30, 2008, thus the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed,* No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request. [28]

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

---

[27] *See* 42 C.F.R. § 405.1837.

[28] On July 10, 2017, one of the Medicare contractors, Wisconsin Physicians Service ("WPS"), filed an objection to the EJR request for PRRB Case Nos. 08-2922GC, 09-2257GC, 13-0272GC, 13-0718GC, 13-0727GC, 13-1275GC and 15-2592GC. In its filing, WPS argues that the Board should deny the EJR request because the Board has the authority to decide the issue under appeal since it is not bound by the Secretary's regulation that the federal district court vacated in *Allina.* The Board's explanation of its authority regarding this issue addresses the arguments set out in WPS' challenge.

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

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

Board Members Participating:

Charlotte F. Benson, CPA
Jack Ahern, MBA, CHFP
Gregory H. Ziegler

FOR THE BOARD:

Charlotte F. Benson, CPA
Board Member

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

cc: Pam Van Arsdale, NGS (Certified Mail w/Schedules of Providers)
Geoff Pike, First Coast Service Options (Certified Mail w/Schedules of Providers)
Bruce Snyder, Novitas Solutions (Certified Mail w/Schedules of Providers)
Byron Lamprecht, Wisconsin Physician Service (Certified Mail w/Schedules of Providers)
Bill Tisdale, Novitas Solutions (Certified Mail w/Schedules of Providers)
Wilson Leong, (w/Schedules of Providers)