DEPARTMENT OF HEALTH & HUMAN SERVICES

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

AUG 0 1 2017

CERTIFIED MAIL

Toyon Associates, Inc.
Sandra Lee
Assistant Director – Client Services
1800 Sutter Street – Suite 600
Concord, CA 94520-2546

Noridian Healthcare Solutions, LLC
Evaline Alcantara
Appeals Coordinator – Jurisdiction E
P.O. Box 6782
Fargo, ND 58108-6782

RE: Doctors Medical Center of San Pablo
Provider No.: 05-0079
FYE: 12/31/09
PRRB Case No.: 14-0516

Dear Ms. Lee 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 November 5, 2013, based on a Notice of Program Reimbursement ("NPR") dated May 10, 2013. The hearing request included eight issues.[1] Subsequently, four issues were transferred to group appeals and two issues were withdrawn. Two issues remain in the appeal: 1) Issue 1B – Medicare Settlement Data – Outlier Payments and 2) Issue 7 – Medicare Bad Debt Reimbursement.

The Medicare Contractor submitted a jurisdictional challenge on these issues on May 24, 2017. The Provider submitted a responsive brief on June 21, 2017.

Medicare Contractor's Position

Issue 1B – Medicare Settlement Data – Outlier Payments

The Medicare Contractor explains that the Provider identified adjustments 1, 4, 5, 9-14, and 25-29 as the adjustments in controversy for this issue. These adjustments were to Inpatient Medicare Routine days and discharges, Routine and Ancillary charges, Inpatient Settlement Items, Outpatient Medicare charges, and Protested Items. None of these adjustments were related to the Outlier Payment issue. Additionally, although the Provider's as filed cost report did include

[1] The Provider labeled Issue 1 as Issue 1A – Medicare Settlement Data and Issue 1B – Medicare Settlement Data – Outlier Payments. The Provider subsequently withdrew Issue 1A.

reimbursement amounts claimed as Protested Amounts, the issues specifically identified as filed under protest did not include any issues related to the outlier payments.[2]

The Medicare Contractor contends that the Provider has not preserved its right to claim dissatisfaction with the contested outlier payments on this cost report, as it did not include a claim for this on its as-filed cost report. The Provider also failed to include the reimbursement impact of the contested outlier payments as a Protested Amount on its as filed cost report. Therefore, the Medicare Contractor did not make an adjustment to the contested outlier payments on the final cost report. The Medicare Contractor has not made a determination with respect to the Provider for the issue appealed.[3]

Issue 7 – Medicare Bad Debt Reimbursement

The Medicare Contractor contends that the bad debts under appeal were not submitted on the as-filed Medicare cost report. The Medicare Contractor states that the Provider's Final Position Paper gives no indication that they were precluded from including these bad debts on their as-filed cost report, either by the Medicare Contractor or through statutory provision. In addition, even if the Provider had included these bad debts on their cost report, the Medicare Contractor's adjustments to the Provider's bad debts did not relate to the issue under appeal, namely unclaimed Crossover Bad Debts. The Medicare Contractor states that the adjustments related to the following issues: 1) 2% Share of Cost for Inpatient and Outpatient Crossover Bad Debts, 2) State Reduction on certain Outpatient Crossover Bad Debts, and 3) Write-off issues for Outpatient Crossover Bad Debts.[4]

Additionally, the Medicare Contractor states that although the Provider also referenced Adjustments 14 and 20, the Medicare Contractor's adjustments to Inpatient and Outpatient Protested Items, as adjustments in controversy, the Provider did not include a claim for this particular issue as a protested item. Although the Provider's as-filed cost report did include reimbursement amounts claimed as Protested Amounts, the issues specifically identified as filed under protest did not include any issues related to Unclaimed Crossover Bad Debts. The Medicare Contractor states that the Provider's Medicare Bad Debts protested amounts related to the following: 1) Understated bad debts due to the exclusion of bad debts related to services paid under a fee schedule methodology, 2) Understated crossover bad debts reimbursement related to share of cost claims, and 3) Understatement of bad debt reimbursement due to a dispute concerning the date the bad debt was deemed worthless (proper bad debt write-off date).[5]

The Medicare Contractor contends that the Provider has not preserved its right to claim dissatisfaction with the Unclaimed Crossover Bad Debts on this cost report. The Provider did not include a claim on its submitted cost report for the specific Crossover Bad Debts involved in the issue being appealed. The Medicare Contractor did not make an adjustment to the Unclaimed Crossover Bad Debts on the final cost report. The Provider also failed to include the reimbursement impact of the Unclaimed Crossover Bad Debts as a Protested Amount on its filed

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[2] Medicare Contractor's jurisdictional challenge at 2-3.
[3] Medicare Contractor's jurisdictional challenge at 6.
[4] Medicare Contractor's jurisdictional challenge at 7-8.
[5] Medicare Contractor's jurisdictional challenge at 9.

cost report. The Medicare Contractor did not make a determination with respect to the Provider for the issue appealed.[6]

Provider's Position

Issue 1B – Medicare Settlement Data – Outlier Payments

The Provider contends that the NPR issued on May 10, 2013 constitutes a final determination by the Medicare Contractor with respect to the provider's cost report. In 42 C.F.R. § 405.1801(a)(2), it defines a final determination as follows: "An intermediary determination is defined as a "determination of the total amount of payment due to the hospital, pursuant to § 405.1803 following the close of the hospital's cost reporting period…"[7]

The Provider argues that the Medicare Contractor posted adjustments to the Provider's items of costs claimed in the as-filed cost report in the final NPR, which satisfy the criteria of dissatisfaction at 42 U.S.C. § 1395oo(a) and 42 C.F.R. § 405.18359(a). The Provider contends the Medicare Contractor made audit adjustments that revised the as-filed outlier payments to agree with the Medicare Contractor's Provider Statistical & Reimbursement (PS&R) Report dated April 14, 2011, per audit adjustment number 13. Therefore, the Provider is afforded a right to appeal the outlier payments based on this audit adjustment.[8]

The Provider explains that the Medicare Contractor cited 42 C.F.R. § 412.110 as the Medicare regulations to support their audit adjustments. As set forth in 42 C.F.R. § 412.110, Medicare's total payment for inpatient hospital services will equal the sum of the payments listed in § 412.112 through § 412.115. The total payments in § 412.112 include a provision that appropriate outlier payment amounts must be determined under subpart F – § 412.80, § 412.82, § 412.84 and § 412.86. These cited Medicare regulations outline the methods in establishing the outlier thresholds. The Provider contends that its appeal of the outlier payments is in accordance with these Medicare regulations in order to account for the proper calculation of the outlier threshold.[9]

Issue 7 – Medicare Bad Debt Reimbursement

The Provider contends the Medicare Contractor made adjustments that adjusted the Provider's as-filed inpatient and outpatient bad debts per audit adjustment numbers 15, 17, 21, 22, 23 and 24. The Medicare Contractor also made adjustments to the Provider's filed protested amounts, which included amounts related to Medicare Bad Debts per audit adjustment numbers 14 and 20.[10]

First, the Provider contends that a review of audit adjustment numbers 15, 17, 21, 22, 23 and 24 revels the Medicare Contractor revised the Provider's as-filed Medicare bad debts from $649,374

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[6] Medicare Contractor's jurisdictional challenge at 13.
[7] Provider's jurisdictional response at 2 (Emphasis included).
[8] Provider's jurisdictional response at 4.
[9] Provider's jurisdictional response at 4.
[10] Provider's jurisdictional response at 5.

to $649,311 and $528,835 to $516;961 in inpatient and outpatient bad debts, respectively. Specifically, audit adjustment number 24 disallowed $3,851 bad debts related to "write off issues." In sum, the Medicare Contractor made various adjustments to the Provider's filed Medicare bad debts thereby creating a situation of dissatisfaction with the Provider. In the Provider's appeal language for Issue No. 7, the Provider's appeal of Medicare bad debts originating from Adjustment Nos. 15, 17, 21, 22, 23 and 24 is compliant with 42 C.F.R. § 405.1835.[11]

Second, the Provider contends that a review of the Provider's listing of protested amounts reveals the Provider protested the understatement of Medicare bad debt reimbursement related to "dispute concerning the date the bad debt was deemed worthless (i.e. dispute of proper bad debt write-off date)" (Protest Item No. 24). The Provider states that the Medicare Contractor has apparently not considered this fact in their jurisdiction challenge and has focused solely on finding a protested item with a description containing "Unclaimed Crossover Bad Debts." The Provider explains that audit adjustment numbers 14 and 20 eliminate $1,578,678 and $28,892 of protested amounts reported on Worksheet E, Part A, line 30 and Worksheet E, Part B, line 36, respectively. The Provider contends that it has preserved its appeal rights on this issue through an adjustment to amounts filed under protest. The Provider's appeal of Medicare bad debts from Adjustment Nos. 14 and 20 is compliant with 42 C.F.R. § 405.1835.[12]

Board's Decision

Issue 1B – Medicare Settlement Data – Outlier Payments

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2012), a provider has a right to a 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.....[13]

The Board concludes that it does not have jurisdiction over the Outlier Payments issue because the appeal does not comply with the requirements of 42 C.F.R. § 405.1835(a)(1)(i) (2009) or 42 C.F.R. § 405.1835(a)(1)(ii) (2009).

The Provider states that adjustments made by the Contractor regarding its outlier payments were covered by Adjustment No. 13. Upon review of this adjustment, the Board finds that the Medicare contractor did make a PS&R adjustment to the outliers line. However, that adjustment would have only been to adjust the paid outliers to the PS&R and would not have specifically

[11] Provider's jurisdictional response at 5.
[12] Provider's jurisdictional response at 5.
[13] 42 C.F.R. § 405.1835(a).

adjusted the contested Outlier Payments that are under appeal. The Provider indicates that it was under-reimbursed for outlier claims. The Board finds that the Provider could have computed an estimate and included them as a protested amount, but failed to do so. Those payments were not claimed and therefore were not adjusted by the Medicare contractor as required by 42 C.F.R. §405.1835(a)(1)(i) (2009) and 42 C.F.R. §405.1835(a)(1)(ii).

Effective with cost report periods that end on or after December 31, 2008, CMS amended the regulations governing cost report appeals to incorporate Provider Reimbursement Manual (PRM) 15-2 § 115 *et seq.* into the regulations at 42 C.F.R. §405.1835(a)(1)(ii) (2009) by specifying that, where a provider seeks payments that it believes may not be allowable or may not be in accordance with Medicare policy, the provider must claim the items as self-disallowed costs "by following the applicable procedures for filing a cost report under protest." Here, the Provider's cost report was for FYE December 31, 2009; therefore, any self-disallowed items are required to be protested.

The Board finds that the Provider did file a Protested Amount of $1,578,678 on line 30 of Worksheet E, Part A of its as-filed cost report that was removed in Adjustment No. 14. However, the Board finds that a review of the composition of the Protested Amount reveals that the Provider failed to include the Outlier Payments issue under dispute in that protested amount.. Therefore, the Provider failed to preserve its rights to claim dissatisfaction.

Therefore, the Board concludes that it does not have jurisdiction over the Medicare Settlement Data - Outlier Payments issue as there was no adjustment related to the issue and the issue was not properly protested, and dismisses the issue from the appeal.

Issue 7 – Medicare Bad Debt Reimbursement

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2012), a provider has a right to a 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.....[14]

The Board concludes that it does not have jurisdiction over the Medicare Bad Debt Reimbursement issue because the appeal does not comply with the requirements of 42 C.F.R. § 405.1835(a)(1)(i) (2009) or 42 C.F.R. § 405.1835(a)(1)(ii) (2009).

Effective with cost report periods that end on or after December 31, 2008, CMS amended the regulations governing cost report appeals to incorporate Provider Reimbursement Manual (PRM) 15-2 § 115 *et seq.* into the regulations at 42 C.F.R. §405.1835(a)(1)(ii) (2009) by specifying that,

[14] 42 C.F.R. § 405.1835(a).

where a provider seeks payments that it believes may not be allowable or may not be in accordance with Medicare policy, the provider must claim the items as self-disallowed costs "by following the applicable procedures for filing a cost report under protest." Here, the Provider's cost report was for FYE December 31, 2009; therefore, any self-disallowed items are required to be protested.

The Provider's Final Position Paper dated March 28, 2017 stated the following with respect to the bad debts at issue:

> "The Provider has reviewed its Medicare crossover bad debts records, verified additional documentation from the State of California, and concluded $11,883 ($5,296 + $6,587) and $67,244 ($52,057 + $15,187) should have been included in the Provider's allowable Medicare inpatient and outpatient crossover bad debts, respectively."[15]

The Board finds that the Provider did not include the additional Medicare crossover bad debts in its as-filed cost report. Additionally, the Board finds that there is no evidence in the record that the Provider included a protested amount on its as-filed cost report related to the additional Medicare crossover bad debts it believed it would be due. The Provider could have protested, but failed to do so. Nothing in the record shows the bad debts in question were presented on audit. Therefore, the Board concludes that it does not have jurisdiction over the additional Medicare crossover bad debts under 42 U.S.C. § 1395oo(a) or § 1395oo(d) as they were not claimed for payment or properly protested. Consequently, the Board dismisses the Medicare Bad Debt Reimbursement issue from the appeal.

In considering jurisdiction over the Medicare Settlement Data – Outlier Payments and Medicare Bad Debt Reimbursement issues, the Board acknowledges the recent United States District Court for the District of Columbia decision in *Banner Heart Hosp. v. Burwell* (DDC August 19, 2016).[16]

As no issues remain in the appeal, the Board closes the case. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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[15] Provider's Final Position Paper at 5.

[16] The District Court in *Banner* concluded that the Board "violates the administrative appeal provision of the Medicare statute and the key Supreme Court precedent interpreting it, *Bethesda*". *Bethesda* emphasizes the futility of presenting a legal challenge to an intermediary when the intermediary has no authority to entertain or decide such challenges. However, *Banner* did not go as far as invalidating the regulation and the Board is not bound by a District Court decision.

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

FOR THE BOARD

Charlotte Benson for

L. Sue Andersen, Esq.
Chairperson

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

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

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CERTIFIED MAIL

AUG 01 2017

Christopher Keough, Esq.
Akin Gump Strauss Hauer & Feld, LLP
1333 New Hampshire Avenue, NW
Washington, DC 20036 1564

Re: Southwest Consulting 2008 DSH SSI Dual Eligible Pt. C Days Group, Case No. 13-0673G

Dear Mr. Keough:

The Provider Reimbursement Review Board (the Board) has received your July 26, 2017 request to bifurcate the issues in the above-captioned group appeal into separate groups. The pertinent facts with regard to request and the Board's determination are set forth below.

Pertinent Facts:

The optional group appeal for the Southwest Consulting 2008 DSH SSI Dual Eligible Pt. C Days was filed on February 11, 2013. The group issue statement challenged three aspects of the calculation of the disproportionate share hospital (DSH) Supplemental Security Income Part A/(SSI) fraction: 1) the data matching process used to calculate the numerator (Baystate Errors); 2) the inclusion of Part C days in the SSI fraction; and 3) the inclusion of Part A non-covered days in the SSI fraction.

By letter dated July 26, 2017, the Representative requested the bifurcation of the issues into separate groups.[1] The Representative also filed a simultaneous request for expedited judicial review (EJR) of the Part C days issue.

Board's Decision

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

The Board finds that the group issue statement clearly identifies the Part C days issue as well as the SSI Data Match (Baystate Errors) issue and the inclusion of Part A non-covered days in the SSI fraction.[2] Therefore, the Board agrees to bifurcate the SSI Data Match (Baystate

[1] In the July 26, 2017 request for bifurcation, the Providers simultaneously withdrew the portion of the issue challenging the Part A non-covered days.
[2] The Representative requested that the Part C days group proceed under group case

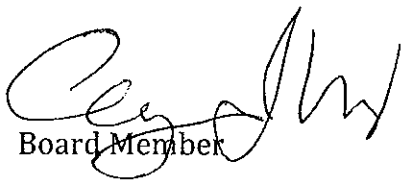
Errors) issue from the group. Although there is already a pending optional group for the SSI Data Match issue, the Southwest Consulting 2008 DSH Post 1498R Medicare Part A/SSI% Group (case number 13-2908G), that group is complete and the Schedule of Providers has already been filed. Therefore, the Board has established a new group for the SSI Data Match issue to which we've assigned case number 17-1926G.[3] Since the participants were bifurcated from case number 13-0673G which is fully formed, and for which preliminary position papers were already filed, the new SSI Data Match group is also considered to be complete and the Board is waiving the requirement for preliminary position papers and a new Schedule of Providers.[4] The Parties will receive a Notice of Hearing scheduling the SSI Data Match case for a hearing date under separate cover.

The Part C days issue will remain in case number 13-0673G which has been renamed the Southwest Consulting 2008 DSH SSI Fraction Part C Days Group. The Parties will receive the Board's determination with regard to the EJR request under separate cover once a review of the jurisdiction of all participants has been completed.

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

FOR THE BOARD



Board Member

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

cc: Wilson Leong, Esq., CPA, Federal Specialized Services
Byron Lamprecht, Wisconsin Physicians Service (J-5)

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number 13-0673G and a new case number be established for the SSI Data Match (calculation of the numerator of the Part A SSI fraction) group.

[3] This letter serves as the Acknowledgement of the new Southwest Consulting 2008 DSH SSI Data Match (Baystate Errors) Group II.

[4] The Board is retaining the Schedule of Providers and jurisdictional documentation submitted on May 1, 2014 in case number 13-0673G to be used as the Schedule of Providers in the new group, case number 17-1926G.

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AUG 0 1 2017

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

Re: CHI 2005 DSH Medicare + Choice Group, PRRB Case No. 08-0324GC

Dear Mr. Keough & Ms. Webster:

The Provider Reimbursement Review Board (the Board) has received your July 26, 2017 request to bifurcate the above-captioned group appeal based on discharges occurring before October 1, 2004 and discharges occurring on or after that date. The pertinent facts with regard to this case and the Board's determination are set forth below.

Pertinent Facts:

The common issue related party (CIRP) group appeal for the CHI 2005 DSH Medicare + Choice Days issue was filed on December 3, 2007. In the group issue statement, the participants in the group "... contend that the Centers for Medicare and Medicaid Services (CMS) and its fiscal intermediaries have improperly failed to include Medicare + Choice days in the number of Medicaid patient days used for purposes of calculating Medicare disproportionate share hospital ("DSH") payments, and thereby failed to pay the hospital's proper DSH entitlements."[1]

By letter dated July 26, 2017, the Representative requests the bifurcation of the pre and post 10/1/2004 discharges at issue in this group. The Representative maintains that the Part C days are treated differently for periods ending before and those ending on or after 10/1/2004.[2]

All cost reporting periods in the subject group appeal end on June 30, 2005. Therefore, a portion of each cost report year overlaps the 10/1/2004 effective date of the CMS policy change regarding the inclusion of Part C days in the SSI fraction and their exclusion from the Medicaid fraction.

In the July 26, 2017 correspondence, the Representative advises that the Medicare Contractor may resolve the Part C days issues for patients with discharges prior to

[1] Group Appeal request dated November 30, 2007 at p.1.
[2] 10/1/2004 was the effective date of CMS's policy change which required the inclusion of Part C days in the SSI fraction and the exclusion of those days from the Medicaid fraction.

10/1/2004. A request for expedited judicial review (EJR) has also been filed for Providers with discharges on or after 10/1/2004.

Board Determination:

In accordance with your request, the Board agrees to bifurcate the period from 7/1/2004 to 9/30/2004 for the participants in the subject group. The Board has created a new group called the CHI Pre 10/1/2004 Medicare + Choice CIRP Group to which it has assigned case number 17-1918GC.[3] Since the participants were bifurcated from case number 08-0324GC which is fully formed, the new Pre 10/1/2004 group is also considered to be complete. The Parties will receive a Notice of Hearing scheduling the case for a hearing date under separate cover.

The cost reporting period from 10/1/2004 to 6/30/2005 will remain in case number 08-0324GC (which will now be referred to as the 10/1/2004 - 6/30/2005 DSH Medicare + Choice CIRP Group) for which EJR has been requested. The Parties will receive the Board's determination with regard to the EJR request under separate cover once a review of the jurisdiction of all participants has been completed.

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

For the Board:

Charlotte Benson

Board Member

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

[3] This notice serves as the Acknowledgement of the new CIRP group.

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AUG 02 2017

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William J. Emrhein
Emrhein & Associates
7515 Pearl Road, Ste. 202
Middleburg Heights, OH 44130

Danene Hartley
National Government Services, Inc.
Appeals Lead
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206 – 6474

RE: Jurisdictional Decision
Case Number: 12-0283GC
Case Name: Aspirus 2010 Investment Income CIRP Group
FYE: 06/30/2010

Dear Mr. Emrhein and Ms. Hartley:

Background

The Providers filed this CIRP group appeal with the Provider Reimbursement Review Board ("Board") on March 19, 2012. The Providers are appealing a Home Office Cost Statement dated September 27, 2011 which was issued for Home Office Number 90-1003 (Aspirus, Inc.). The group appeal request at Tab 1 states "No N.P.R. notices have been received for any of the providers listed below...", then proceeds to list the following Provider Numbers:

1) Aspirus Ontonagon Hospital, Provider Number 23-1309,
2) Langlade Hospital, Provider Number 52-1350,
3) Aspirus Keweenaw Hospital, Provider Number 23-1319,
4) Memorial Health Center, Provider Number 52-1324, and
5) Aspirus Wausau Hospital, Provider Number 52-0030.

The Provider's filed a Model Form G: Schedule of Providers on September 30, 2016. Column A which lists the date of the final determination under appeal states

> 9/27/11 Note 1 – The Home Office Cost Statement dated September 27, 2011 is the determination that was appealed. Attached is the determination as received by Aspirus, Inc. Home Office, which includes the cover letter, as-settled cost statement, and audit adjustment report.

The Medicare Contractor, National Government Services, Inc, has challenged the Board's jurisdiction to hear this case. The Medicare Contractor filed briefs challenging jurisdiction on both November 4, 2016 and on April 25, 2017.

Medicare Contractor's Position

The Medicare Contractor has challenged the Board's jurisdiction, alleging that the appeal is based on the Home Office Cost Statement which is not a final determination and is not appealable. The Medicare Contractor also asserts that a Home Office is not a Provider, and only a Provider or group of Providers is entitled to file an appeal to the Board. The Medicare Contractor claims that only when modifications flowing from the Home Office Cost Statement's adjustments are reflected on the Providers' Cost Reports are they appealable.

The Medicare Contractor refers to CMS Pub. 15-1, Chapter 10, Section 1000, stating

> The home office of a chain is not in itself certified by Medicare; therefore, its costs may not be directly reimbursed by Medicare...To the extent the home office furnished services related to patient care to a provider, the reasonable costs of such services are includable in the provider's cost report and are reimbursable as part of the provider's costs.[1]

The Medicare Contractor concludes that the Providers failed to properly or timely appeal the final determinations of the individual Providers noted in the Schedule of Providers.

Providers' Position

The Providers filed responses to the jurisdictional challenges. The Providers state they are appealing the impact of the Home Office Cost Statements on their individual reimbursements, and that the Providers and Provider numbers were named on the appeal request. The Providers also claim they are challenging the amount of reimbursement due the hospitals as a result of the determination rendered by the Medicare Contractor through the Home Office Finalization Letter issued on September 27, 2011.

The Providers contend that the Home Office Finalization Letter is used to determine the amount of reimbursement due to the Providers, and it meets the definition of an Intermediary determination under 42 C.F.R. § 405.1801. The Providers cite to *Central 99-00 Dixie Diamond Ranch HO Adj. #2 CIRP Group, et al. v. BlueCross BlueShield Assn'/Cahaba Govt. Benefit Admins.*, PRRB Decision 2007-D25 (Apr. 12, 2007), alleging that the Board exercised jurisdiction over a home office cost allocation in this case.

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2011), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if it is

[1] Medicare Contractor's Jurisdictional Challenge (April 24, 2017) at 1-3.

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

A "final determination" is a Medicare contractor determination of the amount of total reimbursement due the provider…following the close of the provider's cost reporting period…", whether the hospital is paid on a reasonable cost basis or under the prospective payment system.[2]

Board Rule 4.2 states

> Only a Provider or group of Providers is entitled to file an appeal to the Board. A home office is not a Provider and cannot file an appeal. (Allocations made to a Provider from the home office cost statement can be appealed by a Provider *only from an adjustment made to the Provider's claimed home office costs on the Provider's Medicare cost report.*)(emphasis added).

Additionally, Board Rule 7.3 states

> If you are appealing from a final determination other than a cost report adjustment, provide:
>
> - The date of the determination,
> - The controlling authority in dispute,
> - The authority granting the Board's jurisdiction over the dispute, and
> - an explanation regarding why the Intermediary or CMS determination was improper.

The Board finds in this appeal that the Providers appealed a Home Office Cost Statement which is not a final determination of the amount of total reimbursement due the provider, and there is no authority granting the Board jurisdiction over the Home Office Cost Statement. Therefore, the Board dismisses this appeal due to lack of jurisdiction. This case is now closed.

Board Members

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

FOR THE BOARD

L. Sue Andersen /cw/
L. Sue Andersen
Board Member

cc: Wilson Leong, Esq., FSS

[2] 42 C.F.R. §405.1801(a).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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7515 Pearl Road, Ste. 202
Middleburg Heights, OH 44130

Danene Hartley
National Government Services, Inc.
Appeals Lead
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206 – 6474

RE: Jurisdictional Decision
Case Number: 12-0285GC
Case Name: Aspirus 2010 Excess Capital CIRP Group
FYE: 06/30/2010

Dear Mr. Emrhein and Ms. Hartley:

Background

The Providers filed this CIRP group appeal with the Provider Reimbursement Review Board ("Board") on March 19, 2012. The Providers are appealing a Home Office Cost Statement dated September 27, 2011 which was issued for Home Office Number 90-1003 (Aspirus, Inc.). The group appeal request at Tab 1 states "No N.P.R. notices have been received for any of the providers listed below...", then proceeds to list the following Provider Numbers:

1) Aspirus Ontonagon Hospital, Provider Number 23-1309,
2) Langlade Hospital, Provider Number 52-1350,
3) Aspirus Keweenaw Hospital, Provider Number 23-1319,
4) Memorial Health Center, Provider Number 52-1324, and
5) Aspirus Wausau Hospital, Provider Number 52-0030.

The Provider's filed a Model Form G: Schedule of Providers on September 30, 2016. Column A which lists the date of the final determination under appeal states

> 9/27/11 Note 1 – The Home Office Cost Statement dated September 27, 2011 is the determination that was appealed. Attached is the determination as received by Aspirus, Inc. Home Office, which includes the cover letter, as-settled cost statement, and audit adjustment report.

The Medicare Contractor, National Government Services, Inc, has challenged the Board's jurisdiction to hear this case. The Medicare Contractor filed briefs challenging jurisdiction on both November 4, 2016 and on April 25, 2017.

Medicare Contractor's Position

The Medicare Contractor has challenged the Board's jurisdiction, alleging that the appeal is based on the Home Office Cost Statement which is not a final determination and is not appealable. The Medicare Contractor also asserts that a Home Office is not a Provider, and only a Provider or group of Providers is entitled to file an appeal to the Board. The Medicare Contractor claims that only when modifications flowing from the Home Office Cost Statement's adjustments are reflected on the Providers' Cost Reports are they appealable.

The Medicare Contractor refers to CMS Pub. 15-1, Chapter 10, Section 1000, stating

> The home office of a chain is not in itself certified by Medicare; therefore, its costs may not be directly reimbursed by Medicare...To the extent the home office furnished services related to patient care to a provider, the reasonable costs of such services are includable in the provider's cost report and are reimbursable as part of the provider's costs.[1]

The Medicare Contractor concludes that the Providers failed to properly or timely appeal the final determinations of the individual Providers noted in the Schedule of Providers.

Providers' Position

The Providers filed responses to the jurisdictional challenges. The Providers state they are appealing the impact of the Home Office Cost Statements on their individual reimbursements, and that the Providers and Provider numbers were named on the appeal request. The Providers also claim they are challenging the amount of reimbursement due the hospitals as a result of the determination rendered by the Medicare Contractor through the Home Office Finalization Letter issued on September 27, 2011.

The Providers contend that the Home Office Finalization Letter is used to determine the amount of reimbursement due to the Providers, and it meets the definition of an Intermediary determination under 42 C.F.R. § 405.1801. The Providers cite to *Central 99-00 Dixie Diamond Ranch HO Adj. #2 CIRP Group, et al. v. BlueCross BlueShield Assn'/Cahaba Govt. Benefit Admins.*, PRRB Decision 2007-D25 (Apr. 12, 2007), alleging that the Board exercised jurisdiction over a home office cost allocation in this case.

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2011), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if it is

[1] Medicare Contractor's Jurisdictional Challenge (April 24, 2017) at 1-3.

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

A "final determination" is a Medicare contractor determination of the amount of total reimbursement due the provider…following the close of the provider's cost reporting period…", whether the hospital is paid on a reasonable cost basis or under the prospective payment system.[2]

Board Rule 4.2 states

> Only a Provider or group of Providers is entitled to file an appeal to the Board. A home office is not a Provider and cannot file an appeal. (Allocations made to a Provider from the home office cost statement can be appealed by a Provider *only from an adjustment made to the Provider's claimed home office costs on the Provider's Medicare cost report.*)(emphasis added).

Additionally, Board Rule 7.3 states

> If you are appealing from a final determination other than a cost report adjustment, provide:
>
> - The date of the determination,
> - The controlling authority in dispute,
> - The authority granting the Board's jurisdiction over the dispute, and
> - an explanation regarding why the Intermediary or CMS determination was improper.

The Board finds in this appeal that the Providers appealed a Home Office Cost Statement which is not a final determination of the amount of total reimbursement due the provider, and there is no authority granting the Board jurisdiction over the Home Office Cost Statement. Therefore, the Board dismisses this appeal due to lack of jurisdiction. This case is now closed.

Board Members

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

FOR THE BOARD

L. Sue Andersen
Board Member

cc: Wilson Leong, Esq., FSS

[2] 42 C.F.R. §405.1801(a).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

AUG 0 2 2017

CERTIFIED MAIL

William J. Emrhein
Emrhein & Associates
7515 Pearl Road, Ste. 202
Middleburg Heights, OH 44130

Danene Hartley
National Government Services, Inc.
Appeals Lead
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206 – 6474

RE: Jurisdictional Decision
Case Number: 12-0284GC
Case Name: Aspirus 2010 Dividend Revenue Abatement CIRP Group
FYE: 06/30/2010

Dear Mr. Emrhein and Ms. Hartley:

Background

The Providers filed this CIRP group appeal with the Provider Reimbursement Review Board ("Board") on March 19, 2012. The Providers are appealing a Home Office Cost Statement dated September 27, 2011 which was issued for Home Office Number 90-1003 (Aspirus, Inc.). The group appeal request at Tab 1 states "No N.P.R. notices have been received for any of the providers listed below...", then proceeds to list the following Provider Numbers:

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4) Memorial Health Center, Provider Number 52-1324, and
5) Aspirus Wausau Hospital, Provider Number 52-0030.

The Provider's filed a Model Form G: Schedule of Providers on September 30, 2016. Column A which lists the date of the final determination under appeal states

> 9/27/11 Note 1 – The Home Office Cost Statement dated September 27, 2011 is the determination that was appealed. Attached is the determination as received by Aspirus, Inc. Home Office, which includes the cover letter, as-settled cost statement, and audit adjustment report.

The Medicare Contractor, National Government Services, Inc, has challenged the Board's jurisdiction to hear this case. The Medicare Contractor filed briefs challenging jurisdiction on both November 4, 2016 and on April 25, 2017.

Medicare Contractor's Position

The Medicare Contractor has challenged the Board's jurisdiction, alleging that the appeal is based on the Home Office Cost Statement which is not a final determination and is not appealable. The Medicare Contractor also asserts that a Home Office is not a Provider, and only a Provider or group of Providers is entitled to file an appeal to the Board. The Medicare Contractor claims that only when modifications flowing from the Home Office Cost Statement's adjustments are reflected on the Providers' Cost Reports are they appealable.

The Medicare Contractor refers to CMS Pub. 15-1, Chapter 10, Section 1000, stating

> The home office of a chain is not in itself certified by Medicare; therefore, its costs may not be directly reimbursed by Medicare...To the extent the home office furnished services related to patient care to a provider, the reasonable costs of such services are includable in the provider's cost report and are reimbursable as part of the provider's costs.[1]

The Medicare Contractor concludes that the Providers failed to properly or timely appeal the final determinations of the individual Providers noted in the Schedule of Providers.

Providers' Position

The Providers filed responses to the jurisdictional challenges. The Providers state they are appealing the impact of the Home Office Cost Statements on their individual reimbursements, and that the Providers and Provider numbers were named on the appeal request. The Providers also claim they are challenging the amount of reimbursement due the hospitals as a result of the determination rendered by the Medicare Contractor through the Home Office Finalization Letter issued on September 27, 2011.

The Providers contend that the Home Office Finalization Letter is used to determine the amount of reimbursement due to the Providers, and it meets the definition of an Intermediary determination under 42 C.F.R. § 405.1801. The Providers cite to *Central 99-00 Dixie Diamond Ranch HO Adj. #2 CIRP Group, et al. v. BlueCross BlueShield Assn'/Cahaba Govt. Benefit Admins.*, PRRB Decision 2007-D25 (Apr. 12, 2007), alleging that the Board exercised jurisdiction over a home office cost allocation in this case.

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2011), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if it is

[1] Medicare Contractor's Jurisdictional Challenge (April 24, 2017) at 1-3.

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

A "final determination" is a Medicare contractor determination of the amount of total reimbursement due the provider…following the close of the provider's cost reporting period…", whether the hospital is paid on a reasonable cost basis or under the prospective payment system.[2]

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> Only a Provider or group of Providers is entitled to file an appeal to the Board. A home office is not a Provider and cannot file an appeal. (Allocations made to a Provider from the home office cost statement can be appealed by a Provider *only from an adjustment made to the Provider's claimed home office costs on the Provider's Medicare cost report.*)(emphasis added).

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> - The date of the determination,
> - The controlling authority in dispute,
> - The authority granting the Board's jurisdiction over the dispute, and
> - an explanation regarding why the Intermediary or CMS determination was improper.

The Board finds in this appeal that the Providers appealed a Home Office Cost Statement which is not a final determination of the amount of total reimbursement due the provider, and there is no authority granting the Board jurisdiction over the Home Office Cost Statement. Therefore, the Board dismisses this appeal due to lack of jurisdiction. This case is now closed.

Board Members

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

FOR THE BOARD

L. Sue Andersen
Board Member

cc: Wilson Leong, Esq., FSS

[2] 42 C.F.R. §405.1801(a).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Baltimore, MD 21207
410-786-2671

AUG 02 2017

CERTIFIED MAIL

William J. Emrhein
Emrhein & Associates
7515 Pearl Road, Ste. 202
Middleburg Heights, OH 44130

Danene Hartley
National Government Services, Inc.
Appeals Lead
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206 – 6474

RE: Jurisdictional Decision
Case Number: 12-0282GC
Case Name: Aspirus Duplicate Expense CIRP Group
FYE: 06/30/2010

Dear Mr. Emrhein and Ms. Hartley:

Background

The Providers filed this CIRP group appeal with the Provider Reimbursement Review Board ("Board") on March 19, 2012. The Providers are appealing a Home Office Cost Statement dated September 27, 2011 which was issued for Home Office Number 90-1003 (Aspirus, Inc.). The group appeal request at Tab 1 states "No N.P.R. notices have been received for any of the providers listed below...", then proceeds to list the following Provider Numbers:

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4) Memorial Health Center, Provider Number 52-1324, and
5) Aspirus Wausau Hospital, Provider Number 52-0030.

The Provider's filed a Model Form G: Schedule of Providers on September 30, 2016. Column A which lists the date of the final determination under appeal states

> 9/27/11 Note 1 – The Home Office Cost Statement dated September 27, 2011 is the determination that was appealed. Attached is the determination as received by Aspirus, Inc. Home Office, which includes the cover letter, as-settled cost statement, and audit adjustment report.

The Medicare Contractor, National Government Services, Inc, has challenged the Board's jurisdiction to hear this case. The Medicare Contractor filed briefs challenging jurisdiction on both November 4, 2016 and on April 25, 2017.

Medicare Contractor's Position

The Medicare Contractor has challenged the Board's jurisdiction, alleging that the appeal is based on the Home Office Cost Statement which is not a final determination and is not appealable. The Medicare Contractor also asserts that a Home Office is not a Provider, and only a Provider or group of Providers is entitled to file an appeal to the Board. The Medicare Contractor claims that only when modifications flowing from the Home Office Cost Statement's adjustments are reflected on the Providers' Cost Reports are they appealable.

The Medicare Contractor refers to CMS Pub. 15-1, Chapter 10, Section 1000, stating

> The home office of a chain is not in itself certified by Medicare; therefore, its costs may not be directly reimbursed by Medicare...To the extent the home office furnished services related to patient care to a provider, the reasonable costs of such services are includable in the provider's cost report and are reimbursable as part of the provider's costs.[1]

The Medicare Contractor concludes that the Providers failed to properly or timely appeal the final determinations of the individual Providers noted in the Schedule of Providers.

Providers' Position

The Providers filed responses to the jurisdictional challenges. The Providers state they are appealing the impact of the Home Office Cost Statements on their individual reimbursements, and that the Providers and Provider numbers were named on the appeal request. The Providers also claim they are challenging the amount of reimbursement due the hospitals as a result of the determination rendered by the Medicare Contractor through the Home Office Finalization Letter issued on September 27, 2011.

The Providers contend that the Home Office Finalization Letter is used to determine the amount of reimbursement due to the Providers, and it meets the definition of an Intermediary determination under 42 C.F.R. § 405.1801. The Providers cite to *Central 99-00 Dixie Diamond Ranch HO Adj. #2 CIRP Group, et al. v. BlueCross BlueShield Assn'/Cahaba Govt. Benefit Admins.*, PRRB Decision 2007-D25 (Apr. 12, 2007), alleging that the Board exercised jurisdiction over a home office cost allocation in this case.

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2011), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if it is

[1] Medicare Contractor's Jurisdictional Challenge (April 24, 2017) at 1-3.

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

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Board Rule 4.2 states

> Only a Provider or group of Providers is entitled to file an appeal to the Board. A home office is not a Provider and cannot file an appeal. (Allocations made to a Provider from the home office cost statement can be appealed by a Provider *only from an adjustment made to the Provider's claimed home office costs on the Provider's Medicare cost report.*)(emphasis added).

Additionally, Board Rule 7.3 states

> If you are appealing from a final determination other than a cost report adjustment, provide:
>
> - The date of the determination,
> - The controlling authority in dispute,
> - The authority granting the Board's jurisdiction over the dispute, and
> - an explanation regarding why the Intermediary or CMS determination was improper.

The Board finds in this appeal that the Providers appealed a Home Office Cost Statement which is not a final determination of the amount of total reimbursement due the provider, and there is no authority granting the Board jurisdiction over the Home Office Cost Statement. Therefore, the Board dismisses this appeal due to lack of jurisdiction. This case is now closed.

Board Members

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

FOR THE BOARD

L. Sue Andersen
Board Member

cc: Wilson Leong, Esq., FSS

[2] 42 C.F.R. §405.1801(a).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

AUG 02 2017

Refer to: 14-3442

CERTIFIED MAIL

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

Cahaba GBA
c/o National Government Services, Inc..
Barb Hinkle
Appeals Lead
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

RE: Franklin Woods Community Hospital
Provider No.: 44-0184
FYE: 06/30/2011
PRRB Case No.: 14-3442

Dear Mr. Ravindran and Ms. Hinkle,

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

Background:

The Board received an individual appeal request from the Provider, Franklin Woods Community Hospital, on May 7, 2014; based on a Notice of Program Reimbursement (NPR) from the Medicare Contractor. The Provider appealed eight issues, which included the Disproportionate Share Hospital (DSH) Payment/ Supplemental Security Income (SSI) Percentage (Provider Specific) issue, SSI Systemic Errors issue, and DSH Payment – Medicaid Eligible Days issue. On November 19, 2014, the Board received the Provider's request to transfer the SSI Systemic Errors issue to 14-4296GC. Two issues remain in the appeal: DSH Payment/SSI Percentage (Provider Specific) and DSH Payment – Medicaid Eligible Days.

Board's Decision:

The Board finds that it does not have jurisdiction over the DSH SSI Provider Specific issue as it is duplicative and there is no final determination. 42 C.F.R. § 405.1835 (2012) states,

> A provider . . . has a right to a Board hearing . . . for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination only if . . . [t]he provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue. . .

In this case, the Provider does not appear to have requested a realignment of the SSI calculation and the Medicare Contractor has not made a final determination regarding the DSH SSI Provider Specific issue. Under 42 C.F.R. § 412.106(b)(3), a hospital can, if it prefers, use its cost reporting period data instead of the federal fiscal year data in determining the DSH Medicare fraction. The decision to use its own cost reporting period is the hospitals alone, which then must submit a written request to the Medicare Contractor. Without these requests it is not possible for the Medicare Contractor to have issued a final determination from which any of the Providers 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.

In addition, the majority of the DSH SSI Provider Specific issue is duplicative of the already transferred Systemic Errors issue. The Provider contends in the SSI Provider Specific issue statement that the "Medicare Contractor did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[1] The SSI Systemic Errors issue statement also argues that "the SSI percentages calculated by the Centers for Medicare and Medicaid Services and used by the Lead Medicare Contractor to settle their Cost Report was incorrectly computed."[2]

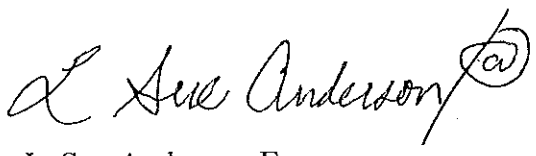
The SSI Systemic Errors issue has been transferred to a group appeal and no longer remains pending. Therefore because the DSH SSI (Provider Specific) issue is duplicative of the Systemic Errors issue and the Medicare Contractor has not made a final determination from which Franklin Woods Community Hospital could appeal, the Board finds that it lacks jurisdiction over the issue and dismisses the issue from case number 14-3442.

Case number 14-3442 will remain open because the Medicaid Eligible Days issue is still pending in this appeal.

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

Board Members:
L. Sue Andersen, Esq.
Gregory H. Ziegler
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Jack Ahern, M.B.A.

FOR THE BOARD



L. Sue Andersen, Esq.
Chairman

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

cc: Scott Berends, FSS

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[1] *See* Provider's Individual Appeal Request at Tab 3, Issue 1 and Issue 2.
[2] *Id.* at Issue 2.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

CERTIFIED MAIL

AUG 07 2017

Stephen P. Nash
Squire Patton Boggs (US) LLP
1801 California Street
Suite 4900
Denver, CO 80202

RE: Patton Boggs 2011 Medicare Outliers- NPR Optional Group
Provider Nos.: Various
FYEs: Various 2011
PRRB Case No.: 14-1429G

Dear Mr. Nash:

The Provider Reimbursement Review Board (Board or PRRB) has reviewed the Providers' comments (received June 30, 2017) regarding the Board's proposed own motion expedited judicial review (EJR). The Board's decision with respect to the proposed EJR is set forth below.

Background

By ORDER dated April 6, 2017, the Centers for Medicare and Medicaid Services (CMS) Administrator vacated the Board's May 13, 2015 decision in this case, case number 14-1429G, and remanded the case to the Board for further proceedings consistent with the United States District Court for the District of Columbia's August 19, 2016 Memorandum Opinion in *Banner Heart Hospital v. Burwell* (*Banner*).[1]

On May 13, 2015, the Board issued a decision concluding that it lacked jurisdiction over the Providers in the group appeal because the Providers failed to protest the outlier reimbursement issue on their cost reports pursuant to 42 C.F.R § 405.1835(a)(1)(ii) (2013).[2] The issue under appeal in the case was stated as "[w]hether [the] Centers for Medicare and Medicaid Services ("CMS") reimbursed the providers in this Group Appeal . . . for the full amount of the supplemental Medicare outlier payments . . . to which the Providers are entitled under the Social Security Act, §§ 1886(d)(5)(A)(i)-(iv) and (d)(3)(B)."[3]

The Providers contended that:

> the Medicare outlier regulations—specifically, the regulations found at 42 CFR §§ 412.80 through 412.86 and the series of annual

[1] 201 F. Supp. 3d 131 (D.D.C. 2016).
[2] Board's May 13, 2015 jurisdictional decision in case number 14-1429G at 4.
[3] *See also*, 42 U.S.C. §§ 1395ww(d)(5)(A)(i)-(iv) and (d)(3)(B) (the Outlier Statute). Providers' December 18, 2013 Hearing Request at Tab 2.

> inpatient prospective payment system ("IPPS") regulations resulting in establishing the Outlier fixed loss thresholds ("FLTs") for their FYE 2011—are contrary to the Social Security Act and the intent of the Congress, are arbitrary and capricious, and are otherwise contrary to law. As a result, the FLTs established and used to calculate the Outlier Case Payments to which the Providers are entitled for FYE 2011 were invalid and must be recalibrated and reset, for the benefit of the Providers, so that the Providers may file amended and additional claims for Outlier Case Payments.[4]

The court in *Banner* held that:

> [U]nder *Bethesda*[5]—and at *Chevron*[6] Step One—the Secretary's self-disallowance regulation [42 C.F.R. § 405.1835(a)(1)(ii) (2013)], as applied to Plaintiffs' specific regulatory challenge, conflicts with the plain text of [42 U.S.C.] section 1395oo. The Board therefore erred in ruling that it lacked jurisdiction to hear Plaintiffs' challenge to the outlier regulations. *Seeid.* at 408, 108 S. Ct. 1255 [*Bethesda Hospital Association v. Bowen 485 U.S. 399,* 408 (1988)] (concluding that the "Board had jurisdiction to entertain this action").[7]

On June 9, 2017, the Board reopened case number 14-1429G pursuant to the Administrator's Order and issued a Board Order concluding that that "the FLT issue, which is published in the Federal Register,[8] is the type of issue to which the decision in *Bethesda* applies and that it has jurisdiction over the Providers in the appeal."[9] The Board included a notice to the Providers that it is considering issuing a determination regarding EJR. The Board requested that the Providers submit their comments with respect to this proposed action within thirty days. On June 30, 2017, the Providers submitted their comments on the Board's proposed own motion EJR.

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[4] Providers' December 18, 2013 Hearing Request at Tab 2.
[5] *Bethesda Hospital Association v. Bowen*, 485 U.S. 399 (1988).
[6] *Chevron U.S.A. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837 (1984).
[7] 201 F. Supp. at 142.
[8] *See e.g.* 73 Fed. Reg. 48,434, 48,763-66 (Aug. 19, 2008)
[9] The Board recognized that the Court discussed but declined to rule on another potential rationale for denying jurisdiction, namely that the Board's jurisdiction is not mandatory but rather discretionary. However, the Board found that this potential alternative rationale is not applicable to this case. Specifically, the Board found that its jurisdiction over the Provider(s) is mandatory under 42 U.S.C. § 1395oo(a) because: (1) 42 C.F.R. § 405.1835(a)(1)(ii) does not apply to the Provider(s) based on Court-order application of the *Banner* decision; and (2) prior to the adoption of 42 C.F.R. § 405.1835(a)(1)(ii) in 2008, the Board consistently found jurisdiction to be mandatory under 42 U.S.C. § 1395oo(a) pursuant to *Bethesda* whenever a provider specifically appeals the validity of a regulation or rule that a Medicare Contractor is otherwise bound to follow and apply regardless of whether the provider protested (or otherwise claimed on its cost report) the cost associated with the challenged regulation/rule.

Providers' Position

The Providers contend that they have not been paid the full amount of supplemental Medicare outlier payments to which they are entitled under the outlier statute.[10] The Providers' request that the Board grant EJR with respect to the following legal question:

> Whether the specific regulations governing Outlier Case Payments as set forth in the two regulatory sources—the Outlier Payment Regulations[11] and the fixed loss threshold ("FLT") Regulations[12] (collectively, the "Medicare Outlier Regulations")—as promulgated by the Secretary of Health and Human Services ("HHS" or the "Secretary") and the Centers for Medicare and Medicaid Services ("CMS"), and as in effect for the appealed years, are contrary to the Outlier Statute and/or are otherwise substantively or procedurally invalid?[13]

The Providers assert despite the anticipated virtues of the inpatient prospective payment system (IPPS), Congress recognized that healthcare providers would inevitably care for some patients whose hospitalizations would be extraordinarily costly or lengthy. To insulate hospitals from bearing a disproportionate share of these atypical costs, Congress authorized HHS to make supplemental outlier case payments. During the year at issue, the outlier payment provisions were set forth in four clauses of the Medicare statute.[14]

The Providers maintain, traditionally, the Secretary has read paragraph (5)(A)(iv) of the statute to mean that prior to the start of each fiscal year, the Secretary must establish a FLT beyond which hospitals will qualify for outlier case payments, at levels resulting in outlier case payments totaling between 5-6% of projected diagnosis related group (DRG) payments for that year. Outlier case payments are, in effect, funded by all of the acute care hospitals participating in Medicare IPPS. Specifically, to fund outlier case payments, each hospital's ordinary IPPS payments are reduced by the percentage amount of total outlier case payments that the Secretary is targeting (5.1% for the year at issue).[15]

The Providers assert that from 1997 until 2003, a relatively small number of hospitals greatly inflated their hospital inpatient charges, a practice which the United States Department of Justice

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[10] 18 S.S.A. §§ 1886(d)(5)(A)(i)-(iv) and (d)(3)(B); 42 U.S.C. §§ 1395ww(d)(5)(A)(i)-(iv) and (d)(3)(b) (the Outlier Statute).
[11] The Outlier Payment Regulations are the base regulations that establish the method for calculating a hospital's imputed costs for a patient case, which are set forth at 42 C.F.R. §§ 412.80 through 412.86.
[12] The FLT Regulations are set forth in the Secretary's annual promulgation of "Medicare Program; Hospital Inpatient Prospective Payment Systems and Fiscal year Rates," which, among other things, establishes the outlier fixed loss thresholds for the coming fiscal year.
[13] Providers' Comments on Board's Proposed Own Motion EJR at 1-2.
[14] 42 U.S.C. § 1395ww(d)(5)(A)(i)-(iv).
[15] 42 U.S.C. § 1395ww(d)(3)(B).

(DOJ) calls "turbo-charging."[16] This systematic practice of "turbo-charging", coupled with the Secretary's decision to use cost-to-charge ratios (CCRs) that were typically 3 to 5 years old and thus, artificially high, resulted in the calculation of greatly inflated imputed costs per case (CPC). These inflated CPC were then used as the predicate for greatly inflated claims (inflated both in number and amounts) for outlier case payments.[17, 18]

The Providers contend, in its later investigations of hospitals it believed had engaged in charge inflation, the DOJ alleged that the practice of "turbo-charging" led directly to inflated claims for payments under the Medicare outlier program, which the DOJ characterized as "false claims." The Providers argue these and other inflated claims led HHS to increase the FLTs at a precipitous rate in an attempt to ensure that the total amount of outlier payments made for discharges in the fiscal year at issue would remain at 5.1 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year.[19]

The Providers maintain beginning in or around federal fiscal year (FFY) 1998, HHS began making substantial upward adjustments to the FLTs. These adjustments were at a rate far in excess of the rate of growth of inflationary indices routinely used by HHS, such as the CPI-Medical Index or the Medicare Market Basket. For instance, from 1997 through 2003, HHS increased the FLTs by more than 246%, when by its own admission there was modest cost inflation (of between 22% and 26%) for the same period. The Providers assert although the Secretary purported to calibrate the FLT adjustments to historical inflation data, the actual increase in FLTs bore no discernible relationship to cost inflation; in fact they were more than 10 times higher.

The Providers contend in late 2002, HHS disclosed that it was aware of "turbo charging" and that it would be amending the outlier payment regulations to fix the vulnerabilities in the same.[20] The Providers assert in its previous rulemakings promulgating and amending the outlier payment regulations, HHS had variously represented that there were no critical flaws in its outlier payment regulations, that it had always used the best available data, and that it would not make retroactive corrections to outlier payments. Then in March 2003, in the process of amending the outlier payment regulations, CMS did an about face on all three of these points, admitting that there were three critical flaws in its outlier payment regulations, that other data, which had always been available and was better, should be used and that the outliers case payments would now be subject to reconciliation.[21, 22]

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[16] *See, e.g., Amicus Curiae Mem.* of U.S.A in Resp. to Tenet Healthcare Corp's Mot. to Dismiss, *Boca Raton Cmty. Hosp.*, ECF No. [49], at 4 (S.D. Fla. May 17, 2005).
[17] *Id.* at 4-5.
[18] Providers' Comments on Board's Proposed Own Motion EJR at 3-4.
[19] *Medicare Outlier Payments to Hospitals: Hearing Before a Subcomm. of the S. Comm. on Appropriations*, 108th Cong. 3-17 (2003) (statement by Thomas A. Scully Administrator, Centers for Medicare and Medicaid Services, Department of Health and Human Services).
[20] *See* CMS *Program Memorandum*, Transmittal A-02-122 (Dec. 3, 2002); CMS *Program Memorandum*, Transmittal A-02-126 (Dec. 20, 2002); CMS *Program Memorandum Intermediaries*, Transmittal A-03-058, July 3, 2003; and CMS Manual System, Pub. 100-04 Medicare Claims Processing, Transmittal 707, October 12, 2005, Change Request 3966.
[21] *See* e.g. 68 Fed. Reg. 34,494, 34,496 and 34,501.
[22] Providers' Comments on Board's Proposed Own Motion EJR at 4-5.

The Providers argue while the agency was in the process of reversing its position on each of these points, HHS had the opportunity (if not the statutory and/or fiduciary obligation) to reset its FLT to correct for what it openly acknowledged had been the improper redistribution of the Medicare funds allocated for outlier case payments—literally billions of dollars of improper payments made to a few (i.e., the "turbo charging" hospitals), at the expense of the many. Instead, after reviewing hundreds of public comments, most urging HHS to lower the FLT, the agency announced that it would leave the threshold where it was, $33,560.

The Providers assert HHS did not disclose that the agency had known six months earlier how to fix the problems engendered by its earlier flawed regulations and believed it was obligated to do so immediately. The Providers contend HHS also did not disclose in that rulemaking that then-HHS Secretary Thompson and then-Administrator Scully had cleared and signed an interim final regulation (the IFR) and submitted the IFR to the Office of Management and Budget (OMB) for presumptive approval on February 12, 2003.[23] The Providers maintain the IFR contained facts and analysis on the basis of which HHS concluded it was required, mid-year, to lower its fiscal year (FY) 2003 FLT from $33,560 to $20,760 (*i.e.*, that the 2003 FLT was approximately 62% higher than it should have been) in order to comply with the outlier statute's mandates and the intent of Congress.[24] The Providers contend in stark contrast, HHS' subsequent rulemakings, beginning with the proposed regulation published on February 28, 2003 (March 5, 2003, in the Federal Register),[25] omitted key data, facts, analysis and conclusions. The Providers argue HHS failed to mention, amongst other key information, the agency's considered analysis quantifying the impact of the "turbo-charging" hospitals on its FLT adjustments, the need and method to remove the "turbo-charged" data and what HHS believed to be its statutory obligation to lower the FLT.

The Providers argue instead HHS announced that it would leave the threshold at $33,560. The Providers contend contrasting the data, other facts, analysis and conclusions set forth in the IFR with HHS' subsequent published rulemakings, it is clear that HHS knowingly used corrupted (turbo-charged) data, and knowingly disregarded its own concurrent provider-favorable conclusions and alternatives in setting the FLTs for fiscal year end (FYEs) 2003-2010. The Providers maintain they did not learn of the IFR until 2012 – and then only through a Freedom of information Act (FOIA) request that through their counsel, submitted to OMB's Office of Information and Regulatory Affairs (OIRA) for various documents related to the Medicare outlier program. The Providers contend as for FYs 2007-2015, the IFR continued to be relevant because HHS' methodology for establishing each FY's threshold regulation is necessarily a function of, and applied, the payment regulation. The Providers argue HHS repeatedly set the FLT at levels which paid out significantly less than the agency's stated target of 5.1% of total IPPS payments. As a result, the Providers did not receive the full amount of the outlier case payments to which they are entitled under the Outlier Statute.[26]

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[23] *Id.* at 6.
[24] *Id.* at 7.
[25] *See* 68 Fed. Reg. 10,420 (March 5, 2003).
[26] Providers' Comments on Board's Proposed Own Motion EJR at 8-9.

The Providers allege on June 28, 2012, HHS Office of Inspector General (OIG) issued a report with results from its review of CMS' outlier reconciliation process for October 1, 2003, through December 31, 2008, (the 2012 OIG Report). The 2012 OIG Report reveals the inaccuracy of (and the key information omitted from) HHS' stated reason for not considering the impact of reconciliation, in establishing the FLTs for FYEs 2004-2013. The Providers maintain the most compelling is the OIG's finding (conceded by CMS) that seven years after 2003, the year in which CMS published its regulation requiring reconciliation, CMS had not reconciled any of the cost reports screened and reported up by its contractors. The Providers contend in a later 2013 OIG Report, OIG noted that although nearly all hospitals received some outlier payments, a small percentage of hospitals received a significantly higher proportion (almost six times higher) of outlier payments than others. These high-outlier hospitals charged Medicare substantially more for the same Medical Severity Diagnostic Related Groups (MS-DRGs), even though their patients had similar (or shorter) lengths of stay as the average of all other hospitals. The Providers argue HHS' admitted failure to follow its own regulations, i.e. its failure to conduct reconciliations, necessarily contributed to HHS' failure to detect these high-outlier hospitals and their inflated (turbo-charged) outlier claims.[27]

The Providers maintain that the FLTs applicable to the claims for which EJR is sought, and as established using the payment regulation and the FLT regulations, are invalid for a number of reasons including but not limited to:

1.) The FLTs established using the payment regulation and the FLT regulations are substantively invalid because, both as written and as implemented, they represent agency action that violated the APA in that it was arbitrary and capricious, exceeded statutory authority and frustrated the intent of Congress as reflected in the outlier statute.[28]

2.) The FLTs themselves, as calculated pursuant to HHS' published criteria, have been (and continue to be) invalid because CMS ignored "new and better data" without articulating a satisfactory explanation, used formulas or criteria that CMS knew to be flawed, and/or were not supported by substantial evidence (or were contrary to the same).[29]

3.) The Medicare Outlier Regulations are both substantively and procedurally invalid because, as written and as implemented, their actual effect has been to frustrate the intent of Congress, and to deprive the Providers of the protection that Congress intended the outlier statute to provide. The agency action described above has consistently violated the outlier statute, and in the absence of adequate explanation, has also violated the Administrative Procedure Act ("APA") as an arbitrary and capricious, and therefore invalid rule-making, and should be set aside.

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[27] *Id.* at 10-11.
[28] *Id.* at 13.
[29] *Id.* at 15.

4.) The Medicare Outlier Regulations are procedurally invalid because, when HHS amended the outlier payment regulations in 2003, it failed to disclose the alternatives set forth in the IFR, alternatives that it had not only considered, but had signed, cleared for distribution outside the agency, and sent to OMB for presumptive approval in the form of an emergency Interim Final Rule. HHS failed to provide any explanation for why it abandoned these alternatives. Indeed, it did not even mention the alternative of removing "turbo-charging" data from its future analysis of setting FLTs.[30]

5.) The 2003 outlier payment regulation, which decided to leave the FLT at its turbocharged peak is also substantively invalid. HHS continued to pay turbo-chargers claims throughout most of FY 2003 and also to use projections of turbo-chargers' unauthorized payments to rationalize leaving the threshold at the turbo-charged $33,560 peak. This constitutes a failure to "stay[] within the bounds of its statutory authority." *City of Arlington v. FCC*, 133 S. Ct. 1863, 1868 (2013). This decision was also arbitrary and capricious because HHS considered factors (payments made for cases that were not extraordinarily costly) that Congress never intended it to consider.[31]

Decision of the Board

The Board has reviewed the Providers' request for hearing and comments regarding EJR. The regulation, 42 C.F.R. § 405.1842(c) (2013), permits the Board to consider whether it lacks the authority to decide a legal question relevant to the matter at issue once it has made a finding that it has jurisdiction to conduct a hearing under the provisions of 42 C.F.R. § 405.1840(a) (2013). The Medicare statute at 42 U.S.C. § 1395oo(f)(1) (2013) and the regulation at 42 C.F.R. § 405.1842(f)(1) (2013) require the Board to grant EJR 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.

With respect to jurisdiction, the Board concluded on June 9, 2017, pursuant to the Administrator's April 6, 2017 Order, that "the FLT issue, which is published in the Federal Register, is the type of issue to which the decision in *Bethesda* applies and that it *has* jurisdiction over the Providers in this appeal. The Board is bound by the regulations and lacks the authority to decide the legal question of whether the Medicare Outlier Regulations and the FLTs established thereunder are contrary to the Outlier Statute and/or are otherwise substantively or procedurally invalid. Therefore, EJR is appropriate for the issue under dispute in this case.

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[30] *Id.* at 19-20.
[31] *Id.* at 21.

The Board finds that:

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

2) based upon the Providers' assertions regarding the outlier regulations, 42 C.F.R. §§ 412.80-412.86, there are no findings of fact for resolution by the Board;

3) it is bound by the regulations; and

4) it is without the authority to decide the legal question of whether the outlier regulations are valid.

Accordingly, the Board finds that the outlier issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) (2013) and hereby grants expedited judicial review on its own motion for the issue and the subject year for the Providers on the updated Schedule of Providers.[32] 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 in case number 14-1429G, the Board hereby closes the case.

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

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

For the Board

L. Sue Andersen
Chairperson

Enclosures: 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877;
Updated Schedule of Providers for case no. 14-1429G

cc: James R. Ward, Noridian Healthcare Solutions, LLC
Wilson Leong, Federal Specialized Services

[32] In the Providers' Comments on the Board's Proposed Own Motion EJR, the Providers state that since the Board's initial jurisdictional decision in May 2015, intervening events necessitated the Provider, Billings Clinic (Provider No. 27-0004, FYE 6/30/2011) to withdraw from this group appeal. The Providers provided an updated Schedule of Provider which lists three Providers in the group appeal (the group appeal previously had four Providers). Providers' Comments on Board's Proposed Own Motion EJR at 22.

15-0327

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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AUG 08 2017

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RE: Jurisdictional Decision
Provider Name: Eden Medical Center
PRRB Case Number: 14-0670
FYE: 12/31/2008

Dear Mr. Jaeger and Ms. Alcantara:

The Provider filed this individual appeal with the Provider Reimbursement Review Board ("Board") on November 12, 2013. The Provider is appealing an original Notice of Program Reimbursement ("NPR") dated May 20, 2013, which was issued for the cost reporting period ending December 31, 2008. The Provider stated eight issues in the request for appeal. The Medicare Contractor, Noridian Healthcare Solutions, has challenged the Board's jurisdiction over Issue Nos. 1, 5, and 6 in the appeal. The Provider references the same three adjustments for all three challenged issues: adjustment nos. 20, 22, and 34.

Background

Issue No. 1

Issue No. 1 is entitled "DSH SSI Percentage Understated – Realignment."[1] DSH refers to the Disproportionate Share Hospital payment adjustment, and the SSI Ratio is the Supplemental Security Income proxy of the DSH payment calculation. The Provider contends its DSH payment adjustment was not calculated properly, and that its DSH payment was reduced as the result of an understated Medicaid ratio.[2] The Provider also states it is permitted to use its cost reporting period instead of the Federal fiscal year, and that this part of the Medicare DSH SSI issue may be easily resolvable with the Medicare contractor's agreement to realign the SSI percentage from the federal fiscal year, to using the Provider's fiscal period.[3]

[1] Provider's Request for Appeal (Nov. 8, 2013), Tab 3, "Medicare Appeal Analysis Summary" at 1.
[2] *Id* at 2-4.
[3] Provider's Final Position Paper (May 22, 2017) at 18.

Issue No. 2

Issue No. 2 is entitled "DSH SSI Percentage Understated – Inaccurate Data".[4] The Provider contends that the SSI percentage as generated by the Social Security Administration (SSA) and put forth by CMS is understated. The Provider states that CMS did not use the best available data at the time of settlement to calculate the DSH SSI fraction. The Provider requested that this issue be transferred to Case No. 15-0327GC via letter dated April 14, 2015.

Issue No. 5

Issue No. 5 is entitled "DSH SSI MMA Section 951 Applicable to SSI Ratio."[5] The Provider asserts that Section 951 of the Medicare Modernization Act requires the Secretary to furnish the data necessary to compute the number of patient days used in computing the hospital's DSH percentage, and that CMS has failed to comply with this law.[6] The Provider requests that its DSH SSI data be recalculated to exclude dual eligible Part A and Part C days, and that CMS furnish the data. The Provider requested that Issue No. 5 be transferred to Case No. 14-0417GC via letter dated April 14, 2015.

Issue No. 6

Issue No. 6 is entitled "Medicare DSH Understated Eligible Days, Admin Days, HMO Days."[7] The Provider contends the purpose of the issue is to "estimate the impact for the inclusion of the Code 1 Days."[8] The Provider alleges that the Medicare Contractor did not include all Medicaid eligible days in its Medicare DSH calculation, specifically Title XIX days, general assistance or other state-only health programs, Medi-Cal managed care programs, indigent, charity care, Medi-Cal SDH, and/or waiver or demonstration population days.[9]

Medicare Contractor's Position

The Medicare Contractor is challenging the Board's jurisdiction over Issue Nos. 1, 5 and 6. The Medicare Contractor contends that Issue No. 1, DSH SSI Percentage Understated – Realignment, should be dismissed from the appeal as it is a provider election and not a final determination of the Medicare Contractor. The Medicare Contractor explains that the decision to change the DSH Medicare computation fiscal year end from federal fiscal year end to the hospital's fiscal year is the provider's decision, and a provider must submit a written request to both the Medicare contractor and the Centers for Medicare & Medicaid to request this change. The Medicare Contractor refers to 42 C.F.R. § 412.106(b)(3). The

[4] Provider's Request for Appeal (Nov. 8, 2013), Tab 3, "Medicare Appeal Analysis Summary" at 1.
[5] Provider's Request for Appeal (Nov. 8, 2013), Tab 3, "Medicare Appeal Analysis Summary" at 1.
[6] Provider's Final Position Paper (May 22, 2007) at 25.
[7] Provider's Request for Appeal (Nov. 8, 2013), Tab 3, "Medicare Appeal Analysis Summary" at 1.
[8] Provider's Request for Appeal (Nov. 8, 2013), Tab 3, "Medicare Appeal Analysis Summary" at 8.
[9] Provider's Final Position Paper (May 22, 2007) at 26-27.

Medicare Contractor also states that in lieu of requesting a PRRB appeal to realign its SSI percentage, the Provider can request a reopening of its cost report pursuant to 42 C.F.R. § 405.188.

The Medicare Contractor contends the Board does not have jurisdiction over Issue No. 5, the DSH SSI MMA Section 951 Applicable to SSI Ratio issue, because the Medicare Contractor did not make a final determination with regards to this issue. The Medicare Contractor's position is that it cannot make a determination with regards to whether or not CMS failed to comply with Section 951 of the MMA by failing to release the supporting data to hospitals upon request.

Regarding Issue No. 6, the Medicare Contractor states the Board does not have jurisdiction over this issue as the Medicare Contractor did not make an adjustment to the number of Medicaid patient days claimed by the Provider, and the as-filed numbers on the cost report were accepted. Additionally, the Medicare Contractor states the Provider is not able to demonstrate that it meets the dissatisfaction requirement as it did not include a claim for the specific additional DSH Medicaid-eligible days now in question, nor did it include the reimbursement impact of these days as a protested amount on its filed cost report.

Provider's Position

The Provider filed an opposition to the Medicare Contractor's jurisdictional challenge dated April 15, 2015. The Provider cites to *Bethesda Hospital Association v. Bowen*[10] and the Board's *Norwalk*[11] decision, and states "the Board has jurisdiction over the eligible days issue because at the time of its cost report submission, final Medicaid *eligible data was not available to the Provider through no fault of its own*."[12] The Provider explains that "the State of California does not allow providers to access the final re-verification eligibility process until 14 months after the fiscal year end,"[13] and as a result "the Provider has established futility and has established that there is a practical impediment to obtaining California's verified final DSH Medi-Cal eligible days…".[14]

Board Decision

APPLICABLE STATUTES, REGULATIONS AND BOARD RULES

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2013), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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[10] *Bethesda,* 485 U.S. 399 (1988).
[11] *Norwalk Hosp. v. Blue Cross & Blue Shield Ass'n,* PRRB Hearing Dec. No. 2012-D14, (Mar. 19, 2012), *vacated,* CMS Adm'r Dec. (May 21, 2012).
[12] Provider's Opposition to Jurisdictional Challenge (Apr. 15, 2017) at 5.
[13] *Id.*
[14] Id. at 16-17.

A provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific items at issue, by either –

> (i) Including a claim for the specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or
>
> (ii) Effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item(s) by following the applicable procedures for filing a cost report under protest, where the provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy…[15]

The applicable procedures for filing a cost report under protest in CMS Publication 15-2, Section 115.1 state:

> When you file a cost report under protest, the disputed item and amount for each issue must be specifically identified in footnotes to the settlement worksheet and the fact that the cost report is filed under protest must be disclosed.

A Provider may not appeal an issue from a final determination in more than one appeal pursuant to PRRB Rule 4.5.

ANALYSIS AND JURISDICTIONAL DETERMINATION

Issue No. 1

In Issue No. 1, the Provider states it is appealing the SSI percentage of the DSH payment calculation as understated, and also that the Provider may request to use its cost reporting period instead of the Federal fiscal year in the computation of its DSH payment. After review of the referenced adjustment nos. 20, 22 and 34, the Board finds that it has jurisdiction over the understatement of the SSI percentage aspect of Issue No. 1 as the DSH SSI percentage was adjusted. However, the Board also finds that this portion of Issue No. 1 is duplicative of Issue No. 2, as the basis of both Issues is that the DSH SSI percentage is understated and must be supplied by CMS. Therefore, Issue No. 1 is dismissed from the appeal as the Provider is prohibited from appealing the same issue from the same cost report in more than one appeal pursuant to Board Rule 4.5. The SSI percentage of the DSH payment calculation (understated) issue now resides in PRRB Case No. 15-0327GC.

With regards to the request that "DSH SSI data be realigned to its fiscal period…"[16] in Issue No. 1, there is no evidence in the record that the Medicare Contractor has made a final determination regarding the use

[15] 42 C.F.R. 405.1835(a)(1)(2013).
[16] Provider's Final Position Paper (May 22, 2017) at 19.

of the Provider's cost reporting period instead of the Federal fiscal year, and therefore this sub-issue does not meet the Board's jurisdictional requirements and is hereby dismissed from this appeal.

Issue No. 5

Section 951 of the Medicare Modernization Act ("MMA") provides:

> Beginning not later than 1 year after the date of the enactment of this Act, the Secretary shall arrange to furnish to subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act, 42 U.S.C. 1395ww(d)(1)(B)) the data necessary for such hospitals to compute the number of patient days used in computing the disproportionate patient percentage under such section for that hospital for the current cost reporting year. Such data shall also be furnished to other hospitals which would qualify for additional payments under Part A of title XVII of the Social Security Act on the basis of such data.

CMS has provided instruction to DSH hospitals on how they can request the data used to calculate their DSH SSI ratios for fiscal year ends 2006 through 2009.[17] Here the Provider argues that CMS has failed to comply with Section 951 of the MMA because it has not furnished all of the data necessary, including "supporting" data.[18]

The Board dismisses Issue No. 5, the "DSH SSI MMA Section 951 Applicable to SSI Ratio" issue because it is duplicative of Issue No. 2, the "DSH SSI Percentage Understated – Inaccurate Data" issue, which is violation of PRRB Rule 4.5. This rule Provides, "A Provider may not appeal an issue from a final determination in more than one appeal."

Issue Nos. 2 and 5 both challenge the DSH SSI ratio utilized to calculate the Provider's DSH payment adjustment, alleging the Provider cannot get the data used to calculate the DSH SSI ratio. Both Issues also claim an identical reimbursement impact of $210,023. Additionally, the Board cannot grant the Provider the relief it seeks with Issue No. 5 – CMS' compliance with Section 951 of the MMA. The Board's jurisdiction does not include matters that are injunctive in nature, as injunctive relief is based in equity, and the Board does not have general equitable authority.[19] The scope of the Board's legal authority is as follows:

> In exercising its authority to conduct proceedings under this subpart, the Board must comply with all the provisions of Title XVIII of the Act and regulations issued thereunder, as well as CMS Rulings issued under the authority of the Administrator as described in §401.108 of this subchapter. The Board shall afford great weight to interpretive rules,

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[17] Department of Health and Human Services, CMS, MLN Matters Number: SE1225 at 1, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1225.pdf.
[18] Provider's Final Position Paper (May 22, 2017) at 25.
[19] *Hospital Corporation of America*, PRRB Dec. No. 2005-D16, *rev'd*, 2005 WL 3447734 (CMS Mar. 3, 2005) (final admin. review).

> general statements of policy, and rules of agency organization, procedure, or practice established by CMS.[20]

The Board denies the Provider's request to transfer Issue No. 5 to PRRB Case No. 14-0417GC, and Issue No. 5 is dismissed from this appeal. The Provider has already appealed the DSH SSI ratio, including the underlying data used to calculate the ratio, in Issue No. 2 which now resides in PRRB Case No. 15-0327GC.

Issue No. 6

The Provider is appealing from a December 31, 2008 cost report, which means that it either had to claim the cost at issue or it must have protested the item on its cost report in order for the Board to have jurisdiction. The Board finds that it does not have jurisdiction over Issue Nos. 6 which seeks additional Medicaid eligible Days in this appeal. The Provider did not protest the Medicaid eligible days it seeks in Issue Nos. 6 on its cost report notwithstanding the fact that it knew California would have additional days at a later point in time. Nor did the Provider included a claim for those specific days on its cost report, as required by 42 C.F.R. § 405.1835(a). Because the Board does not have jurisdiction over Issue Nos. 6, this issue is dismissed.

This appeal will remain open as there are other unresolved issues. 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

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

FOR THE BOARD

Clayton J. Nix, Esq.
Board Member

cc: Wilson Leong, Esq., FSS

[20] 42 C.F.R. § 405.1867.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Case No. 13-1675GC

AUG 1 0 2017

Certified Mail

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Re: Good Shepherd Health System 2006 DSH SSI Fraction Dual Eligible CIRP Group

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") has reviewed your case in light of your June 30, 2017 letter requesting a hearing on the record. The Board finds that the group has improperly changed the issue of this case, and that the improperly-changed issue is duplicative of the issue currently appealed in Case No. 13-1678GC. Therefore, the Board hereby dismisses Case No. 13-1675GC.

BACKGROUND

The group filed a timely appeal on April 9, 2013 for FYE 09/30/2006.[1] Both providers, Marshall Regional Medical Center (45-0032) and Good Shepherd Medical Center (45-0037) appealed from revised NPRs. They appealed Adjustment No. 4, "To update cost report using revised SSI ratios and DSH percentage."[2] The group identified its issue as "Whether the Intermediary's adjustment to adjust the Provider's disproportionate share hospital (DSH) payments to include CMS' published Medicare/Social Security Income (SSI) days is appropriate and in accordance with Medicare regulations as set forth in 42 CFR § 412.106?"[3] In its appeal, the group states:

> The Providers have a good faith belief that CMS understated the Providers' number of patient days furnished to patients that were entitled to both Medicare Part A benefits and SSI benefits when calculating the Providers' Medicare fraction (and resulting DSH patient percentage and DHS payment adjustment) for the cost report period at issue.
>
> The Providers also believe that Medicare/Medicaid dual eligible patient days when benefits are exhausted and Medicare Advantage patient days covered under Medicare Part C should appropriately be excluded from the Medicare (SSI) proxy and instead be included in the Medicaid proxy (assuming documentation proving Medicaid eligibility). The current

[1] Group Appeal Request, Apr. 9, 2013.
[2] Marshall Regional and Good Shepherd Audit Adjustment Reports *located in* Schedule of Providers Tabs 1D and 2D, Sep. 23, 2016.
[3] Description of Issues at 1, *attached to* Group Appeal Request, Tab 2 ("Description of Issues").

> treatment for these days is to include these days in the Medicare (SSI) proxy and exclude them from the Medicaid fraction.[4]

The group then breaks down its issue into (1) SSI days; (2) Medicare/Medicaid Dual Eligible Days ("DE days"); and, (3) Medicare Advantage Days.[5] The Board broke up the appeal into 5 separate group appeals; however, the issues of particular importance here are SSI and DE days:

(1) Good Shepherd Health System 2006 DSH SSI Fraction DE CIRP Group (Case No. 13-1675GC)
(2) Good Shepherd Health System 2006 DSH SSI Fraction Baystate Errors CIRP Group (Case No. 13-1678GC)

Dual Eligible Days (13-1675GC)

In its original appeal, the group described its DE days issue (in its entirety) as follows:

> The provider community contends that Medicare/Medicaid dual eligible patient days should be included in the Medicaid fraction when Part A benefits are exhausted because these days are attributable to patients who were "eligible" for Medicaid benefits although not "entitled" to inpatient Medicare Part A hospital benefits. The current treatment for these days is to include these days in the Medicare (SSI) proxy and exclude them from the Medicaid fraction.
>
> The basis for the providers' position is rooted in how the courts have previously differentiated the terms "entitlement" versus "eligibility." Despite positions held by CMS, the courts deliberated that Congress' distinct usage of these different terms in the same sentence implied Congress' Intention of the two different meanings. Moreover, before acquiescing on the Medicaid "eligibility" issues in the late 1990s, CMS openly defined "entitlement" as meaning actual payment, and accordingly, directed contractors to audit claimed DSH days be requiring verification of Title XIX paid logs. The courts accepted CMS' definition of "entitlement" as meaning payment, but more meaningfully, deliberated that the plain meaning of eligibility does not require proof of payment. For a period of time, these definitions went unchallenged. Both providers and intermediaries applied the recently re-defined logic to the Medicare exhausted benefit day issue, as well. In other words, because these exhausted benefit claims were not covered or paid by the Medicare [P]art A benefit, they were not deemed "entitled" to Medicare Part A benefits and, as such, would appropriately be excluded from the Medicare (SSI) proxy and instead be included in the Medicaid proxy (assuming documentation proving Medicaid eligibility).
>
> In summary, CMS' long-held definition of "entitlement" was accepted by the courts, contractors and the provider community

[4] Description of Issues at 1.
[5] *Id.* at 1-2.

> as being synonymous with paid days. After realizing the costly financial impact of this interpretation to the Medicare Part A trust fund, CMS reversed its position reconstituting its position that entitlement would once again b[e] synonymous with eligibility. Only this time, rather than asserting eligibility would be defined synonymously with entitlement or proof of payment, it asserted the reverse that "entitlement" would be defined as "eligibility" and thus no longer requiring proof of payment.[6]

Therefore, in its original appeal request, the group described the issue as "entitlement" meaning "payment" or "covered" (which also excludes exhausted benefit days). The group argued that these non-paid DE days should be *excluded from the SSI fraction* and *included in the Medicaid fraction*. It argued that CMS changed its definition of "entitled," no longer requiring proof of payment for DE days.

In its April 19, 2017 Final Position Paper, however, the group explained that its DE days issue was about *SSI Eligible* days:

> The issue presented in these appeals is whether the Provider's Medicare Disproportionate Share Hospital ("DSH") reimbursement calculations were understated due to the Centers for Medicare and Medicaid Services' ("CMS" or "Agency") and the Medicare Administrative Contractor's ("MAC's") failure to include all patient days for patients who were eligible for and enrolled in the SSI program but may not have received an SSI payment for the month in which they received services from the Providers ("SSI Eligible days") in the numerator of the Medicare fraction of the DSH percentage, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi).[7]

The group further stated that CMS has excluded SSI Eligible patient days that should rightly be included in the numerator of the Medicare Fraction.[8] It states that CMS has persisted in its treatment of SSI beneficiaries, requiring them to actually receive a cash stipend in a given month of hospitalization in order to be included in the numerator of the Medicare Fraction.[9] The group argued:

> . . . CMS's revised regulations resulted in Medicare exhausted days and days paid by Medicare Advantage plans (authorized under Part C of the Medicare Act), being removed from the numerator of the Medicaid Fraction (i.e., for those patients who were eligible for Medicaid), and moved into the Medicare Fraction, notwithstanding the fact that the patients did not receive inpatient hospital benefits under Part A. These changes had multiple negative impacts on providers, one of which is the subject of this appeal. CMS did not implement concomitant changes to its interpretation of entitlement to SSI benefits when these changes were adopted and implemented. CMS's new policies created a fundamental disconnect between a

---

[6] *Id.*
[7] Case No. 13-1675GC Final Position Paper at 1, Apr. 19, 2017 ("DE Final Position Paper").
[8] DE Final Position Paper at 3.
[9] *Id.* at 4.

> beneficiary's "entitlement" to Part A benefits and "entitlement" to SSA benefits.[10]

The group makes a similar argument in its SSI days appeal, described below.

SSI Days (13-1678GC)

The SSI days case has the same two providers (Marshall Regional Medical Center and Good Shepherd Medical Center) for FYE 09/30/2006 as the DE days case. In its original appeal, the group provided the following statement regarding its SSI days issue: "The provider believes that the SSI days are understated by at least $10,000."[11] The Board interpreted this as a *Baystate* data matching issue when breaking up the appeal into 5 cases (it named the group "Good Shepherd Health System 2006 DSH SSI Fraction Baystate Errors CIRP Group").

In its April 28, 2017 Final Position Paper, the group described its SSI days issue as follows:

> At issue in this case is whether the Medicare proxy of the Disproportionate Share Hospital (DSH) calculation was improperly understated due to a number of deficiencies, including inaccurate and improper data matching and use of data and improper policies, utilized by the Centers for Medicare and Medicaid Services (CMS), which negatively impacts both the numerator and the denominator of the Medicare percentage of low income patients for DSH purposes, including any related impact on capital DSH.[12]

The group further explained that "[t]he issue under appeal herein is the continued presumed understatement of the SSI ratios used to settle Providers' FY 2012 cost reports. These cost reports use the FFY 2011 and 2012 SSI ratios."[13] The group goes on to raise "SSI Eligible" days:

> There is also a glaring inconsistency between the interpretation of the term "entitled to benefits under Part A" and "entitled to supplemental security benefits" which results in a serious flaw in the computation of the SSI fraction. As noted infra, CMS interprets the term "entitled to benefits under Part A" as including days which are not actually paid under Part A. However, CMS interprets the term "entitled to supplemental security benefits" to include only individuals who actually receive SSI payments, and not individuals who are eligible for SSI. CMS can't have it both ways, one broader interpretation (eligible for Medicare) and one much narrower interpretation (paid SSI) of the same word "entitled."[14]

The group argues that certain SSI status codes continue to be wrongfully excluded from the match process.[15] Again, the crux of the providers' argument is SSI Eligible days.

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[10] *Id.* at 5.
[11] Description of Issues at 1.
[12] Case No. 13-1678GC Final Position Paper at 3, Apr. 28, 2017 ("SSI Final Position Paper").
[13] *Id.* at 7.
[14] *Id.* at 12.
[15] *Id.* at 19.

DECISION

The Board evaluated the issue descriptions raised by the group in its DE days appeal. The Board finds that the group's description in its Appeal Request focused on whether "entitlement" should mean "payment" (which would also exclude exhausted benefit days) for DE (Medicare/Medicaid) days. The group argued that non-paid DE days should be excluded from the Medicare fraction and included in the Medicaid fraction. In contrast, the Board finds that the group's Final Position Paper focused on SSI Eligible days in the Medicare fraction numerator, arguing that those SSI-entitled days include total, not just paid, days. According to Board Rule 41.2, the Board may dismiss a case or an issue on its own motion if it has a reasonable basis to believe that the issue has been abandoned.[16] Here, the group changed its issue description of DE days to SSI Eligible days in its filings with the Board. Therefore, the original DE days issue was effectively abandoned by the group.

Moreover, the Board finds that the SSI Eligible days issue, as briefed in the DE days Final Position Paper, is duplicative of the issue in the SSI days case. The Board notes that both cases have the same providers and fiscal year end. The Board hereby dismisses Case No. 13-1675GC (DE days) as abandoned, but the duplicative case, Case No. 13-1678GC (SSI days) will move forward.

Board Members
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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Bill Tisdale, Novitas Solutions, Inc.

[16] PRRB Rules, Rule 41.2 at 40 (Jun. 1, 2015).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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AUG 1 0 2017

Certified Mail

Michael G. Newell
Southwest Consulting Associates
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Plano, TX 75093

RE: Request for Reconsideration and Expedited Judicial Review
Holy Family Hospital, Provider No. 22-0080
FYE: September 30, 2012
PRRB Case No.: 15-1546GC

Dear Mr. Newell:

On July 26, 2017, the Provider Reimbursement Review Board ("PRRB" or "Board') received Holy Family Hospital's ("Holy Family's") Request for Reconsideration ("Request"). Within its Request, Holy Family asks the Board to reconsider its July 19, 2017 decision in which the Board found that it lacked jurisdiction to hear Holy Family's appeal of the Centers for Medicare & Medicaid Services ("CMS") treatment of Medicare Part C Days in the Supplemental Security Income ("SSI") fraction of the Disproportionate Share Hospital ("DSH") calculation for Holy Family's fiscal year end ("FYE") September 30, 2012 cost reporting period. As the Board determined that it lacked jurisdiction to hear Holy Family's appeal of this issue, the Board also found that it was unable to grant Holy Family's request for expedited judicial review ("EJR") of the issue as included within Southwest Consulting Associates' June 26, 2017 group EJR request.[1] Upon review of Holy Family's Request, the Board has reconsidered its jurisdictional determination regarding Holy Family's appeal and, based on the additional documentation submitted by Holy Family, finds that it has jurisdiction over Holy Family's appeal and grants Holy Family's EJR request, as explained below.

Board's July 19, 2017 EJR Decision

On July 19, 2017, the Board issued its decision regarding the Southwest Consulting DSH Part C Days Groups' June 26, 2017 EJR request for the following issue:

> [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 fraction and excluded from the Medicaid fraction numerator or vice-versa.[2]

Within its EJR decision, the Board dismissed Holy Family Hospital, Participant 11, from PRRB Case No. 15-1546GC because Holy Family did not provide jurisdictional documentation to show

[1] *See* 42 C.F.R. § 405.1842(f)(1) (2016).
[2] June 26, 2017 EJR Request at 4.

that the Medicare contractor adjusted its SSI%[3] within the appealed Notice of Program Reimbursement ("NPR") nor did it provide documentation to show that it protested the Medicare Part C/SSI% issue on its as-filed cost report. As such, pursuant to the jurisdictional regulations governing Board hearings,[4] the Board concluded that Holy Family had not preserved its right to claim dissatisfaction with the appealed issue for this cost reporting period and, therefore, the Board lacked the jurisdiction to hear Holy Family's appeal of this issue. Based on this jurisdictional determination, the Board also found that it lacked the authority to grant Holy Family's EJR request.[5]

Holy Family's July 26, 2017 Reconsideration Request

On July 26, 2017, the Board received Holy Family's Request in which it asks the Board to reconsider its jurisdictional determination regarding Holy Family's FYE September 30, 2012 appeal. Holy Family states that although PRRB Case No. 15-1546GC's Schedule of Providers lists adjustment numbers 14 and 18 as Holy Family's adjustments pertinent to the appeal, it "inadvertently excluded" the audit adjustment pages for these two adjustments when it filed its jurisdictional documents. Holy Family attached the missing pages of the Audit Adjustment Report to its Request.

Board's Analysis and Determination

Pursuant to Board Rule 46.1, a provider may request, via written motion, that the Board reinstate an issue or case within three years from the date of the Board's decision to dismiss the issue/case.[6] Board Rule 46.3 states that upon written motion demonstrating good cause, the Board may reinstate a case dismissed for failure to comply with Board procedures. Generally, administrative oversight, settlement negotiations or a change in representative will not be considered good cause to reinstate. Board Rule 46.3 goes on to state that if the Board's dismissal was for failure to file a required position paper, Schedule of Providers, or other filing, the motion for reinstatement must, as a prerequisite, include the required filing before the Board will consider the motion.

In the instant Request, Holy Family claims that it inadvertently excluded the audit adjustment pages that documented the Medicare contractor's adjustment of Holy Family's SSI% for the appealed cost reporting period. Holy Family timely filed its motion in writing, along with the missing documentation, as required under the pertinent regulations and Board Rules. In addition, the original Schedule of Providers for PRRB Case No. 15-1546GC lists audit adjustment numbers 4, 9, 14, 17 and 18 as being Holy Family's adjustments pertinent to the appealed issue. Holy Family included, within its original jurisdictional documentation, the Audit Adjustment Report pages for adjustments 4 and 9 but not 14, 17 and 18. Audit Adjustment Number 14 refers to the Medicare contractor's removal of Holy Family's protested amount from its as-filed cost report and Audit Adjustment Number 18 refers to the contractor's adjustment to Worksheet E, Part A, Line 30.00 "[p]ercentage of SSI recipient patient days to Medicare Part A days."

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[3] The terms "Medicare fraction," "SSI fraction" and "SSI%" are synonymous for purposes of this decision.
[4] *See* 42 C.F.R. § 405.1835(a)(1) (2011).
[5] *See* 42 C.F.R. § 405.1842(f)(2)(i) (2016).
[6] *See* 42 C.F.R. § 405.1885 (2016) (addressing reopening of Board decisions).

The Board finds that, based upon the audit adjustments listed on PRRB Case No. 15-1546GC's original Schedule of Providers, Holy Family included the appropriate audit adjustment numbers when it filed its EJR request as part of the larger group appeal. Based on the documentation submitted with the original appeal request and subsequent documentation filed by Holy Family, the Board accepts Holy Family's explanation that Holy Family inadvertently excluded the pertinent audit adjustment pages when it filed its jurisdictional documents. As the additional audit adjustment pages show that the Medicare contractor adjusted Holy Family's SSI% on the appealed NPR, the Board finds, pursuant to 42 C.F.R. § 405.1835(a)(1) (2011), that it has jurisdiction to hear Holy Family's appeal of the Medicare Part C/SSI% issue as included within PRRB Case No. 15-1546GC.

Furthermore, under the Medicare statute codified at 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2016), the Board is required to grant 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. Here, the Board has determined that it has jurisdiction to conduct a hearing on the specific matter at issue appealed by Holy Family Hospital and it previously determined in its July 19, 2017 EJR Decision that it lacked the authority to decide the specific legal question relevant to Holy Family's appealed issue. Therefore, the Board is also granting Holy Family Hospital's EJR request for the Medicare Part C/SSI% issue.[7] Holy Family Hospital, Provider No. 22-0080, will be reinstated as Participant 11 in PRRB Case No. 15-1546GC and the Board's July 19, 2017 EJR Decision for the group that includes PRRB Case No. 15-1546GC is hereby incorporated by reference into this determination.

Board Members Participating:

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

FOR THE BOARD:

Jack Ahern

Jack Ahern, MBA, CHFP
Board Member

Enclosures: Board's July 19, 2017 EJR Decision
Updated Schedule of Providers for 15-1546GC

[7] The Board attaching a copy of its July 19, 2017 EJR decision and an updated Schedule of Providers for PRRB Case No. 15-1546GC with Holy Family Hospital, Provider No. 22-0080, reinstated within the group. This updated Schedule of Providers for PRRB Case No. 15-1546GC should replace the Schedule for PRRB Case No. 15-1546GC that was issued along with the Board's July 19, 2017 EJR Decision.

cc: Pam Van Arsdale, NGS (Certified Mail w/updated Schedule of Providers for 15-1546GC)

Judith E. Cummings, CGS Administrators, LLC (Certified Mail w/updated Schedule of Providers for 15-1546GC)

Laurie Polson, Palmetto GBA c/o NGS (Certified Mail w/updated Schedule of Providers for 15-1546GC)

Bruce Snyder, Novitas Solutions (Certified Mail w/updated Schedule of Providers for 15-1546GC)

Byron Lamprecht, Wisconsin Physician Service (Certified Mail w/updated Schedule of Providers for 15-1546GC)

Bill Tisdale, Novitas Solutions (Certified Mail w/ updated Schedule of Providers for 15-1546GC)

Geoff Pike, First Coast Service Options (Certified Mail w/updated Schedule of Providers for 15-1546GC)

Wilson Leong, (updated Schedule of Providers for 15-1546GC)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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AUG 17 2017

CERTIFIED MAIL

Stephanie A. Webster
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James Lowe
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Morrisville, NC 27560-2008

RE: Jurisdictional Decision
Case Number: 13-1346
Provider Name: Memorial Hermann Hospital – Texas Medical Center
FYE: 06/30/2008

Dear Ms. Webster and Mr. Lowe:

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documentation submitted in the above captioned case, including the Medicare Contractor's challenge regarding the penultimate Direct Graduate Medical Education (GME) Full Time Equivalent (FTE) component of Issue no. 3 in this appeal. The Boards jurisdictional decision is set forth below.

BACKGROUND

Issue No. 3 in this case is described as IME/GME Flow Adjustments (3-yr Rolling Ave, Intern Resident to Bed Ratio, and Capital IME Payments), Prior and Penultimate IME & GME FTES. The parties have signed a Partial Administrative Resolution which has resolved all issues in the case except for the penultimate year GME FTE component of Issue no. 3.

INTERMEDIARY'S CONTENTIONS

The Intermediary contends that the Board does not have jurisdiction over the penultimate GME FTE component of issue no. 3 in this appeal because the Medicare contractor made no changes to the penultimate GME FTE counts on the Medicare cost report. The Medicare contractor refers to 42 C.F.R. §405.1835:

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

Medicare Contractor's Jurisdictional Challenge (Oct. 11, 2013) at 2.

The Medicare Contractor avers there were no adjustments made to this cost issue, and also there were no changes to the as-filed Worksheets E and E-3 as evidenced by the as-finalized Worksheets E and E-3.

The Medicare Contractor requests the Board dismiss this component of Issue no. 3 from the case due to lack of jurisdiction.

PROVIDER'S CONTENTIONS

The Provider contends that its GME payments for FYE 2008 should reflect the corrected, final FTE counts allowed for the 2006, 2007, and 2008 cost reporting periods. The Provider claims that by filing its cost report in accordance with the rules then in effect, the Provider did not waive dissatisfaction with the Medicare Contractor's final determination of the penultimate year's FTE count. The Provider cites to *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988), stating that the Supreme Court has established that "the submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations." *Id.* at 404.

DECISION

The Board finds it has jurisdiction over the penultimate year GME component of Issue No. 3.

Pursuant to 42 U.S.C. §1395oo(a) and 42 C.F.R. §§405.1835 – 1841 (2013), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for a hearing is filed within 180 days of the date of the Notice of Program Reimbursement (NPR).

This jurisdictional challenge alleges the Provider does not meet the dissatisfaction requirement above as the Medicare Contractor "did not make any changes to the Penultimate Graduate Medical Education (GME)...FTE counts on the Medicare cost report." *Medicare Contractor's Jurisdictional Challenge (Oct. 11, 2013) at 2.*

The cost issue raised by the Provider involves self-disallowed items for its fiscal year end ("FYE") prior to December 31, 2008, which puts the instant case under the purview of *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988). Bethesda holds that a provider need not protest self-disallowed costs that are barred from being claimed because of a specific statute, regulation, or ruling. *Id.* at 404. The Supreme Court stated:

> . . . [T]he submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations. No statute or regulation expressly mandates that a challenge to the validity of a regulation be submitted first to the [Contractor]. Providers know that, under the statutory scheme, the [Contractor] is confined to the mere application of the Secretary's regulations, that the [Contractor] is without power to award reimbursement except as the regulations provide, and that any attempt to persuade the [Contractor] to do otherwise would be futile.

Bethesda at 404.

The Supreme Court recognized that a situation where a regulation pre-determines a disallowance is distinct from those in which a provider simply neglects to include an item on the cost report for which it would be due reimbursement:

> Thus, petitioners stand on different ground than do providers who bypass a clearly prescribed exhaustion requirement or *who fail to request from the intermediary reimbursement for all costs to which they are entitled under applicable rules.* While such defaults might well establish that a provider was satisfied with the amounts requested in its cost report and awarded by the fiscal intermediary, those circumstances are not presented here.

Bethesda at 404-405.

The penultimate GME FTE component of issue no. 3 relates to FTEs on the Provider's second to last cost report (penultimate year). The Board concludes that at the time the Provider filed its FYE June 30, 2008 cost report, it was required to enter the penultimate year's FTE count from the penultimate year's cost report. Any attempt to not use the as-filed penultimate year data would have been futile, and this issue is a properly self-disallowed cost under *Bethesda.* Therefore, the Board finds that it has jurisdiction over the Penultimate Year GME component of Issue No. 3.

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

Board Members

Clayton J. Nix, Esq.
Jack Ahern, MBA, CHFP
Gregory Ziegler

FOR THE BOARD

Clayton J. Nix
Board Member

cc: Wilson Leong, Esq., FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Certified Mail

AUG 17 2017

Kenneth R. Marcus
Honigman Miller Schwartz & Cohn
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RE: Expedited Judicial Review Request
Baptist Memorial Health Care Corporation 2007-2013 DSH[1] SSI[2]/Medicaid Medicare Advantage Days CIRP[3] Groups
FYE: 2007-2013
PRRB Case Nos.: 14-0731GC, 14-0732GC, 14-1345GC, 14-1461GC, 15-2666GC, 15-2753GC, 16-0275GC and 16-1800GC

Dear Mr. Marcus:

On July 21, 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 but 2 of the CIRP groups, as explained below.

The issue in these appeals is:

> [W]hether "enrollees in Medicare Part C are 'entitled to benefits' under Part A, such that they should be counted in the Medicare [Part A/SSI] fraction, or whether, if not regarded as 'entitled to benefits under Part A,' they should instead be included in the Medicaid fraction" of the DSH adjustment.[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").[5] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[6]

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[1] The abbreviation "DSH" stands for "disproportionate share hospital."
[2] The abbreviation "SSI" stands for "Supplemental Security Income."
[3] The abbreviation "CIRP" stands for "Common Issue Related Party."
[4] July 21, 2017 EJR Request at 8.
[5] *See* 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.
[6] *Id.*

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[7] 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.[8]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[9] 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.[10] The DPP is defined as the sum of two fractions expressed as percentages.[11] 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.[12]

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

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

> 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.[13]

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[14] 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].[15]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[16]

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[13] 42 C.F.R. § 412.106(b)(4).
[14] of Health and Human Services
[15] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).
[16] *Id.*

With the creation of Medicare Part C in 1997,[17] 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. [18]

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)[19]

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."[20] 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*

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[17] 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.

[18] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).

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

[20] 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.[21] (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.[22] 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,*[23] 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.[24]

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.[25]

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."[26] The providers point out that because the Secretary has not acquiesced to the decision, the 2004 regulation requiring Part C days be included in the Part

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[21] *Id.*
[22] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[23] 746 F. 3d 1102 (D.C. Cir. 2014).
[24] July 21, 2017 EJR Request at 1.
[25] 69 Fed. Reg. at 49,099.
[26] *Allina* at 1109.

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.

Decision of the Board

Under the Medicare statute codified at 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1) (2016), the Board is required to grant 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 CIRP groups

Pursuant to the pertinent sections of the Medicare statute[27] regarding Board jurisdiction and the regulations implementing the statute, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $50,000 or more for a group, and the request for hearing was timely filed.[28]

The CIRP group cases included in this EJR request involve providers' appeals of original notices of program reimbursement in which the Medicare contractor settled cost reporting periods ending between September 30, 2007, and September 30, 2013.

For providers with appeals of cost reporting periods ending before December 31, 2008, the providers may demonstrate dissatisfaction with the amount of Medicare reimbursement of the Part C days issue appealed from their respective original Notices of Program Reimbursement ("NPRs") by claiming the issue as a "self-disallowed cost" pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen*.[29]

For providers with appeals of cost reporting time periods ending on or after December 31, 2008, the providers preserve their rights to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either including a claim for the specific item on their respective

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[27] The pertinent section of the Medicare statute may be found at 42 U.S.C. § 1395oo(a).
[28] For appeals filed prior to August 21, 2008, a hearing request is considered timely if it is filed within 180 days of the date the notice of the Medicare contractor's determination was mailed to the provider. 42 C.F.R. § 405.1841(a) (2007). For appeals filed on or after August 21, 2008, a hearing request is considered timely if it is filed within 180 days of the date of receipt of the final determination. 42 C.F.R. § 405.1835(a) (2008).
[29] 108 S.Ct. 1255 (1988).

cost reports for the period where the providers seek payment they believe to be in accordance with Medicare policy, or self-disallowing the specific item by following the applicable procedures for filing a cost report under protest. See 42 C.F.R. § 405.1835(a)(1) (2008).

The Board has determined that, except for two CIRP groups listed below, the providers involved with the instant EJR request have had Part C days excluded from the Medicaid fraction, have had a specific adjustment to the SSI fraction, or have properly protested the appealed issue such that the Board has jurisdiction to hear their respective appeals. In addition, the providers' documentation shows that the estimated amount in controversy for each group appeal exceeds $50,000, as required for a group appeal[30] 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.

PRRB Case No. 15-2666GC, BMHCC 2010 DSH SSI/Medicaid Medicare Advantage Days CIRP Group; Baptist Memorial Hospital DeSoto Southaven ("Baptist Memorial"), Provider No. 25-0141—listed as Participants 2A and 2B; Fiscal Year Ending ("FYE") September 30, 2010

To substantiate Board jurisdiction over its appeal involved with the instant EJR request, Baptist Memorial submitted an Audit Adjustment Report to the Board to show that the Medicare contractor adjusted its SSI% on its appealed NPR. Unfortunately, the Audit Adjustment Report is illegible and the Board is unable to determine whether it has jurisdiction to hear Baptist Memorial's appeal of the Part C days issue. In an attempt to verify the adjustment cited by Baptist Memorial, the Board also reviewed Baptist Memorial's original hearing request but the jurisdictional documentation was similarly illegible.

The Board has, therefore, issued a development letter under separate cover for this provider and CIRP group in order to allow either Baptist Memorial or the Medicare contractor to file a "clean copy" of the Audit Adjustment Report for the cost reporting period under appeal. Pursuant to the regulations governing CIRP group appeals and EJR requests before the Board, this development letter affects the 30-day period for the Board to respond to the EJR request for all providers within PRRB Case No. 15-2666GC.[31]

PRRB Case No. 16-1800GC, BMHCC 2013 DSH SSI/Medicaid Medicare Advantage Days CIRP Group; Baptist Memorial Hospital Memphis ("Memphis"), Provider No. 48-0048—listed as Participants 4A and 4B, FYE September 30, 2013

With respect to BMHCC 2013 DSH/SSI Medicaid/Medicare Advantage Days CIRP Group, PRRB Case No. 16-1800GC, the Board received correspondence dated July 12, 2017, from Baptist Memorial Hospital—Memphis (Provider No. 48-0048) in which Memphis requests to be added to the CIRP group. In this correspondence, the provider indicates that it has not yet been issued its NPR for the FYE September 30, 2013. In response, the Board issued a July 25, 2017

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[30] *See* 42 C.F.R. § 405.1837.
[31] *See* 42 C.F.R. § § 405.1837(b)(1) and (e)(1) (2016); 42 C.F.R. § § 405.1842(b)(2), (e)(2)(ii) and (e)(3)(ii) (2016).

letter to the Memphis in which it states that it is denying the provider's request to be added to PRRB Case No. 16-1800GC because the request to be added to the group is premature. The Board informed the provider that if its add-request is based upon the Medicare contractor's failure to timely issue a final determination, the provider must submit additional jurisdictional documentation as outlined in Board Rule 7.4. In addition, the representative for CIRP Group PRRB Case No. 16-1800GC has yet to indicate that this CIRP group is fully formed as required under Board Rule 19.2 and 42 C.F.R. § 405.1837(e) (2016).

As such, the Board has issued, under separate cover, a development letter in which it requests that the representative indicate whether the instant CIRP group is fully formed, and if so, confirm that the CIRP group providers intend to proceed with the EJR request for PRRB Case No. 16-1800GC without Memphis as part of the appeal. In the alternative, Memphis may file jurisdictional documentation to demonstrate that it is filing an appeal from the Medicare contractor's failure to timely issue a final determination.

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

For the remaining CIRP group appeals in this EJR request, the providers' appeals span fiscal years 2007-2009 and 2011-2012, 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.

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 participants in these group appeals are entitled to a hearing before the Board except as otherwise noted above;

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

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

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

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

FOR THE BOARD:

Charlotte Benson

Board Member

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

cc: Barb Hinkle, Cahaba GBA c/o National Government Services, Inc. (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

AUG 18 2017

Certified Mail

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

RE: Expedited Judicial Review Request
Akin Gump DSH Part C Days Groups
FYEs 2008, 2009 and 2012
PRRB Case Nos. 10-0310GC, 13-0349GC, 13-0673GC, 13-0708GC, 13-3458GC, 15-1510GC, 15-1511GC

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' July 26, 2016 request for expedited judicial review (EJR) (received July 27, 2017) for the above-referenced appeals. The Board's determination is set forth 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 [Supplemental Security Income] fraction and excluded from the Medicaid fraction numerator 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]

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[4] These cases involve the hospital-specific DSH adjustment, which requires the

[1] July 26, 2017 EJR Request at 4.
[2] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[3] *Id.*
[4] *See* 42 U.S.C. § 1395ww(d)(5).

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 the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors 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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[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 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.[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 Medicare contractors to calculate DSH payments for the fiscal year 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 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."[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

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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.

> 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 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] The Providers point out that because the Secretary has not acquiesced to the decision, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R.
§§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

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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] June 26, 2017 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. The Providers maintain that 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

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

Jurisdictional Determination

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2008, 2009 and 2012.

For purposes of Board jurisdiction over a participant's appeals filed from a cost reporting period that ends on or before December 30, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[24] With respect to a participant's appeals filed from a cost reporting period that ends on or after December 31, 2008, in order to demonstrate dissatisfaction with the amount of Medicare payment for the appealed issue, a participant filing an appeal from an original NPR must show that the Medicare contractor adjusted its SSI fraction when it settled the participant's cost report or the participant must have self-disallowed the appealed issue by filing its cost report under protest.[25]

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.[26] The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

The Board has determined that participants involved with the instant EJR request have had Part C days excluded from the Medicaid fraction, had a specific adjustment to the SSI fraction, or properly protested the appealed issue such that the Board has jurisdiction to hear their respective

[24] 108 S.Ct. 1255 (1988).
[25] *See* 42 C.F.R. § 405.1835 (2008).
[26] See 42 C.F.R. § 405.1889(b)(1) (2008).

appeals. The Providers which filed appeals from revised NPRs have adjustments to the SSI percentage, as required for jurisdiction. In addition, the participants' documentation shows that the estimated amount in controversy 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.

Board's Analysis Regarding the Appealed Issue

The group appeals in this EJR request span fiscal years 2008, 2009 and 2012, 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 participants in these group appeals are entitled to a hearing before the Board except as otherwise noted above;

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

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

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

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[27] *See* 42 C.F.R. § 405.1837.

[28] On August 3, 2017, one of the Medicare contractors, Wisconsin Physicians Service ("WPS"), filed an objection to the EJR request in a number of cases identified in the EJR request. 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.

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:

Clayton J. Nix, Esq.
Jack Ahern, MBA, CHFP
Gregory H. Ziegler

FOR THE BOARD:

Board Member

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

cc: 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)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

AUG 18 2017

Certified Mail

Christopher L. Keough
Akin Gump Straus Hauer & Feld LLP
1333 New Hampshire Avenue, NW
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RE: Expedited Judicial Review Request
Southwest Consulting DSH Part C Days Groups
FYEs 2008, 2009 and 2012
PRRB Case Nos. 08-0324GC, 09-0844GC, 09-2003GC, 13-0887GC, 13-2226GC, 13-2762GC, 13-2863GC, 13-2864GC[1]

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' July 26, 2016 request for expedited judicial review (EJR) (received July 27, 2017) for the above-referenced appeals. The Board's determination is set forth 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 [Supplemental Security Income] fraction and excluded from the Medicaid fraction numerator or vice-versa.[2]

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").[3] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[4]

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[1] The referenced line of the July 26, 2017 EJR request includes five additional case numbers. Four of the cases has been closed and transferred to cases that are part of this EJR determination. Case numbers 13-1828GC and 13-1830GC were closed when they were consolidated with case number 08-0328GC and case numbers 13-2250GC and 13-2252GC were closed when they were consolidated with case number 09-2003GC. The fifth, case number 08-0328GC, had jurisdictional issues; a jurisdictional determination and EJR determination will be issued under separate cover for this case.

[2] July 26, 2017 EJR Request at 4.

[3] *See* 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

[4] *Id.*

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[5] 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.[6]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[7] 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.[8] The DPP is defined as the sum of two fractions expressed as percentages.[9] 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.[10]

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

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

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

> number of the hospital's patient days for such period. (emphasis added)

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

Medicare Advantage Program

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

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

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

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

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

With the creation of Medicare Part C in 1997,[15] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.[16]

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the 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)[17]

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

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

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

[16] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).

[17] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).

[18] 69 Fed. Reg. at 49,099.

> *adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[19] (emphasis added)

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.[20] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule. As a result, Part C days were required to be included in the Medicare fraction as of October 1, 2004.

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

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.[23]

In *Allina*, the Court affirmed the district court's decision "that the Secretary's final rule was not a logical outgrowth of the proposed rule."[24] The Providers point out that because the Secretary has not acquiesced to the decision, the 2004 regulation requiring Part C days be included in the Part

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[19] *Id.*
[20] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[21] 746 F. 3d 1102 (D.C. Cir. 2014).
[22] June 26, 2017 EJR Request at 1.
[23] 69 Fed. Reg. at 49,099.
[24] *Allina* at 1109.

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. The Providers maintain that 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

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

Jurisdictional Determination

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2008, 2009 and 2012.

For purposes of Board jurisdiction over a participant's appeals filed from a cost reporting period that ends on or before December 30, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[25] With respect to a participant's appeals filed from a cost reporting period that ends on or after December 31, 2008, in order to demonstrate dissatisfaction with the amount of Medicare payment for the appealed issue, a participant filing an appeal from an original NPR must show that the Medicare contractor adjusted its SSI fraction when it settled the participant's cost report or the participant must have self-disallowed the appealed issue by filing its cost report under protest.[26]

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.[27] The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

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[25] 108 S.Ct. 1255 (1988).
[26] *See* 42 C.F.R. § 405.1835 (2008).
[27] See 42 C.F.R. § 405.1889(b)(1) (2008).

The Board has determined that participants involved with the instant EJR request have had Part C days excluded from the Medicaid fraction, had a specific adjustment to the SSI fraction, or properly protested the appealed issue such that the Board has jurisdiction to hear their respective appeals. The Providers which filed appeals from revised NPRs have adjustments to the SSI percentage, as required for jurisdiction.[28] In addition, the participants' documentation shows that the estimated amount in controversy 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's Analysis Regarding the Appealed Issue

The group appeals in this EJR request span fiscal years 2008, 2009 and 2012, 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. [30]

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 participants in these group appeals are entitled to a hearing before the Board except as otherwise noted above;

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[28] For those Providers that have appealed from both original and revised NPRs in case number 09-2003GC, the Board will not issue a jurisdictional determination for the revised NPR appeals. The Board has determined that these Providers have jurisdictionally valid appeals pending for the same fiscal year ends from the original NPRs; therefore reaching a decision on the revised NPR appeals is futile as the outcome for these Providers will not be affected.

[29] *See* 42 C.F.R. § 405.1837.

[30] On August 3, 2017, one of the Medicare contractors, Wisconsin Physicians Service ("WPS"), filed an objection to the EJR request in a number of cases identified in the EJR request. 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.

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

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

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

Clayton J. Nix, Esq.
Jack Ahern, MBA, CHFP
Gregory H. Ziegler

FOR THE BOARD:

Board Member

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

cc: 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)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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AUG 18 2017

Certified Mail

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RE: Expedited Judicial Review Request
CHI 2006 DSH Medicare+Choice Days Group
FYE 2006
PRRB Case No. 08-0328GC[1]

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' July 26, 2016 request for expedited judicial review (EJR) (received July 27, 2017) for the above-referenced appeal. The Board's determination with respect to the request for EJR and jurisdiction over Provider # 12, Mercy Hospital, is set forth below.

The issue in this appeal 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 [Supplemental Security Income] fraction and excluded from the Medicaid fraction numerator or vice-versa.[2]

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").[3] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[4]

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[5] These cases involve the hospital-specific DSH adjustment, which requires the

[1] The EJR request contains a number of other cases. The EJR determination for those cases is being sent under separate cover.
[2] July 26, 2017 EJR Request at 4.
[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*
[5] *See* 42 U.S.C. § 1395ww(d)(5).

Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[6]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[7] 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.[8] The DPP is defined as the sum of two fractions expressed as percentages.[9] 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.[10]

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

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

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

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

Medicare Advantage Program

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

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

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

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

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

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[11] 42 C.F.R. § 412.106(b)(4).
[12] of Health and Human Services
[13] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).
[14] *Id.*
[15] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered

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

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the 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)[17]

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

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

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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.

[16] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).

[17] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).

[18] 69 Fed. Reg. at 49,099.

> associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[19] (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.[20] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule. As a result, Part C days were required to be included in the Medicare fraction as of October 1, 2004.

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

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.[23]

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

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

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[19] *Id.*
[20] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[21] 746 F. 3d 1102 (D.C. Cir. 2014).
[22] June 26, 2017 EJR Request at 1.
[23] 69 Fed. Reg. at 49,099.
[24] *Allina* at 1109.

validity of the 2004 rule that the Board lacks the authority to grant. The Providers maintain that 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

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

Jurisdictional Determination

#12 Mercy Hospital, Provider Number 16-0028, FYE 6/30/2006

The Provider appeal was received January 21, 2010 and appealed a revised Notice of Program Reimbursement issued July 28, 2009. The Provider was directly added to the current case and identified adjustment 4 as the subject of the appeal. That adjustment generically adjusted Medicaid Eligible days (increased), but there is no indication that Medicare Part C days was the subject of that adjustment. Further, there was adjustment to the SSI percentage, which could also include a revision to Medicare Part C days. The SSI percentage is reported on Worksheet E, Part A, Line 4 of the cost report and there was no adjustment to that line item. Therefore there is no evidence that Medicare Part C Days were revised as part of the revised determination.

The regulation, 42 C.F.R. 405.1889 (2008), states that a revised determination is a separate determination for purposes of appeal to the Board and only those matters specifically revised are with the scope of the appeal of the revised determination. Any matter not specifically revised may not be considered in the appeal of the revised determination.

Since the Provider appealed a revised NPR and they failed to document that Medicare Part C days were specifically revised in the separate determination, the Board finds that the Provider failed to meet the requirements for Board jurisdiction under 42 C.F.R. § 405.1889. Therefore the Board concludes that it lacks jurisdiction over Mercy Hospital (provider number 16-0028) and dismisses the Provider from the appeal. Since jurisdiction is a prerequisite to granting a providers request for EJR. Mercy Hospital's request for EJR is hereby denied. *See* 42 C.F.R. § 405.1842(a) and (f)(2)(i).

EJR and Jurisdictional Determination for the Remaining Providers

The participants that comprise the group appeal within this EJR request have filed appeals involving fiscal years 2006.

For purposes of Board jurisdiction over a participant's appeals filed from a cost reporting period that ends prior to December 30, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[25] For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.[26] The Board notes that all the remaining participants revised NPR appeals included within this EJR request were issued after August 21, 2008.

The Board has determined that the remaining participants involved with the instant EJR which appealed from original NPRs had a specific adjustment to the SSI fraction or appealed issue as a self-disallowed cost under *Bethesda.* As a result, the Board has jurisdiction to hear their respective appeals. The remaining Providers which filed appeals from revised NPRs have adjustments to the SSI percentage, as required for jurisdiction. In addition, the participants' documentation shows that the estimated amount in controversy 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.

Board's Analysis Regarding the Appealed Issue

The group appeals in this EJR request involves fiscal year 2006, 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.

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 participants in this group appeals are entitled to a hearing before the Board except as otherwise noted above;

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[25] 108 S.Ct. 1255 (1988).
[26] See 42 C.F.R. § 405.1889(b)(1) (2008).
[27] *See* 42 C.F.R. § 405.1837.

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

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

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

Board Members Participating:

Clayton J. Nix, Esq.
Jack Ahern, MBA, CHFP
Gregory H. Ziegler

FOR THE BOARD:

Board Member

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

cc: Bill Tisdale, Novitas Solutions (Certified Mail w/Schedule of Providers)
Wilson Leong, (w/Schedule of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

AUG 21 2017

Refer to: 17-1799

CERTIFIED MAIL

Baker, Donelson, Bearman, Caldwell
& Berkowitz, P.C.
Susan Turner
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Washington, DC 20005

Cahaba GBA
c/o National Government Services, Inc.
Barb Hinkle
Appeals Lead
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

RE: Jurisdictional Decision
Provider: High Ridge House
Provider No.: 33-1990
FYE: 12/31/2011
PRRB Case No: 17-1799

Dear Ms. Turner and Ms. Hinkle,

The Provider Reimbursement Review Board ("the Board") has reviewed the jurisdictional documents in the above-referenced case. For the reasons stated below, the Board: 1) finds that it lacks jurisdiction over this appeal wherein the amount in controversy is $8,540; and 2) refers the appeal request to the Medicare Contractor Hearing Officer for consideration.

Decision of the Board

The Board finds that it does not have jurisdiction over this appeal because it does not meet the $10,000 threshold required for Board jurisdiction. Pursuant to 42 U.S.C. § 1395oo(a)(2) and 42 C.F.R. § 405.1835(a)(2), a provider has a right to a hearing before the Board with respect to a final contractor or Secretary determination if: 1) it is dissatisfied with the final determination of the total amount of reimbursement due the provider; 2) the amount in controversy is $10,000 or more; and 3) the request for a hearing is received by the Board within 180 days of the date of receipt of the final determination.

Based on the Provider's appeal request, it is clear that the amount in controversy in this case, $8,540, does not meet the $10,000 threshold required for an individual appeal.[1] Therefore, the Board finds that it lacks jurisdiction over this case and dismisses the above-referenced appeal for failure to comply with the amount in controversy requirement.

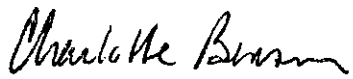
[1] Appeal request at 3.

However, since the amount in controversy in this appeal is at least $1,000, but less than $10,000, the Provider may be entitled to a hearing before a Medicare Contractor Hearing Officer pursuant to 42 C.F.R. § 405.1809. As stated in the Notification of Appeal/Reopening Procedures you attached to your appeal request behind Tab 1, all Intermediary Hearings (between $1,000 and $10,000), are heard by Federal Specialized Services. The Board will forward a copy of your appeal request to FSS, as they are the correct venue for the dollar value of the appeal. PRRB appeal 17-1799 is hereby closed.

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

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

FOR THE BOARD



Board Member

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

cc: PRRB Appeals, Federal Specialized Services (with copy of original appeal request)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Refer to: 14-3022

AUG 2 2 2017

CERTIFIED MAIL

James C. Ravindran
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Cahaba GBA
c/o National Government Services, Inc.
Barb Hinkle
Appeals Lead
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

RE: Franklin Woods Community Hospital
Provider No.: 44-0184
FYE: 06/30/2007
PRRB Case No.: 14-3022

Dear Mr. Ravindran and Ms. Hinkle,

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

Background:

The Board received an individual appeal request from the Provider, Franklin Woods Community Hospital, on March 25, 2014; based on a Notice of Program Reimbursement ("NPR") from the Medicare Contractor issued September 27, 2013. The Provider appealed four issues, which included the Disproportionate Share Hospital (DSH) Payment/ Supplemental Security Income (SSI) Percentage (Provider Specific) issue, and SSI Systemic Errors issue. On November 21, 2014, the Board received the Provider's Preliminary Position Paper, which stated that all other issues other than the SSI Provider Specific had been transferred to relevant QRS group appeals.

Medicare Contractor's Position:

The Medicare Administrative Contractor (MAC) filed a jurisdictional challenge on February 26, 2015. The MAC contends that no evidence has been provided to show that errors were made in the calculation of the SSI ratio; therefore, suggesting that the Provider's request for an appeal is based on speculation. The Medicare Contractor states that because the Provider failed to properly request a realignment of the SSI ratio; the request is premature. The MAC requests that the Board dismiss the issue and close the case.

Provider's Position:

The Provider contends that the MAC is incorrect when arguing that the DSH/SSI realignment issue is not an appealable issue.[1] The Provider states that it is addressing not only a realignment of the SSI percentage but also addressing various errors of omission and commission that do not fit into the "systemic errors" category.[2] Thus, the Provider argues that this is an appealable item because the Medicare Contractor specifically adjusted the Provider's SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year end ("FYE") as a result of its understated SSI percentage.[3]

Further, the Provider asserts that in *Northeast Hospital Corporation v. Sebelius*, the Centers for Medicare and Medicaid Services ("CMS") abandoned the CMS Administrator's December 1, 2008 decision. 657 F.3d 1 (D.C. Cir. 2011).[4] The decision here that was abandoned was that the SSI ratio cannot be revised based upon updated data after it has been calculated by CMS.[5] Thus, the Provider reasons that the Provider can submit data to prove its SSI percentage was understated.[6] However, the Provider mentions that, to this point, the Provider has been unable to submit such data because CMS has not released the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") data—HHS/HCFA/OIS, 09-07-009, published in the Federal Register on August 18, 2000—in support of the SSI percentage.[7]

The Provider contends that CMS has just now started releasing the MEDPAR data, but the Provider has not yet received its MEDPAR data and has been unable to reconcile its records with that of CMS.[8] The Provider argues that it is unable to specifically identify patients believed to be entitled both to Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal FYE (September 30) when it determined the Provider's SSI percentage.[9] The Provider states that though the Provider may choose to request realignment, this still will not correct these errors of omission and commission that are understating the Provider's SSI percentage.[10] Therefore, the Provider requests that the Board finds that it has jurisdiction over the DSH/SSI "provider specific" and realignment sub-issues.

Board's Decision:

The Board finds that it does not have jurisdiction over the DSH SSI Provider Specific issue as it is duplicative and there is no final determination. 42 C.F.R. § 405.1835 (2012) states,

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[1] *See* Provider's Jurisdictional Response dated March 16, 2015.

[2] *Id.*

[3] *Id.*

[4] *Id. At 2*

[5] *Id.*

[6] *Id.*

[7] *Id.* (citing 65 Fed. Reg. 50, 548 (2000)).

[8] *Id.*

[9] *Id.* (citing *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008)).

[10] *Id.*

> A provider . . . has a right to a Board hearing . . . for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination only if . . . [t]he provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue. . .

In this case, the Provider does not appear to have requested a realignment of the SSI calculation and the Medicare Contractor has not made a final determination regarding the DSH SSI Provider Specific issue. Under 42 C.F.R. § 412.106(b)(3), a hospital can, if it prefers, use its cost reporting period data instead of the federal fiscal year data in determining the DSH Medicare fraction. The decision to use its own cost reporting period is the hospitals alone, which then must submit a written request to the Medicare Contractor. Without these requests it is not possible for the Medicare Contractor to have issued a final determination from which any of the Providers 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.

In addition, the majority of the DSH SSI Provider Specific issue is duplicative of the already transferred Systemic Errors issue. The Provider contends in the SSI Provider Specific issue statement that the "Medicare Contractor did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[11] The SSI Systemic Errors issue statement also argues that "the SSI percentages calculated by the Centers for Medicare and Medicaid Services and used by the Lead Medicare Contractor to settle their Cost Report was incorrectly computed."[12]

The SSI Systemic Errors issue has been transferred to a group appeal and no longer remains pending. Therefore because the DSH SSI (Provider Specific) issue is duplicative of the Systemic Errors issue and the Medicare Contractor has not made a final determination from which Franklin Woods Community Hospital could appeal, the Board finds that it lacks jurisdiction over the issue and dismisses the issue from case number 14-3002. As no issues remain, case number 14-3022 is now closed.

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

Board Members:
L. Sue Andersen, Esq.
Gregory H. Ziegler
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Jack Ahern, M.B.A.

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: Scott Berends, FSS

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[11] *See* Provider's Individual Appeal Request at Tab 3, Issue 1 and Issue 2.
[12] *Id.* at Issue 2.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Refer to: 15-2504

AUG 2 2 2017

CERTIFIED MAIL

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Cahaba GBA
c/o National Government Services, Inc.
Barb Hinkle
Appeals Lead
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

RE: Franklin Woods Community Hospital
Provider No.: 44-0184
FYE: 06/30/2012
PRRB Case No.: 15-2504

Dear Mr. Ravindran and Ms. Hinkle,

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

Background:

The Board received an individual appeal request from the Provider, Franklin Woods Community Hospital, on April 29, 2015; based on a Notice of Program Reimbursement ("NPR") from the Medicare Contractor dated October 30, 2014. The Provider appealed eight issues, which included the Disproportionate Share Hospital (DSH) Payment/ Supplemental Security Income (SSI) Percentage (Provider Specific) issue, SSI Systemic Errors issue, and DSH Payment – Medicaid Eligible Days issue. On December 7, 2015, the Board received the Provider's request to transfer the SSI Systemic Errors issue to 16-0284GC. Two issues remain in the appeal: DSH Payment/SSI Percentage (Provider Specific) and DSH Payment – Medicaid Eligible Days.

Board's Decision:

The Board finds that it does not have jurisdiction over the DSH SSI Provider Specific issue as it is duplicative and there is no final determination. 42 C.F.R. § 405.1835 (2012) states,

> A provider . . . has a right to a Board hearing . . . for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination only if . . . [t]he provider has preserved its right to claim dissatisfaction with

the amount of Medicare payment for the specific item(s) at issue. . .

In this case, the Provider does not appear to have requested a realignment of the SSI calculation and the Medicare Contractor has not made a final determination regarding the DSH SSI Provider Specific issue. Under 42 C.F.R. § 412.106(b)(3), a hospital can, if it prefers, use its cost reporting period data instead of the federal fiscal year data in determining the DSH Medicare fraction. The decision to use its own cost reporting period is the hospitals alone, which then must submit a written request to the Medicare Contractor. Without these requests it is not possible for the Medicare Contractor to have issued a final determination from which any of the Providers 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.

In addition, the majority of the DSH SSI Provider Specific issue is duplicative of the already transferred Systemic Errors issue. The Provider contends in the SSI Provider Specific issue statement that the "Medicare Contractor did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[1] The SSI Systemic Errors issue statement also argues that "the SSI percentages calculated by the Centers for Medicare and Medicaid Services and used by the Lead Medicare Contractor to settle their Cost Report was incorrectly computed."[2]

The SSI Systemic Errors issue has been transferred to a group appeal and no longer remains pending in this appeal. Therefore because the DSH SSI (Provider Specific) issue is duplicative of the Systemic Errors issue and the Medicare Contractor has not made a final determination from which Franklin Woods Community Hospital could appeal, the Board finds that it lacks jurisdiction over the issue and dismisses the issue from case number 15-2504.

Case number 15-2504 will remain open because the Medicaid Eligible Days issue is still pending in this appeal.

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

Board Members:
L. Sue Andersen, Esq.
Gregory H. Ziegler
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Jack Ahern, M.B.A.

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: Scott Berends, FSS

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[1] *See* Provider's Individual Appeal Request at Tab 3, Issue 1 and Issue 2.
[2] *Id.* at Issue 2.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
1508 Woodlawn Drive, Suite 100
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Refer to: 14-2766

AUG 2 2 2017

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Barb Hinkle
Appeals Lead
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

RE: North Side Hospital
Provider No.: 44-0184
FYE: 06/30/2010
PRRB Case No.: 14-2766

Dear Mr. Ravindran and Ms. Hinkle,

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

Background:

The Board received an individual appeal request from the Provider, North Side Hospital, on March 4, 2014; based on a Notice of Program Reimbursement ("NPR") from the Medicare Contractor issued September 4, 2013. The Provider appealed nine issues, which included the Disproportionate Share Hospital (DSH) Payment/ Supplemental Security Income (SSI) Percentage (Provider Specific) issue, SSI Systemic Errors issue, and DSH Payment – Medicaid Eligible Days issue. On October 9, 2014, the Board received the Provider's request to transfer the SSI Systemic Errors issue to 14-3954GC. Two issues remain in the appeal: DSH Payment/SSI Percentage (Provider Specific) and DSH Payment – Medicaid Eligible Days.

Board's Decision:

Issue 1: DSH SSI Provider Specific issue

The Board finds that it does not have jurisdiction over the DSH SSI Provider Specific issue as it is duplicative and there is no final determination. 42 C.F.R. § 405.1835 (2012) states,

> A provider . . . has a right to a Board hearing . . . for specific items claimed for

> a cost reporting period covered by an intermediary or Secretary determination only if . . . [t]he provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue. . .

In this case, the Provider does not appear to have requested a realignment of the SSI calculation and the Medicare Contractor has not made a final determination regarding the DSH SSI Provider Specific issue. Under 42 C.F.R. § 412.106(b)(3), a hospital can, if it prefers, use its cost reporting period data instead of the federal fiscal year data in determining the DSH Medicare fraction. The decision to use its own cost reporting period is the hospitals alone, which then must submit a written request to the Medicare Contractor. Without these requests it is not possible for the Medicare Contractor to have issued a final determination from which any of the Providers 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.

In addition, the majority of the DSH SSI Provider Specific issue is duplicative of the already transferred Systemic Errors issue. The Provider contends in the SSI Provider Specific issue statement that the "Medicare Contractor did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[1] The SSI Systemic Errors issue statement also argues that "the SSI percentages calculated by the Centers for Medicare and Medicaid Services and used by the Lead Medicare Contractor to settle their Cost Report was incorrectly computed."[2]

The SSI Systemic Errors issue has been transferred to a group appeal and no longer remains pending. Therefore because the DSH SSI (Provider Specific) issue is duplicative of the Systemic Errors issue and the Medicare Contractor has not made a final determination from which Bellflower Medical Center could appeal, the Board finds that it lacks jurisdiction over the issue and dismisses the issue from case number 14-2766.

Issue 2: Medicaid Eligible Days

The Board finds that it does not have jurisdiction over the Medicaid eligible days issue in this appeal. The Provider did not protest the Medicaid eligible days currently under appeal on its cost report. The Provider references Audit Adjustment numbers 1, 13, 21, 25, 26, and S-D in its appeal request for the eligible days issue. The adjustments cited are to adjust Medicare days for adults and peds., HMO, and Intensive Care Unit to the PS&R report. There is no adjustment to Medicaid eligible days. In addition, the Provider indicates that the eligible days were self-disallowed. As the FYE under appeal is 6/30/2010, if the Provider did not make a specific claim for the days, the Board could only have jurisdiction over those days if the Provider included the days as a protested item as required by 42 C.F.R. §§ 405.1835(a)(1).

The Board finds that the Provider did not include a claim for the specific days at issue in this appeal on its cost report, nor did they include those days as a protested amount, therefore it does

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[1] *See* Provider's Individual Appeal Request at Tab 3, Issue 1 and Issue 2.
[2] *Id.* at Issue 2.

not have jurisdiction over the Medicaid eligible day in the appeal. The Medicaid eligible days issue is thereby dismissed.

As both remaining issues in the appeal have been dismissed, there are no issues remaining in Case No. 14-2766. The appeal is now closed. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:
L. Sue Andersen, Esq.
Gregory H. Ziegler
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Jack Ahern, M.B.A.

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: Scott Berends, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

AUG 2 2 2017

Certified Mail

Joseph Gemperline
Healthcare Management Solutions, Inc.
924 D and RG Drive
Durango, CO 81393

RE: **Expedited Judicial Review Request Determination**[1]

08-2109GC VHS 2005-2006 DSH Part C Days Group
13-1096GC PHH 2008 DSH Medicaid Fraction Group
14-2942GC PHH 2010 DSH Medicaid Fraction Group
15-1758GC PHH 2011 DSH Medicaid Fraction Group

Individual Appeals

08-1621 Tri City Medical Center, Provider No. 05-0128, FYE 6/30/2006
08-2731 Tri City Medical Center, Provider No. 05-0128, FYE 6/30/2007

Dear Mr. Gemperline:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' July 28, 2017 request for expedited judicial review (EJR) (received August 1, 2017) for the above-referenced appeals. The Board's determination is set forth 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 [Supplemental Security Income] fraction and excluded from the Medicaid fraction numerator or vice-versa.[2]

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").[3] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[4]

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[1] The EJR request included case number 09-1742GC, VHS DSH Medicare Non-Covered Days Group. The Board sent a letter asking for additional information to make a jurisdictional determination. The EJR in that case will be reviewed upon receipt of the additional information.
[2] July 28, 2017 EJR Request at 1.
[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[5] 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.[6]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[7] 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.[8] The DPP is defined as the sum of two fractions expressed as percentages.[9] 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.[10]

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

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

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

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

Medicare Advantage Program

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

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

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

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

With the creation of Medicare Part C in 1997,[15] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.[16]

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[11] 42 C.F.R. § 412.106(b)(4).
[12] of Health and Human Services
[13] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).
[14] *Id.*
[15] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[16] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).

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)[17]

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

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

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.[20] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule. As a result, Part C days were required to be included in the Medicare fraction as of October 1, 2004.

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[17] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).
[18] 69 Fed. Reg. at 49,099.
[19] *Id.*
[20] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius,*[21] 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.[22]

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

In *Allina I*, the Court affirmed the district court's decision "that the Secretary's final rule was not a logical outgrowth of the proposed rule."[24] 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. The Providers contend that since the Secretary has not acquiesced to the decision in *Allina*, the regulations requiring Part C days be included in the Part A/SSI fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B). The Board remains bound by the regulation. Hence, EJR is appropriate.

Decision of the Board

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

Jurisdictional Determination

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2005, 2006, 2007, 2008, 2010 and 2011.

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[21] 746 F. 3d 1102 (D.C. Cir. 2014).
[22] June 26, 2017 EJR Request at 1.
[23] 69 Fed. Reg. at 49,099.
[24] *Allina* at 1109.

For purposes of Board jurisdiction over a participant's appeals filed from a cost reporting period that ends on or before December 30, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[25] With respect to a participant's appeals filed from a cost reporting period that ends on or after December 31, 2008, in order to demonstrate dissatisfaction with the amount of Medicare payment for the appealed issue, a participant filing an appeal from an original NPR must show that the Medicare contractor adjusted its SSI fraction when it settled the participant's cost report or the participant must have self-disallowed the appealed issue by filing its cost report under protest.[26]

The Board has determined that participants involved with the instant EJR request have had Part C days excluded from the Medicaid fraction, had a specific adjustment to the SSI fraction, or properly protested the appealed issue such that the Board has jurisdiction to hear their respective appeals. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[27] or $10,000 as required for an individual appeal. The appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeals in this EJR request span fiscal years 2005, 2006, 2007, 2008, 2010 and 2011, 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.

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 participants in these group appeals are entitled to a hearing before the Board;

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

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

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[25] 108 S.Ct. 1255 (1988).
[26] *See* 42 C.F.R. § 405.1835 (2008).
[27] *See* 42 C.F.R. § 405.1837.

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:

Clayton J. Nix, Esq.
Jack Ahern, MBA, CHFP
Gregory H. Ziegler

FOR THE BOARD:

Board Member

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

cc: Evaline Alcantara, Noridian (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

Refer to: 14-1123

AUG 25 2017

CERTIFIED MAIL

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

Cahaba GBA
c/o National Government Services, Inc.
Barb Hinkle
Appeals Lead
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

RE: Franklin Woods Community Hospital
Provider No.: 44-0184
FYE: 06/30/2009
PRRB Case No.: 14-1123

Dear Mr. Ravindran and Ms. Hinkle,

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

Background:

The Board received an individual appeal request from the Provider, Franklin Woods Community Hospital, on November 29, 2013; based on a Notice of Program Reimbursement ("NPR") issued by the Medicare Contractor on June 5, 2013. The Provider appealed nine issues, which included the Disproportionate Share Hospital (DSH) Payment/ Supplemental Security Income (SSI) Percentage (Provider Specific) issue, SSI Systemic Errors issue, and DSH Payment – Medicaid Eligible Days issue. On August 14, 2014, the Board received the Provider's request to transfer the SSI Systemic Errors issue to 14-3113GC. Two issues remain in the appeal: DSH Payment/SSI Percentage (Provider Specific) and DSH Payment – Medicaid Eligible Days.

Medicare Contractor's Jurisdictional Challenge:

The Medicare Contractor filed a jurisdictional challenge on December 1, 2014 for both the SSI-Provider Specific issue and the DSH Medicaid Eligible Days issue.

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

The MAC contends that no request for SSI realignment has been submitted to the Medicare Contractor for this Provider or cost reporting period.[1] The MAC contends that no evidence has been provided to show that errors were made in the calculation of the SSI ratio; therefore, suggesting that the Provider's request for an appeal is based on speculation. The Medicare Contractor states that because the Provider failed to properly request a realignment of the SSI ratio; the request is premature. The MAC requests that the Board dismiss the issue and close the case.

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

For the issue of eligible days, the MAC argues that the Provider failed to include all Medicaid eligible days on the cost report. No audit of Medicaid eligible days was performed, and the provider received reimbursement for the amount claimed. The MAC's position is that 42 C.F.R. § 405.1801 and § 405.1803 require an identifiable adverse finding in order for the Board to have jurisdiction. In addition § 405.1835(a) requires a provider to make a claim on its cost report, either specifically for payment or as a protested item. The Provider did not report unclaimed Medicaid days as a protested amount. The MAC concludes that as the Provider failed to make a claim for the days under appeal either for payment or as protested item, the Board would lack jurisdiction.

Provider's Response to Jurisdictional Challenge:

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

The Provider contends that the MAC is incorrect when arguing that the DSH/SSI realignment issue is not an appealable issue.[2] The Provider states that the Provider is addressing not only a realignment of the SSI percentage but also addressing various errors of omission and commission that do not fit into the "systemic errors" category.[3] Thus, the Provider argues that this is an appealable item because the Medicare Contractor specifically adjusted the Provider's SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year end ("FYE") as a result of its understated SSI percentage.[4]

Further, the Provider asserts that in *Northeast Hospital Corporation v. Sebelius*, the Centers for Medicare and Medicaid Services ("CMS") abandoned the CMS Administrator's December 1, 2008 decision. 657 F.3d 1 (D.C. Cir. 2011).[5] The decision here that was abandoned was that the SSI ratio cannot be revised based upon updated data after it has been calculated by CMS.[6] Thus, the Provider reasons that the Provider can submit data to prove its SSI percentage was understated.[7] However, the Provider mentions that, to this point, the Provider has been unable to submit such data because CMS has not released the Medicare Part A or Medicare Provider

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[1] Medicare Contractor's Jurisdictional Challenge at II. Issue #1.
[2] *See* Provider's Jurisdictional Response at 3.
[3] *Id.*
[4] *Id.*
[5] *Id.*
[6] *Id.* at 3-4.
[7] *Id.* at 4.

Analysis and Review ("MEDPAR") data—HHS/HCFA/OIS, 09-07-009, published in the Federal Register on August 18, 2000—in support of the SSI percentage.[8]

The Provider contends that CMS has just now started releasing the MEDPAR data, but the Provider has not yet received its MEDPAR data and has been unable to reconcile its records with that of CMS.[9] The Provider argues that it is unable to specifically identify patients believed to be entitled both to Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal FYE (September 30) when it determined the Provider's SSI percentage.[10] The Provider states that though the Provider may choose to request realignment, this still will not correct these errors of omission and commission that are understating the Provider's SSI percentage.[11] Therefore, the Provider requests that the Board finds that it has jurisdiction over the DSH/SSI "provider specific" and realignment sub-issues.[12] The Provider also argues that there was an adjustment to DSH at Audit Adjustment Numbers 15 and 16. According to The Provider, such an adjustment over the SSI Provider Specific issue.

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

The Provider argues that it was unnecessary for the Medicare Contractor to adjust its DSH payments to give rise to jurisdiction over the eligible days issue. The Provider states that the necessary documentation in order to pursue DSH is often not available from the State in time to include all DSH/Medicaid Eligible Days on the cost report. Accordingly, the Provider also self-disallowed DSH in the cost report in according with the Board Rule 7.2(B).

Board's Decision:

Issue 1: DSH SSI Provider Specific issue

The Board finds that it does not have jurisdiction over the DSH SSI Provider Specific issue as it is duplicative and there is no final determination. 42 C.F.R. § 405.1835 (2012) states,

> A provider . . . has a right to a Board hearing . . . for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination only if . . . [t]he provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue. . .

In this case, the Provider does not appear to have requested a realignment of the SSI calculation and the Medicare Contractor has not made a final determination regarding the DSH SSI Provider Specific issue. Under 42 C.F.R. § 412.106(b)(3), a hospital can, if it prefers, use its cost reporting period data instead of the federal fiscal year data in determining the DSH Medicare fraction. The decision to use its own cost reporting period is the hospitals alone, which then must submit a written request to the Medicare Contractor. Without these requests it is not possible for the

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[8] *Id.* (citing 65 Fed. Reg. 50, 548 (2000)).
[9] *Id.* at 4.
[10] *Id.* (citing *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008)).
[11] *Id.* at 4.
[12] *Id.*

Medicare Contractor to have issued a final determination from which any of the Providers 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.

In addition, the majority of the DSH SSI Provider Specific issue is duplicative of the already transferred Systemic Errors issue. The Provider contends in the SSI Provider Specific issue statement that the "Medicare Contractor did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[13] The SSI Systemic Errors issue statement also argues that "the SSI percentages calculated by the Centers for Medicare and Medicaid Services and used by the Lead Medicare Contractor to settle their Cost Report was incorrectly computed."[14]

The SSI Systemic Errors issue has been transferred to a group appeal and no longer remains pending. Therefore because the DSH SSI (Provider Specific) issue is duplicative of the Systemic Errors issue and the MAC has not made a final determination from which Franklin could appeal, the Board finds that it lacks jurisdiction over the issue and dismisses it from case 14-1123.

Issue 2: Medicaid Eligible Days

The Board finds that it does not have jurisdiction over the Medicaid eligible days issue in this appeal. The Provider did not claim for payment or protest the Medicaid eligible days currently under appeal on its cost report. The Provider references Audit Adjustment numbers 2, 15, and 16 in its appeal request for the eligible days issue. These adjustments are to update the Medicare claims data from the PS&R report, and to update the SSI% and the DSH percentage based on the change in SSI%. There are no adjustments related to Medicaid data. In addition, the Provider indicated in the appeal request and the jurisdictional response that the eligible days were self-disallowed. For cost reporting periods ending after 12/31/2008, providers can no longer self disallow by failing to claim, as 42 C.F.R. §§ 405.1835(a) is clear that a claim must be made on the cost report.

As the Board finds that it does not have jurisdiction over the SSI Provider Specific and eligible days issues, Case No. 14-1123 will be closed as there are no remaining issues. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:
L. Sue Andersen, Esq.
Gregory H. Ziegler
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Jack Ahern, M.B.A.

FOR THE BOARD

L. Sue Andersen
Chairperson

[13] *See* Provider's Individual Appeal Request at Tab 3, Issue 1 and Issue 2.
[14] *Id.* at Issue 2.

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

cc: Scott Berends, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Refer to: 00-1229GC

CERTIFIED MAIL

AUG 25 2017

Nan Chi, Director - Budget & Compliance
Houston Methodist Hospital System
8100 Greenbriar GB240
Houston, TX 77054

RE: Reconsideration Request/Request for Expedited Judicial Review
Methodist HCS 91-94, 03-05 DSH/SSI Proxy Group
Provider No.: Various
FYE: Various
PRRB Case No.: 00-1229GC

Dear Ms. Chi:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed Methodist HCS 91-94, 03-05 DSH/SSI[1] Proxy Group's ("Methodist's") request that the Board reconsider its decision to remand the above-referenced group appeal. If the Board chooses to reconsider its decision and reinstate the group appeal, Methodist asks that the Board then consider its request for expedited judicial review ("EJR") of the issue. Upon review, the Board denies Methodist's request to reconsider its remand and reinstate the instant group appeal because the Board no longer has jurisdiction over the issue for the fiscal years involved in the request. As the Board does not have jurisdiction over the issue, the Board is also unable to grant Methodist's request for EJR, as explained below.

Pertinent Facts

On February 22, 2000, the Board received Methodist's request to form a group appeal regarding the following issue: "[w]hether the SSI percentage (proxy) used to compute Medicare Disproportionate Share (DSH) Payments was in accordance with the Provider's underlying records." Subsequently, by letter dated June 10, 2013, Methodist requested that the Board remand its SSI percentage issue pursuant to the Centers for Medicare & Medicaid Services' ("CMS") Ruling 1498-R ("CMS-1498-R"). The Board issued Methodist's remand letter on March 5, 2014, and on November 16, 2015, the Board received Methodist's "Reconsideration Request[/]Request for Expedited Judicial Review" ("Request").

Methodist summarizes its Request in its cover letter by stating that the "Provider contends that reconsideration is necessary as there is a conflict between the regulations and CMS Ruling 1498-R for which only a court has the authority to resolve." Methodist claims that "remand is inappropriate given the conflict[,]" and that "EJR would be appropriate." Methodist concludes its Request by stating that

[1] "DSH" stands for "Disproportionate Share Hospital" and "SSI" stands for "Supplemental Security Income."

> The Providers respectfully request that the Board reconsider and withdraw its . . . order remanding this case to [the] MAC, and instead grant the petition for EJR so that the lawfulness of CMS Ruling 1498-R and the instructions contained therein can be determined by the U.S. District Court for the District of Columbia.[2]

Board's Analysis and Decision

On March 5, 2014, the Board issued a jurisdictional determination for the providers within the Methodist HCS 91-94, 03-05 DSH/SSI Proxy Group. For those providers with jurisdictionally valid appeals that met the standard for remand under CMS Ruling 1498-R ("CMS-1498-R" or "the Ruling"), the Board also issued a remand order of the same date. In considering Methodist's two-part Request currently before the Board, the Board must first consider whether it has jurisdiction to reinstate the providers' group appeal following its remand, pursuant to CMS-1498-R, to the Medicare contractor.

Under 42 C.F.R. § 401.108(b)-(c) (2011), 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. Accordingly, CMS Rulings are binding on all Department of Health and Human Services, Social Security Administration and CMS components that adjudicate matters under the jurisdiction of CMS. Medicare appeals tribunals such as the PRRB, the Medicare contractors and CMS reviewing officials are all examples of CMS components that adjudicate matters under the jurisdiction of CMS, thus the Medicare appeals tribunals are all bound by CMS Rulings. In addition, under 42 C.F.R. § 405.1867 (2011), in exercising its authority to conduct proceedings, the PRRB must comply with all 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 CMS Administrator.

On April 28, 2010, the CMS Administrator issued CMS-1498-R in order to address three specific Medicare DSH issues. One of these issues involved CMS' processes for matching Medicare and SSI eligibility data when calculating providers' SSI fractions. With respect to this data matching process issue, the Ruling requires that the Medicare appeals tribunal remand each qualifying appeal of this issue to the appropriate Medicare contractor. Upon remand, CMS and the Medicare contractor will apply a revised data matching process and recalculate each provider's DSH payment adjustment.[3]

Under the terms of the Ruling, by effectuating this remand, the CMS Administrator "eliminates any case or controversy regarding the hospital's previously calculated SSI fraction and DSH payment adjustment and thereby renders moot each properly pending claim in a DSH appeal involving the hospital's previously calculated SSI fraction and the process by which CMS matches Medicare and SSI eligibility data, provided that such claim otherwise satisfies the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines." The Ruling further provides "that the PRRB

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[2] Request at 28.
[3] CMS 1498-R at 6-7.

and the other administrative tribunals lack jurisdiction over each properly pending claim on the SSI fraction data matching process issue, provided that such claim otherwise satisfies the applicable jurisdictional and procedural requirements for appeal."[4]

In exercising its authority to conduct proceedings, such as hearings, the Board must comply with and is bound by the directives set out in CMS Rulings issued under the authority of the CMS Administrator. Here, within CMS-1498-R, the CMS Administrator has spoken directly on the issue of Board jurisdiction over a provider's SSI percentage issue that is subject to the mandatory remand. In the present case, once the Board initially determined that the providers' SSI Percentage issue for fiscal years 2003-2004 and 2006 was within CMS-1498-R's mandates, the Board no longer had jurisdiction over the issue and was required to remand the issue to the Medicare contractor. Nothing within CMS-1498-R indicates that the Board may reassume jurisdiction over this issue once it has been remanded. In fact, CMS-1498-R states that upon remand, "CMS' action eliminates any actual case or controversy regarding the hospital's previously calculated SSI fraction and DSH payment adjustment and thereby renders moot each properly pending claim in a DSH appeal involving the hospital's previously calculated SSI fraction and the process by which CMS matches Medicare and SSI eligibility data . . ."[5]

Accordingly, the Board is precluded from reinstating Methodist's appeal regarding the SSI fraction data matching issue because, according to the text of CMS-1498-R, the Board lacks jurisdiction over the issue. As the Board is without authority to reinstate the appeal for this issue, the Board is also unable to grant Methodist's EJR request.

Board Members Participating:
L. Sue Andersen, Esq.
Clayton J. Nix, Esq.
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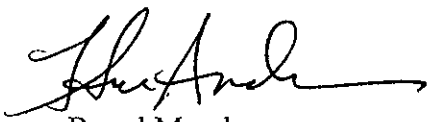
For the Board:



Board Member

cc: Bill Tisdale, Novitas Solutions, Inc.
Wilson Leong, Federal Specialized Services

[4] CMS 1498-R at 6-7.
[5] *Id.* at 6.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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AUG 28 2017

Certified Mail

Christopher L. Keough
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RE: **Expedited Judicial Review Determination**
CHI 2009 DSH SSI Fraction Denominator Part C Days Group, PRRB Case No. 13-0876GC
CHI 2009 DSH Medicare Advantage Days Group, PRRB Case No. 13-0877GC

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' August 2, 2017 request for expedited judicial review (EJR) (received August 3, 2017) for the above-referenced appeals.[1] The Board's determination is set forth 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 [Supplemental Security Income] fraction and excluded from the Medicaid fraction numerator or vice-versa.[2]

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").[3] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[4]

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[5] These cases involve the hospital-specific DSH adjustment, which requires the

[1] The August 2, 2017 EJR request listed a third case in the reference line of the letter. The determination in that case, PRRB case number 13-1187GC, is being addressed in separate correspondence.
[2] August 2, 2017 EJR Request at 4.
[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*
[5] *See* 42 U.S.C. § 1395ww(d)(5).

Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[6]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[7] 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.[8] The DPP is defined as the sum of two fractions expressed as percentages.[9] 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.[10]

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

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

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

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

Medicare Advantage Program

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

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

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

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

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

With the creation of Medicare Part C in 1997,[15] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.[16]

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the 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)[17]

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

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

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

[16] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).

[17] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).

[18] 69 Fed. Reg. at 49,099.

> *beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[19] (emphasis added)

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.[20] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule. As a result, Part C days were required to be included in the Medicare fraction as of October 1, 2004.

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

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.[23]

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[19] *Id.*
[20] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[21] 746 F. 3d 1102 (D.C. Cir. 2014).
[22] August 2, 2017 EJR Request at 1.
[23] 69 Fed. Reg. at 49,099.

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

In these cases, the Providers contend that all Part C days should be excluded from the Part A/SSI fraction and the Medicaid-eligible Part C days should be included in the numerator of the Medicaid fraction. To obtain relief, the Providers seek a ruling on the procedural and substantive validity of the 2004 rule that the Board lacks the authority to grant. The Providers maintain that since the Secretary has not acquiesced to the decision in *Allina*, the Board remains bound by the regulation. Hence, EJR is appropriate.[25]

Decision of the Board

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

Jurisdictional Determination

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal year 2009.

For purposes of Board jurisdiction over a participant's appeals filed from a cost reporting period that ends on or after December 31, 2008, in order to demonstrate dissatisfaction with the amount of Medicare payment for the appealed issue, a participant filing an appeal from an original NPR must show that the Medicare contractor adjusted its SSI fraction when it settled the participant's cost report or the participant must have self-disallowed the appealed issue by filing its cost report under protest.[26] For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.[27] The Board notes that all participants' revised NPR appeals included within this EJR request were issued after August 21, 2008.

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[24] *Allina* at 1109.
[25] *See also Allina Health Services v. Price*, 2017 WL 3137996 (D.C. Cir. July 25, 2017)
[26] *See* 42 C.F.R. § 405.1835(a) (2008).
[27] See 42 C.F.R. § 405.1889(b)(1) (2008).

The Board has determined that participants involved with the instant EJR request have had Part C days excluded from the Medicaid fraction, had a specific adjustment to the SSI fraction, or properly protested the appealed issue such that the Board has jurisdiction to hear their respective appeals. The Providers which filed appeals from revised NPRs have adjustments to the SSI percentage, as required for jurisdiction. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[28] and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The group appeals in this EJR request involve fiscal year 2009, thus the appealed cost reporting period falls 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.

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

[28] *See* 42 C.F.R. § 405.1837.

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 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 these cases.

Board Members Participating:

L. Sue Anderson, 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)
Schedules of Providers

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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AUG 2 8 2017

Certified Mail

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RE: **Expedited Judicial Review Determination**
SWC 2011 DSH Medicaid Fraction Part C Days Group II, PRRB Case No. 15-0042G
SWC 2011 DSH SSI Fraction Part C Days Group II, PRRB Case No. 15-0041G

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' August 1, 2017 request for expedited judicial review (EJR) (received August 3, 2017) for the above-referenced appeals. The Board's determination in both cases with respect to the request for EJR and jurisdiction over Provider # 29, Aria Health, is set forth below.

The issue in this appeal 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 [Supplemental Security Income] fraction and excluded from the Medicaid fraction numerator 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]

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[4] These cases involve the hospital-specific DSH adjustment, which requires the

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

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 the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors 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 addcd)

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[5] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(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).

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.[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 Medicare contractors to calculate DSH payments for the fiscal year 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 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."[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 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] The Providers point out that because the Secretary has not acquiesced to the decision, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

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

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[18] *Id.*
[19] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[20] 746 F. 3d 1102 (D.C. Cir. 2014).
[21] August 1, 2017 EJR Requests 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. The Providers maintain that 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

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

Jurisdictional Determination

29 Aria Health (provider number 39-0115) (case number 15-0041G)
27 Aria Health (provider number 39-0115) (case number 15-0042G)

The Provider was directly add to these group appeals through correspondence dated March 2, 2016 (received March 4, 2016). The Provider's Notice of Program Reimbursement was issued September 25, 2016. The Provider identified adjustments 49 and 50 as the subject of this appeal, which are adjustments to Worksheets S-2 and S-3. There is no evidence that Provider protested the inclusion of Part C Days in the DSH calculation through Worksheet E, Part A.

The regulation, 42 C.F.R. § 405.1835(a)(1)(ii) (2008), requires that effective with cost reporting periods ending on or after December 31, 2008, a provider preserves its right to claim dissatisfaction with the amount of Medicare reimbursement by including a claim for payment it believes is in accordance with Medicare policy or self-disallowing the specific items by filing the costs under protest on their cost reports.

The Provider appealed an NPR that did not adjusted the SSI payment or Part C Days as required for Board nor did the audit adjustments appealed demonstrate that the Provider had protested the inclusion of Part C days in the Medicare fraction of the DSH adjustment on Worksheet E, Part A. Consequently, the Board concludes that it lacks jurisdiction over Aria Health (provider number 39-0115) in both cases and dismisses the Provider from case numbers 15-0041G and 15-0042G. Since jurisdiction is a prerequisite to granting a providers request for EJR. Aria Health's request for EJR is hereby denied in both 15-0041G and 15-0042G. *See* 42 C.F.R. § 405.1842(a) and (f)(2)(i).

EJR and Jurisdictional Determination for the Remaining Providers

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal year 2011.

The Board has determined that the remaining participants involved with the instant EJR which appealed from original NPRs had a specific adjustment to the SSI fraction or protested the issue as required by 42 C.F.R. § 405.1835(a)(1)(ii). As a result, the Board has jurisdiction to hear their respective appeals. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[24] and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The group appeals in this EJR request involves fiscal year 2011, 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.

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

[24] *See* 42 C.F.R. § 405.1837.

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 Anderson, Esq
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler

FOR THE BOARD:

L. Sue Andersen
Chairperson

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

cc: Danene Hartley, NGS(Certified Mail w/Schedule of Providers)
Wilson Leong, (w/Schedule of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Refer to: 13-2180

AUG 2 8 2017

CERTIFIED MAIL

Corinna Goron
Healthcare Reimbursement Services, Inc.
President
c/o Appeals Department
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Dallas, TX 75248-1372

Evaline Alcantara
Noridian Healthcare Solutions
Appeals Coordinator – Jurisdiction E
P.O. Box 6782
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RE: Paradise Valley Hospital
Provider No.: 05-0024
FYE: 12/31/2007
PRRB Case No.: 13-2180

Dear Ms. Goron and Ms. Alcantara,

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

Background:

The Board received an individual appeal request from the Provider, Paradise Valley Hospital, on May 21, 2013, based on a Notice of Program Reimbursement ("NPR") issued by the Medicare Contractor on November 20, 2012. The Provider appealed six issues, including the SSI Provider Specific issue. The Provider transferred the Rural Floor Budget Neutrality Adjustment issue to a group.

The Provider's Preliminary Position Paper was due to the Medicare Contractor on February 1, 2014. The Board received a copy of the first page of the Preliminary Position Paper on January 23, 2014. The Position Paper stated that the Provider would only be briefing the SSI Provider specific issue. On February 14, 2014, the Board received the Provider's "supplemental edition" of the Preliminary Position Paper, which stated that the Provider "inadvertently failed to brief all of the issues related to the DSH/SSI Percentage."

Board's Decision:

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

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

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

The first aspect of the SSI Percentage (Provider Specific) issue—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the Systemic Errors issue that was allegedly transferred to a group appeal.[1] Because the Board received a transfer request form only for the Rural Floor Budget Neutrality Adjustment issue (and not for the Systemic Errors issue), it is unclear whether the Systemic Errors issue was actually transferred to a group appeal or whether that issue was abandoned.[2] Thus, this first aspect of the SSI Percentage (Provider Specific) issue is hereby dismissed by the Board because it is duplicative of the Systemic Errors issue or because the Provider abandoned the Systemic Errors issue and thereby lost its appeal rights.

To explain this further, the SSI Percentage (Provider Specific) issue concerns "whether the Medicare Contractor "used the correct [SSI] percentage in the [DSH] calculation."[3] The Provider asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with 42 U.S.C. § 1395ww(d)(5)(F)(i)."[4] The Provider argues that the SSI percentage calculated by CMS "was incorrectly computed . . . ."[5] Similarly, the Systemic Errors issue which the Provider allegedly transferred to a group appeal is whether the "Secretary properly calculated the Provider's [DSH]/[SSI] percentage."[6] The Provider argues—with respect to the Systemic Errors issue—that the Medicare Contractor's "determination of Medicare Reimbursement for [its] DSH Payments [is] not in accordance with . . . 42 U.S.C. § 1395ww(d)(5)(F)(i)."[7] Moreover, the Provider claims that the SSI percentages were incorrect due to the availability of Medicare Provider Analysis and Review ("MEDPAR") and Social Security Administration ("SSA") records, and the consideration of paid days versus eligible days, to name a few reasons.[8] Therefore, the Provider's disagreement with how the Medicare Contractor calculated the SSI percentage is duplicative of the Systemic Errors issue which was allegedly filed into a group appeal. Because the Systemic Errors issue is allegedly in a group appeal (or was abandoned by the Provider), the Board hereby dismisses this aspect of the SSI Percentage (Provider Specific) issue.

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[1] *See* Provider's Preliminary Position Paper (Jan. 23, 2014) (stating that "[a]ll other issues have been transferred to various groups; therefore we are only briefing SSI Provider Specific").
[2] *See* Model Form D – Request to Transfer Issue to a Group Appeal (Sep. 20, 2013) (transferring one issue to a group appeal—the Rural Floor Budget Neutrality Adjustment issue (Group Case No. 13-3787GC)).
[3] Provider's Model Form A – Individual Appeal Request (May 21, 2013) at Issue 2.
[4] *Id.*
[5] *Id.*
[6] *Id.* at Issue 1.
[7] *Id.*
[8] *Id.*

The second aspect of the SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—should be dismissed by the Board for lack of jurisdiction. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use[s] its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes.

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

Issue No. 2: jurisdiction over the additional issues included in the Provider's supplemental edition of the Preliminary Position Paper

The Board finds that it does not have jurisdiction over the additional issues that the Provider included in the supplemental edition of the Provider's Preliminary Position Paper.

PRRB Rule 23.3 stipulates that if the parties to an appeal do not jointly execute a proposed Joint Scheduling Order ("JSO") by the due date, then the deadlines for the preliminary position papers in the Acknowledgement Letter control.[9] Furthermore, the commentary to PRRB Rule 23.3 states that "the Board expects preliminary position papers to be *fully developed* and include all available documentation necessary to give the parties a thorough understanding of their opponent's position" (emphasis added).[10] Thus, "new arguments and documents not included in the preliminary position paper may be excluded at the hearing," unless the parties demonstrate good cause.[11]

In this case, the deadline from the Acknowledgement Letter for the Provider to send its Preliminary Position Paper to the Medicare Contractor was February 1, 2014.[12] On January 23, 2014, the Board received the Provider's Preliminary Position Paper, which stated that the

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[9] Provider Reimbursement Review Board Rule 23.3 - Preliminary Position Papers Required if no proposed JSO is Executed (July 1, 2015).
[10] *Id.*
[11] *Id.*
[12] *See* Email from Carol J. Fox to the Provider, Medicare Contractor and Blue Cross Blue Shield (May 23, 2013 2:14 p.m. EST) (detailing in an Acknowledgement Letter the critical due date for the Provider's Preliminary Position Paper to be sent to the Medicare Contractor).

Provider would only be briefing the SSI Percentage (Provider Specific) issue.[13] However, on February 14, 2014, the Board received the Provider's supplemental edition of the Preliminary Position Paper, which stated that the Provider "inadvertently failed to brief all of the issues related to the DSH/SSI Percentage."[14] When applying PRRB Rule 23.3 and its commentary to these facts, the Board finds that the Provider erred by not including all issues being appealed in the Preliminary Position Paper that was received on January 23, 2014. Consequently, the Board finds that it does not have jurisdiction over the additional issues that the Provider included in its supplemental edition of the Preliminary Position Paper.

As the Board finds that it does not have jurisdiction over the SSI Provider Specific issue or the additional issues from the supplemental Preliminary Position Paper, Case No. 13-2180 is hereby closed.

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

Board Members:
L. Sue Andersen, Esq.
Gregory H. Ziegler
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Jack Ahern, M.B.A.

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: Wilson Leong, FSS

[13] *See* Provider's Preliminary Position Paper (Jan. 23, 2014) (stating that "[a]ll other issues have been transferred to various groups; therefore we are only briefing SSI Provider Specific").
[14] Provider's Supplemental Edition of the Preliminary Position Paper (addressed to Mr. Mike Smith of the Noridian Healthcare Solutions).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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AUG 28 2017

Certified Mail

Christopher L. Keough
Akin Gump Straus Hauer & Feld LLP
1333 New Hampshire Avenue, NW
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RE: **Expedited Judicial Review Determination**
CHI 2010 DSH Medicare Advantage Days Group
FYE 2010
PRRB Case No. 13-1187GC[1]

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' August 2, 2017 request for expedited judicial review (EJR) (received August 3, 2017) for the above-referenced appeal. The Board's determination with respect to the request for EJR and jurisdiction over the appeals of 2 revised Notices of Program Reimbursement (NPRs) issue to St. Francis Medical Center (lines #19 and #20 on the Schedule of Providers), is set forth below.

The issue in this appeal 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 [Supplemental Security Income] fraction and excluded from the Medicaid fraction numerator or vice-versa.[2]

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").[3] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[4]

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[5] These cases involve the hospital-specific DSH adjustment, which requires the

[1] The EJR request included case numbers 13-0876GC and 13-0877GC in addition to the case referenced above. The EJR determination for those cases is being sent under separate cover.
[2] August 2, 2017 EJR Request at 4.
[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*
[5] *See* 42 U.S.C. § 1395ww(d)(5).

Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[6]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[7] 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.[8] The DPP is defined as the sum of two fractions expressed as percentages.[9] 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.[10]

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

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

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

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

Medicare Advantage Program

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

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

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

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

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

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[11] 42 C.F.R. § 412.106(b)(4).
[12] of Health and Human Services
[13] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).
[14] *Id.*
[15] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered

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

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the 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)[17]

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

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

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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.

[16] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).

[17] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).

[18] 69 Fed. Reg. at 49,099.

> associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[19] (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.[20] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule. As a result, Part C days were required to be included in the Medicare fraction as of October 1, 2004.

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

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.[23]

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

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

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[19] *Id.*
[20] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[21] 746 F. 3d 1102 (D.C. Cir. 2014).
[22] August 2, 2017 EJR Request at 1.
[23] 69 Fed. Reg. at 49,099.
[24] *Allina* at 1109.

validity of the 2004 rule that the Board lacks the authority to grant. The Providers maintain that 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

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

Jurisdictional Determination

#19 St. Francis Medical Center (provider number 28-0023, FYE June 20, 2010)

The revised NPR under Tab 19-A of the jurisdictional documents was issued on September 6, 2013, and was appealed through a hearing request that received on March 5, 2014 (180 days). The Provider indicated that adjustment number 4 was the subject of the appeal.

The audit adjustment report indicates that adjustment 4 was made to include additional Medicaid days used to calculate the DSH adjustment. The adjustment increases the DSH percentage slightly. There is nothing in the record to document that Medicare Part C days were adjusted through audit adjustment number 4, nor is there an adjustment to the SSI percentage which would include Medicare Part C days.

The regulation, 42 C.F.R. 405.1889 (2008), states that a revised determination is a separate determination for purposes of appeal to the Board and only those matters specifically revised are with the scope of the appeal of the revised determination. Any matter not specifically revised may not be considered in the appeal of the revised determination.

Since the Provider appealed a revised NPR that did not adjusted the Medicare Part C days or SSI percentage as required for Board jurisdiction under 42 C.F.R. § 405.1889, the Board concludes that lacks jurisdiction over St. Francis Medical Center's September 6, 2013 revised NPR. The appeal of this revised NPR is hereby dismissed from the case. Since jurisdiction is a prerequisite to granting a provider's request for EJR, the request for EJR for St. Francis Medical Center's September 6, 2013 NPR is denied. *See* 42 C.F.R. § 405.1842(a) and (f)(2)(i).

#20 St. Francis Medical Center (provider number 28-0023, FYE June 20, 2010)

The revised NPR under Tab 20-A of the jurisdictional documents was issued on March 14, 2016, and was appeal in a hearing request was received on August 18, 2016 (157 days). The Provider indicated that adjustment numbers 5 and 6 were the subject of the appeal.

The audit adjustment report indicates that the adjustments was made to "include the hospital's Realignment SSI percentage."[25] The adjustment increases the DSH percentage slightly. The regulation dealing with realignment of the SSI percentage is found at 42 C.F.R. § 412.106(b)(3). This regulation permits a provider which prefers that CMS use its cost reporting period instead of the Federal fiscal year to compute its DSH adjustment to request this action though its Medicare Administrative Contractor. If a realignment is requested it becomes the hospital's official SSI percentage for the fiscal period.

The Board hereby dismisses the appeal of the St. Francis Medical Center's March 14, 2016 revised NPR because the issue appealed does not comply with the requirements of 42 C.F.R. § 405.1889. The regulation, 42 C.F.R. 405.1889 (2008), states that a revised determination is a separate determination for purposes of appeal to the Board and only those matters specifically revised are with the scope of the appeal of the revised determination. Any matter not specifically revised may not be considered in the appeal of the revised determination.

The Board concludes that the Provider appealed a revised NPR that did not specifically adjusted the Part C days or the SSI percentage which would include Part C Days, as required for Board jurisdiction under 42 C.F.R. § 405.1889. Reviewability of a revised NPR is issue specific. The reopening was to revise DSH adjustment so it was computed to correspond with the Provider's cost report year rather than the Federal fiscal. That issue is not the same as the Part C day issue. The data that CMS used to calculate the DSH payment based on the Providers fiscal year end rather than the Federal fiscal year did not change, only the period to which the data was applied changed. Consequently, the Board concludes that it lacks jurisdiction over the March 14, 2016 revised NPR and dismisses the appeal from the case. Since jurisdiction is a prerequisite to granting a providers request for EJR, the request for EJR of the March 14, 2016 revised NPR for St. Francis Medical Center is hereby denied. *See* 42 C.F.R. § 405.1842(a) and (f)(2)(i).

EJR and Jurisdictional Determination for the Remaining Providers

The participants that comprise the group appeal within this EJR request have filed appeals involving fiscal year 2010. For purposes of Board jurisdiction over a participant's appeals filed from a cost reporting period that ends on or after December 31, 2008, in order to demonstrate dissatisfaction with the amount of Medicare payment for the appealed issue, a participant filing an appeal from an original NPR must show that the Medicare contractor adjusted its SSI fraction when it settled the participant's cost report or the participant must have self-disallowed the appealed issue by filing its cost report under protest.[26] For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.[27] The Board notes that only remaining participant which appeal a revised NPR that was included within this EJR request was issued after August 21, 2008 and adjusted the cost as required.

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[25] Schedule of Providers and associated jurisdictional documents, Tab 20-D.
[26] *See* 42 C.F.R. § 405.1835 (2008).
[27] See 42 C.F.R. § 405.1889(b)(1) (2008).

The Board has determined that participants involved with the instant EJR request have had Part C days excluded from the Medicaid fraction, had a specific adjustment to the SSI fraction, or properly protested the appealed issue such that the Board has jurisdiction to hear their respective appeals. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[28] The appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The group appeals in this EJR request involves fiscal year 2010, 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.[29]

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 participants in this group appeals are entitled to a hearing before the Board except as otherwise noted above;

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

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

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

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[28] *See* 42 C.F.R. § 405.1837.
[29] *See also Allina Health Services v. Price*, 2017 WL 3137996 (D.C. Cir. July 25, 2017).

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 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 case.

Board Members Participating:

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

FOR THE BOARD:

L. Sue Andersen
Chairperson

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

cc: Bruce Synder, Novitas Solutions (Certified Mail w/Schedule of Providers)
Wilson Leong, (w/Schedule of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

AUG 2 8 2017

Certified Mail

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

RE: Expedited Judicial Review Request
Akin Gump/SWC DSH Part C Days Groups
FYEs 2009 and 2010
PRRB Case Nos. 13-0962GC, 13-0963GC, 14-3191GC and 14-3192GC

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' August 2, 2017 request for expedited judicial review (EJR) (received August 3, 2017) for the above-referenced appeals. The Board's determination is set forth 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 [Supplemental Security Income] fraction and excluded from the Medicaid fraction numerator 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]

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

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

provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[6]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[7] 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.[8] The DPP is defined as the sum of two fractions expressed as percentages.[9] 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.[10]

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

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

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

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

Medicare Advantage Program

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

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

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

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

With the creation of Medicare Part C in 1997,[15] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.[16]

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

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[12] of Health and Human Services
[13] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).
[14] *Id.*
[15] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[16] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).

> . . . 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)[17]

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

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

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.[20] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule. As a result, Part C days were required to be included in the Medicare fraction as of October 1, 2004.

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[17] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).
[18] 69 Fed. Reg. at 49,099.
[19] *Id.*
[20] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius,*[21] 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.[22]

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.[23]

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

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

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

Jurisdictional Determination

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2009 and 2010.

Participant's appeals filed from a cost reporting period that ends on or after December 31, 2008, in order to demonstrate dissatisfaction with the amount of Medicare payment for the appealed issue, a participant filing an appeal from an original NPR must show that the Medicare contractor adjusted its SSI fraction

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[21] 746 F. 3d 1102 (D.C. Cir. 2014).
[22] August 2, 2017 EJR Request at 1.
[23] 69 Fed. Reg. at 49,099.
[24] *Allina* at 1109.

when it settled the participant's cost report or the participant must have self-disallowed the appealed issue by filing its cost report under protest.[25] The Board has determined that participants involved with the instant EJR request have had Part C days excluded from the Medicaid fraction, had a specific adjustment to the SSI fraction, or properly protested the appealed issue such that the Board has jurisdiction to hear their respective appeals.[26] In addition, the participants' documentation shows that the estimated amount in controversy 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.

Board's Analysis Regarding the Appealed Issue

The group appeals in this EJR request span fiscal years 2009 and 2010, 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.

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 participants in these group appeals are entitled to a hearing before the Board;

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

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

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

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[25] *See* 42 C.F.R. § 405.1835 (2008).

[26] The Board has determined that the Providers in case number 13-0962GC have jurisdictionally valid appeals pending for the same fiscal year end from the original NPRs; therefore reaching a decision on the revised NPR appeals is futile as the outcome for these Providers will not be affected.

[27] *See* 42 C.F.R. § 405.1837.

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 Anderson, Esq.
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler

FOR THE BOARD:

L. Sue Anderson
Chairperson

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

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