DEPARTMENT OF HEALTH & HUMAN SERVICES

SEP 05 2017

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

CERTIFIED MAIL

Wade H. Jaeger
Reimbursement Manager
Eden Medical Center
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Sacramento, CA 95833

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

RE: Jurisdictional Decision
Provider: Eden Medical Center
Case Number: 13-0819
FYE: 12/31/2007

Dear Mr. Jaeger and Ms. Alcantara:

**Background:**

Eden Medical Center, or the Provider, is appealing the amount of Medicare Reimbursement as determined by the Medicare contractor. The following issues are stated in the Model Form A – Individual Appeal Request (Feb. 13, 2013) in the Statement of Appeal Issues section:

1) Issue No. 1 is entitled "Medicare DSH - SSI Ratio Issued March 16, 2012, Realignment, Adjustment Numbers 5, 6 and 9";
2) Issue No. 2 is entitled "Medicare DSH - SSI Ratio Issued March 16, 2012, Accurate Data, Adjustment Numbers 5, 6 and 9".

The Medicare Contractor has filed a jurisdictional challenge regarding Issue No. 1 pertaining to the Medicare DSH - SSI Ratio Realignment.

**Medicare Contractor's Position**

The Medicare Contractor alleges that the decision to change the DSH Medicare computation from the federal fiscal year end to the Provider's fiscal year is the Provider's decision and is not a Medicare Contractor final determination. The Medicare Contractor asserts that the right to a Board hearing derives from a Medicare Contractor final determination pursuant to 42 C.F.R. § 405.1801(a). The Medicare Contractor states it "did not make a determination in terms of Medicare SSI Realignment." *Jurisdictional Challenge (Dec. 20, 2013) at 2.* Therefore, the Medicare Contractor's position is that the

Board does not have jurisdiction over Issue No. 1, the Medicare DSH - SSI Ratio Issued March 16, 2012, Realignment issue.

**The Provider's Position**

The Provider did not file a response to the Medicare Contractor's December 20, 2013 Jurisdictional Challenge. The Provider describes Issue No. 1 "the SSI percentage as generated by the Social Security Administration (SSA) and put forth by CMS is understated." *Provider's Model Form A – Individual Appeal Request (Feb. 13, 2013), Statement of Appeal Issues at 3.* The Provider also states regarding Issue No. 1 "that 42 C.F.R. § 412.106(b) provides that the Provider may choose to use its cost reporting period instead of the Federal fiscal year." *Id.*

The Provider describes Issue No. 2 also as "the SSI percentage as generated by the Social Security Administration (SSA) and put forth by CMS is understated." *Provider's Model Form A – Individual Appeal Request (Feb. 13, 2013), Statement of Appeal Issues at 4.* Additionally, regarding Issue No. 2, the Provider contends that CMS did not use the best available data at the time of settlement to calculate the SSI fraction because of various reasons including but not limited to: not using updated current data, using data that excluded inactive claims, retroactive claims and forced or manual pay claims. *Id.*

**Board Decision**

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a hospital 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 $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. Additionally, PRRB Rule 4.5 states that a Provider may not appeal an issue from a final determination in more than one appeal.

Pursuant to 42 C.F.R. 412.106(b)(3), a Provider may request that CMS use its cost reporting period instead of the Federal fiscal year in calculating the SSI percentage of the DSH payment calculation. It must make such a request in writing to its Medicare Contractor.

The Board finds regarding Issue No. 1 (Medicare DSH - SSI Ratio Issued March 16, 2012, Realignment), that it has jurisdiction over the portion of this issue challenging the data used to calculate the SSI percentage as there were adjustments to the SSI percentage (Adj. 5, 6 and 9), and the appeal meets the amount in controversy and timely filing requirements. However, the Board also finds that the

inaccurate data portion of Issue No. 1 is duplicative of Issue No. 2, the Medicare DSH - SSI Ratio Issued March 16, 2012, Accurate Data issue. The basis of both Issues is that the SSI percentage is improperly calculated, and the Provider does not have the underlying data to determine if the SSI percentage is accurate. This part of Issue No. 1 is dismissed from the appeal because is duplicative which is prohibited.

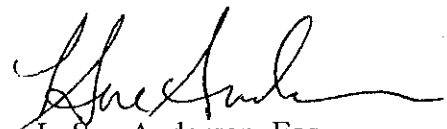
Regarding the portion of Issue No. 1 addressing realignment of the DSH calculation to the Provider's fiscal year end, the Board finds that realignment using the Provider's fiscal year end is a Provider election, and there is no evidence in the record that the Medicare Contractor has made a final determination regarding this issue. Therefore, the Board does not have jurisdiction over Issue No. 1, the the Medicare DSH - SSI Ratio Issued March 16, 2012, Realignment issue, and it is hereby dismissed from the appeal.

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

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, Esq.
Chairperson

cc: Wilson Leong, Esq., FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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SEP 05 2017

Refer to: 15-0281 and 14-3237G

CERTIFIED MAIL

Healthcare Reimbursement Services, Inc.
Corinna Goron
President
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Noridian Healthcare Solutions
Evaline Alcantara
Appeals Coordinator - Jurisdiction E
P.O. Box 6782
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RE: HRS 2011 DSH SSI Percentage Group
Torrance Memorial Medical Center
Jurisdictional Challenge
PN: 45-0379
FYE: 12/31/2011
PRRB Case Numbers: 15-0281 and 14-3237G

Dear Ms. Goron and Ms. Alcantara,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal in response to the Medicare contractor's jurisdictional challenge concerning the subject provider.

**Background:**

Torrance Memorial Medical Center, or the Provider, is appealing the amount of Medicare Reimbursement as determined by the Medicare contractor. When the Provider filed its individual appeal in Case No. 15-0281, the issue was stated as "Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific) … Whether the Medicare Administrative Contractor ("MAC") used the correct SSI percentage in the DSH calculation. … the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 USC 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 CFR 412.106(b)(2)(i) of the Secretary's Regulations. …"[1]

When Healthcare Reimbursement Services, Inc. ("HRS") filed the appeal request for Case No. 14-3237G, the appeal issue was stated as "Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/Supplemental Security Income (SSI) percentage. … The Providers contend that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statue 42 USC

[1] Torrance Memorial Medical Center appeal request under tab 3. (November 5, 2014)

1395ww(d)(5)(F)(i). … does not address all the deficiencies as described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, as amended, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) …"[2]

On November 5, 2014, the Provider filed a Model Form E – Request to Join An Existing Group Appeal regarding the DSH/SSI Systemic Errors issue. The issue in Case No. 15-0281 and Case No. 14-3237G allege that the SSI percentage calculated by CMS and used by the Medicare Contractor does not address all of the deficiencies identified in the *Baystate* case.

On August 18, 2015, the Medicare Contractor filed a jurisdictional challenge regarding this issue in the individual appeal, Case No. 15-0281. On September 15, 2015, the Provider filed its Jurisdictional Response.

On June 15, 2017, the Medicare Contractor filed a jurisdiction challenge in Case No. 14-3237G. The Medicare Contractor challenges the Board jurisdiction over Torrance Memorial Medical Center stating that the Provider has the issue pending in two cases, Case No. 15-0281 and Case No. 14-3237G. On July 13, 2017, HRS filed its Jurisdictional Response in Case No. 14-3237G.

**Medicare Contractor's Position**

The Medicare Contractor asserts that the Provider has the SSI (Provider Specific) issue pending in Case No. 15-0281 and the SSI (Systemic Errors) issue pending in Case No. 14-3237G. The Medicare Contractor asserts that the issues in these two cases are duplicative. The Medicare Contractor states that Torrance Memorial Medical Center is in violation of Board Rule 4.5. The Medicare Contractor requests that the Board dismiss the SSI (Provider Specific) issue from Case No. 15-0281 and dismiss the case.[3]

**The Provider's Position**

The Provider contends that each of the appealed SSI issue is separate and distinct, and that the Board should find jurisdiction over PRRB Group Case No. 14-3237G. The SSI Systemic Issue addresses various errors discussed in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, as amended, 587 F. Supp. 2d 37, 44 (D.D.C. 2008), where the MedPAR did not reflect all individuals who are eligible for SSI. These systemic errors are the result of CMS improper policies and data matching process. The SSI Provider Specific issue is not addressing the errors from improper data matching process, but is addressing the various errors of omission and commission that do not fit into the "systemic errors" category.[4]

**Board Decision**

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a hospital 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 $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of

[2] Case No. 14-3237G appeal request under tab 2. (April 14, 2014)
[3] Medicare Contractor's Jurisdictional Challenge (June 15, 2017).
[4] HRS Jurisdictional Response at 2. (July 13, 2017)

the date of receipt of the final determination. Additionally, PRRB Rule 4.5 states that a Provider may not appeal an issue from a final determination in more than one appeal.

The Board finds, regarding the DSH SSI Provider Specific issue[5], that it has jurisdiction over this issue as there was an adjustment to the SSI percentage (Adj. 22), and the appeal meets the amount in controversy and timely filing requirements. However, the Board also finds that the DSH SSI Provider Specific issue is duplicative of the DSH SSI Systemic Errors issue that is included in Case No. 13-3237G. The basis of both issues is that the SSI percentage is improperly calculated. The Board hereby dismisses the DSH SSI Provider Specific issue from Torrance Memorial Medical Center's individual appeal, Case No. 15-0281. The Board, therefore, closes Case No. 15-0281 as there are no issue remaining. Torrance Memorial Medical Center should remain in Case No. 14-3237G.

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

Board Members Participating
Clayton J. Nix, Esq.
Jack Ahern, MBA
Gregory H. Ziegler

FOR THE BOARD

Clayton J. Nix, Esq.
Acting Chairperson

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

cc: James Lowe, Cahaba Safeguard Administrators, LLC

Federal Specialized Services
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[5] Issue included in Case No. 15-0281

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SEP 0 6 2017

**Certified Mail**

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**Expedited Judicial Review Determination**

RE: University of Rochester Medical Center 2013 Post Allina Medicare Part C Days CIRP Group 12/31/2013, PRRB Case No. 16-0327GC
Akin Gump 2013 Post –Allina Medicare Part C Days CIRP Group 6/30/2013, 9/30/2013, 12/31/2013, PRRB Case No. 16-0328G
NYU Lutheran Medical Center, Provider No. 33-0306, FYE 12/31/2013 PRRB Case No. 16-0295
North Carolina Baptist Hospital, Provider No. 34-0047, FYE 6/30/2014 PRRB Case No. 16-1680

Dear Ms. Webster:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' June 27, 2017 request for expedited judicial review (EJR) (received June 28, 2017) and the Providers' August 10, 2017 response to the Board's July 24, 2017 request for additional information regarding bifurcation in the above-referenced appeals. The Board's determination is set forth below.

The issue in these appeals is:

> Whether "enrollees in [Medicare] Part C patients are 'entitled to benefits' under Part A, such that they should be counted in the Medicare [Part A/SSI[1]] 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[2] adjustment.[3]

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

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

[1] "SSI" is the acronym for "Supplemental Security Income."
[2] "DSH" is the acronym for "disproportionate share hospital."
[3] Providers' June 27, 2017 EJR Request at 4.

prospective payment system ("PPS").[4] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5]

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

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

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

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

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

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

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

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

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

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

Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary[13] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[14]

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

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

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

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicare fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction* . . . (emphasis added)[18]

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

> . . . *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

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

[17] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).

[18] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).

[19] 69 Fed. Reg. at 49,099.

> is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[20] (emphasis added)

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

Although the change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 final rule was issued.[21] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule. As a result, Part C days were required to be included in the Medicare fraction as of October 1, 2004.

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius,*[22] vacated the FFY 2005 IPPS rule. However, the Providers point out, the decision is not binding in actions by other hospitals. Further, the Secretary has not acquiesced to that decision.[23]

**Providers' Request for EJR**

Comments on Bifurcation

In the cover letter to the EJR request, the Providers pointed out that the issue in these appeals is the inclusion of Part C days in the Medicare Part A/SSI fractions and the exclusion from the Medicaid fraction of Part C days for Medicaid eligible patients. The Providers asked that the EJR decision involve only the portions of the Providers' cost years prior to October 1, 2013.

The Board send the Provider a development letter on July 24, 2017 (which extended the Board's 30 day deadline to respond to the original EJR request) asking them to brief why they believe EJR is only appropriate for the portions of the cost reporting periods prior to October 1, 2013. The Providers responded on August 10th, 2017 by noting that in *Allina Health Services v. Sebelius,*[24] *(Allina I)* the Court of Appeals vacated the 2005 DSH regulation governing the treatment of Part C days in both fractions of the DSH calculation that applied to the periods October 1, 2004 until September 30, 2013. However, the regulation is still on the books and governs the calculation of the Medicare Part A/SSI fractions, in addition to the counting of Medicaid eligible Part C days in the numerator of the Medicaid fraction for the periods October

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[20] *Id.*
[21] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[22] 746 F. 3d 1102 (D.C. Cir. 2014).
[23] June 27, 2017 EJR Request at 1.
[24] 746 F.3d (D.C. Cir. 2014)

1, 2004 until September 30, 2013. The Secretary has adopted a new rule effective October 1, 2013.[25]

The Providers explain that all of the cost years in these appeals began in Federal fiscal year 2013, and, thus, the Medicare Part A/SSI fractions for that Federal year apply to them. But the cost report years also cross the October 1, 2013 effective date of the new rule, which raises different legal questions. As a result, the Providers request that the appeals be bifurcated in to periods prior to and subsequent to October 1, 2013, and that the periods subsequent to October 1, 2013 remain pending before the Board.

EJR

The Providers note that they are the same plaintiffs that prevailed in *Allina I.* They expected to have their Part C days appropriately treated for periods prior to October 1, 2013 since they had prevailed in *Allina* and the Court issued a vacatur of the 2004 rule on Part C days. However, the Secretary has not acquiesced to the decision and the Providers have. Since the Secretary has not acquiesced, the Board remains bound by the 2004 rule 42 C.F.R. § 412.106(b)(2), and lacks the authority to decide the validity of the Secretary's continued application of the 2005 rule found at 42 C.F.R. § 412.106(b)(2)-(3). Consequently, the Providers assert, EJR is appropriate.

The Providers point out that prior to the 2004 rulemaking, in which the Secretary attempted to adopt a new policy to begin counting Part C days in the Medicare Part A/SSI fraction, the Secretary treated Part C patients as not entitled to benefits under Part A, rather they should be included in the Medicaid fraction of the DSH adjustment.[26] In the May 2004 proposed rule for Federal fiscal year 2005, the Secretary proposed "to clarify" her long held position that "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."[27] Further, the Secretary went on, "[t]hese days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patients' days for a [Part C] beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction."[28] The Secretary explained that "once a beneficiary has elected to join a Medicare Advantage plan, that beneficiary's benefits are no longer administered under Part A."[29]

However, in the final rule for the Federal fiscal year 2005, the Secretary reversed course and adopted a policy to include Part C days in the Medicare Part A/SSI fraction and exclude the Part C days from the Medicaid fraction effective October 1, 2004.[30] The Secretary's actions were litigated in *Allina I* in which the Court concluded that the Secretary's final rule was not a logical outgrowth of the proposed rule and a vacatur was warranted. The Secretary has continued to issue the DSH fractions as he has for prior years as if the vacatur had never happened, or issuing

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[25] *See* 78 Fed. Reg. 50,496, 50,620 (Aug. 19, 2013).
[26] Providers' EJR Request at 4 citing to Allina 746 F.3d at 1105.
[27] 68 Fed Reg. at 27,208.
[28] *Id.*
[29] *Id.*
[30] 69 Fed Reg. 49,099 (Aug. 11, 2004).

a new rule without notice-and-comment rulemaking.[31] The Providers have separate multiple court actions challenging the calculation of the Providers' DSH adjustment in later years.[32]

The Providers are seeking EJR over the appeal because the Board does not have the authority to decide the current substantive or procedural validity of the 2004 rule vacated in *Allina I* or the continued application of that rule or its policy applied to period prior to October 1, 2013.

**Decision of the Board**

Request to Bifurcate

The Board hereby denies the Providers' request to bifurcate the appeals into Federal fiscal year 2013 and 2014 appeals. The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vii) and (viii) states that the formula used to determine the disproportionate adjustment is made for a cost reporting period.

Pursuant to 42 C.F.R. § 412.106(b)(2) (2013), CMS calculated the EJR participants' SSI percentages using the first month of each participants' fiscal year. The regulation states that for each month of the federal fiscal year in which the *hospital's cost reporting period begins*, CMS (i) determines the number of patient days that (A) are associated with discharges occurring during each month; and (B) are furnished to patients who during that month were entitled to Medicare Part A (including Medicare Advantage (Part C)) and SSI, excluding those patients who received only state supplementation; (ii) adds the results for the whole period; and (iii) divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that (A) are associated with discharges that occur during that period; and are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)). (Emphasis added)

The statute and the regulation are clear, the DSH adjustment is made for a cost reporting period. There are not two different DSH adjustments for cost reports that overlap two Federal fiscal years. Consequently, bifurcation is not appropriate.

EJR

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 2013 and 2014.

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[31] Provides' EJR request at 7.
[32] *Id.*

The Providers in these cases have not received final determinations for the fiscal years under appeal and filed their appeals under the provisions of 42 C.F.R. §405.1835(c)(1)(2014). This regulation permits providers to file appeals where a final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's perfected cost report or amended cost report.[33]

The Board has determined that participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[34] and $10,000 for an individual appeal.[35] 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 2013 and 2014, but each of the providers in the appeals utilizes a FFY 2013 SSI percentage, 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,

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[33] A number of Providers in case numbers 16-0327GC and 16-0328G have two or more appeals listed within the Schedule of Providers ("SOP") for the same Provider. The first appeal is based upon the submission of the as-filed cost report and the subsequent appeal(s) is based upon the submission of an amended cost report for the same fiscal year end. As the Medicare contractor did not issue an NPR for these cost reports, each provider's amended cost report "supersedes" the early filing, thus the Board has made a jurisdictional determination regarding the EJR request for the amended cost report appeals. The Provider Representative obviously understood this and has listed "superseded" in the "Amount of Reimbursement" column on the SOP the original cost report appeals and some of the amended cost report appeals where yet a second or third amended cost report was filed. The Providers listed below submitted amended cost report filings for case numbers 16-0327GC and 16-0628G.

Case number 16-0327GC:
# 2, # 3, # 4 Strong Memorial Hospital

Case number 16-0328G:
# 2 Tampa General Hospital
# 5 Kaleida Health
# 7 New Hospital Queens
# 9 Montefiore Medical Center
#11 New York Presbyterian Hospital
# 16 North Carolina Baptist

To avoid any confusion, the Board has indicated that the original cost report appeals and later amended cost report appeals that were superseded are not included within this EJR Request by striking through the listing for the line numbers referenced above on the SOP.

[34] *See* 42 C.F.R. § 405.1837.

[35] 42 C.F.R. § 405.1835(a)(2).

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:

L. Sue Anderson, Esq.
Clayton J. Nix, Esq.
Jack Ahern, MBA, CHFP
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A

FOR THE BOARD:

L. Sue Andersen
Chairperson

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

cc: Pam VanArdale (Certified Mail w/Schedules of Providers)
Laurie Polston, Palmetto GBS c/o NGS
Wilson Leong, (w/Schedules of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

SEP 0 6 2017

CERTIFIED MAIL

Kathleen Houston Drummy
Davis Wright Tremaine LLP
865 South Figueroa Street
Suite 2400
Los Angeles, CA 90017-2566

RE: **Expedited Judicial Review Determination**
Provider Name: City of Hope National Medical Center
Provider No. 05-0146
FYEs 9/30/2011 & 9/30/2012
PRRB Case Nos. 15-1649 & 15-1651

Dear Ms. Drummy:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's request for Expedited Judicial Review ("EJR") filed with the Board on August 28, 2017. The Board's decision regarding EJR is set forth below.

## Issue under Appeal

Whether the Provider's payment-to-cost ratio (PCR) for fiscal years ("FY") 9/30/2011 and 9/30/2012 under appeal was properly determined in light of the statutory January 1, 2011 implementation date of the OPPS Payment Adjustment for Certain Cancer Hospitals (required under Section 3138 of the Affordable Care Act)?

## Statutory and Regulatory Background

Section 3138 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 ("ACA") amended the outpatient prospective payment statute, in subsection 1833(t) of the Act, by adding a new paragraph 18 requiring a payment adjustment for certain cancer hospitals "described in section 1886(d)(1)(B)(v) of the Social Security Act," which includes the Provider. As amended by the ACA, the statute required the Secretary to perform a study of the costs incurred by the 11 comprehensive cancer centers identified by statute to determine if their costs of services paid under the outpatient prospective payment exceed the costs incurred by other hospitals for those services.[1]

The statute also mandated that the Secretary "shall provide for an appropriate adjustment" to the payments made to the 11 comprehensive cancer centers, including the Provider, if the Secretary were to determine that their costs exceed the costs incurred by other hospitals for outpatient services paid under prospective

[1] Social Security Act § 1833(t)(18)(A), 42 U.S.C. § 1395l(t)(18)(A).

payment systems.[2] The statute stated that the Secretary "shall reflect those higher costs effective for services furnished on or after January 1, 2011."

In 2010, the Secretary performed a study and determined that the 11 comprehensive cancer centers' costs exceed the costs incurred by other hospitals; and that their payments, even including the hold harmless payments, amount to a lower percentage of their reasonable costs than other hospitals receive.[3] Accordingly, the Secretary proposed a payment adjustment that would raise the payments to the comprehensive cancer centers for outpatient services to a level equal to 91% of their reasonable costs, which the Secretary determined to be on par with the average payment-to-cost ratio for other hospitals that are paid under the prospective payment system.

The OPPS Final Rule for FY 2012 states, "because the many public comments we received identified a broad range of very important issues and concerns associated with the proposed cancer hospital payment adjustment, we determined that further study and deliberation was necessary and, therefore, we did not finalize the CY 2011 proposed payment adjustment for certain cancer hospitals."[4] The implementing regulation at issue here reflects the fact that the Secretary did not finalize the adjustment for CY 2011. 42 C.F.R. § 419.43(i)(1) states: "General Rule. CMS provides for a payment adjustment for covered hospital outpatient department services furnished **on or after January 1, 2012**, by a hospital described in section 1886(d)(1)(B)(v) of the Act."[5]

The Provider is challenging the Secretary's actions in failing to implement the PCR adjustment for services provided on or after January 1, 2011 on a number of legal grounds, including that the Secretary's one year delay in implementing the payment adjustment is contrary to law because the ACA set a specific implementation date.[6]

## 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.

*Jurisdiction*

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

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[2] § 1833(t)(B), 42 U.S.C. § 1395l(t)(18)(B).
[3] 78 Fed. Reg. 71800, 71885-71886 (Nov. 24, 2010).
[4] 76 Fed. Reg. 74121, 74202 (Nov. 30, 2011).
[5] Emphasis added.
[6] Provider's Request for EJR at 3.

The Medicare Contractor filed a jurisdictional challenge over a second issue that was pending in both appeals – the TEFRA Target Amount Update issued. The Provider's representative submitted a request to withdraw this issue from both appeals, therefore the jurisdictional challenge is moot.

The Board finds that it has jurisdiction over the Provider for both FYEs under appeal for the PCR cancer adjustment issue. The Provider timely filed its appeal requests from original Notices of Program Reimbursement ("NPR") and the amount in controversy is satisfied for both appeals. The Provider is appealing from FYEs 9/30/2011 and 9/30/2012 and protested the amount on the cost report; the Medicare Contractor removed the protested amounts.[7]

Consequently, the Board has determined that it has jurisdiction over the Provider's appeals. However, the Board finds that it lacks the authority to decide the legal question of whether the implementation date of the OPPS Payment Adjustment for Certain Cancer Hospitals (required under Section 3138 of the Affordable Care Act) violates the Social Security Act; therefore, EJR is appropriate for the issue under dispute in these cases.

The Board finds that:

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

2) based upon the Provider's assertions, there are no findings of fact for resolution by the Board;

3) it is bound by the applicable existing Medicare law and regulation (42 U.S.C. § 1395/(t)(18) and 42 C.F.R. § 419.43(i)(1)); and

4) it is without the authority to decide the legal question of whether the implementation date of the OPPS Payment Adjustment for Certain Cancer Hospitals (required under Section 3138 of the Affordable Care Act) violates the Social Security Act.

Accordingly, the Board finds that the challenge to the implementation date of the OPPS payment adjustment as contrary to the Social Security Act properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants expedited judicial review for the issue and the subject years. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review.

The Provider's challenge to the implementation date of the OPPS adjustment for certain cancer hospitals is the last issue pending in both appeals, therefore PRRB Case Nos. 15-1649 and 15-1651 are hereby closed.

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[7] *See* 42 C.F.R. § 405.1835(a)(1)(ii).

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

FOR THE BOARD:

Enclosures: 42 U.S.C. § 1395oo(f)(1)

cc: Evaline Alcantara
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DEPARTMENT OF HEALTH & HUMAN SERVICES

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SEP 07 2017

**Certified Mail**

Christopher L. Keough
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RE: Expedited Judicial Review Request
Akin Gump/HCA 2004-2005 Medicare Advantage Days Group
FYE 2005
PRRB Case Nos. 07-0005GC

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' August 7, 2017 request for expedited judicial review (EJR) (received August 8, 2017) for the above-referenced appeal. The Board's determination 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

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[1] August 7, 2017 EJR Request at 4.
[2] *See* 42 U.S.C. § 1395ww(d)(1)-(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 added)

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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. § 412.106(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] August 7, 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 2004-2005.

For purposes of Board jurisdiction over a participant's appeals filed from a cost reporting period that ends on or before December 30, 2008,[24] 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]

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[26] and the appeal was timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

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[24] For those Providers that have appealed from both original and revised NPRs, 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.
[25] 108 S.Ct. 1255 (1988).
[26] *See* 42 C.F.R. § 405.1837.

Board's Analysis Regarding the Appealed Issue

The group appeal in this EJR request span fiscal years subsequent to October 31, 2004 and 2005, 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. [27]

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

[27] On August 8, 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.

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

FOR THE BOARD:

L. Sue Andersen
Chairmperson

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

cc: Byron Lamprecht, Wisconsin Physician Service (Certified Mail w/Schedules of Providers)
Wilson Leong, (w/Schedules of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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SEP 07 2017

**Certified Mail**

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RE: **Expedited Judicial Review Determination**
Akin Gump 2013-2014 Post-Allina Decision DSH
Part C Days Groups
PRRB Case Nos. 16-0326GC & 16-1623GC[1]

Dear Ms. Webster:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' August 8, 2017 request for expedited judicial review (EJR) (received August 9, 2017) for the above-referenced appeals. The Board's determination is set forth below.

The issue in these appeals is:

> Whether "enrollees in [Medicare] Part C patients are 'entitled to benefits' under Part A, such that they should be counted in the Medicare [Part A/SSI[2]] fraction, or whether, if not regarded as 'entitled to benefits under Part A,' they should instead be included in the Medicaid fraction" of the DSH[3] 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 August 8, 2017 EJR Request also included case number 16-1761GC. The Board is requesting additional information for this case and the request is being sent under separate cover.
[2] "SSI" is the acronym for "Supplemental Security Income."
[3] "DSH" is the acronym for "disproportionate share hospital."
[4] Providers' August 8, 2017 EJR Request at 4.
[5] *See* 42 U.S.C. § 1395ww(d)(l)-(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 number of the hospital's patient days for such period. (emphasis added)

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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).

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]

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

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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.*
[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

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 adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our

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Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.

[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.

> 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**

Bifurcation

In the cover letter to the EJR request, the Providers pointed out that the issue in these appeals is the inclusion of Part C days in the Medicare Part A/SSI fractions and the exclusion from the Medicaid fraction of Part C days for Medicaid eligible patients. The Providers asked that the EJR decision involve only the portions of the Providers' cost years prior to October 1, 2013.

EJR Request

The Providers note that they are the same plaintiffs that prevailed in *Allina I.* They expected to have their Part C days appropriately treated for periods prior to October 1, 2013 since they had prevailed in *Allina* and the Court issued a vacatur of the 2004 rule on Part C days. However, the Secretary has not acquiesced to the decision and the Providers have. Since the Secretary has not acquiesced, the Board remains bound by the 2004 rule 42 C.F.R. § 412.106(b)(2), and lacks the authority to decide the validity of the Secretary's continued application of the 2005 rule found at 42 C.F.R. § 412.106(b)(2)-(3). Consequently, the Providers assert, EJR is appropriate.

The Providers point out that prior to the 2004 rulemaking, in which the Secretary attempted to adopt a new policy to begin counting Part C days in the Medicare Part A/SSI fraction, the Secretary treated Part C patients as not entitled to benefits under Part A, rather they should be

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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] August 8, 2017 EJR Request at 1.

included in the Medicaid fraction of the DSH adjustment.[25] In the May 2004 proposed rule for Federal fiscal year 2005, the Secretary proposed "to clarify" her long held position that "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."[26] Further, the Secretary went on, "[t]hese days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patients' days for a [Part C] beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction."[27] The Secretary explained that "once a beneficiary has elected to join a Medicare Advantage plan, that beneficiary's benefits are no longer administered under Part A."[28]

However, in the final rule for the Federal fiscal year 2005, the Secretary reversed course and adopted a policy to include Part C days in the Medicare Part A/SSI fraction and exclude the Part C days from the Medicaid fraction effective October 1, 2004.[29] The Secretary's actions were litigated in *Allina I* in which the Court concluded that the Secretary's final rule was not a logical outgrowth of the proposed rule and a vacatur was warranted. The Secretary has continued to issue the DSH fractions as he has for prior years as if the vacatur had never happened, or issuing a new rule without notice-and-comment rulemaking.[30] The Providers have separate multiple court actions challenging the calculation of the Providers' DSH adjustment in later years.[31]

The Providers are seeking EJR over the appeal because the Board does not have the authority to decide the current substantive or procedural validity of the 2004 rule vacated in *Allina I* or the continued application of that rule or its policy applied to period prior to October

**Decision of the Board**

Request to Bifurcate

The Board hereby denies the Providers' request to bifurcate the appeals into Federal fiscal year 2013 and 2014 appeals. The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vii) and (viii) states that the formula used to determine the disproportionate adjustment is made for a cost reporting period.

Pursuant to 42 C.F.R. § 412.106(b)(2) (2013), CMS calculated the EJR participants' SSI percentages using the first month of each participants' fiscal year. The regulation states that for each month of the federal fiscal year in which the *hospital's cost reporting period begins*, CMS (i) determines the number of patient days that (A) are associated with discharges occurring during each month; and (B) are furnished to patients who during that month were entitled to Medicare Part A (including Medicare Advantage (Part C)) and SSI, excluding those patients who received only state supplementation; (ii) adds the results for the whole period; and (iii) divides

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[25] Providers' EJR Request at 4 citing to Allina 746 F.3d at 1105.
[26] 68 Fed Reg. at 27,208.
[27] *Id.*
[28] *Id.*
[29] 69 Fed Reg. 49,099 (Aug. 11, 2004).
[30] Providers' EJR request at 7.
[31] *Id.*

the number determined under paragraph (b)(2)(ii) of this section by the total number of days that (A) are associated with discharges that occur during that period; and are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)). (Emphasis added)

The statute and the regulation are clear, the DSH adjustment is made for a cost reporting period. There are not two different DSH adjustments for cost reports that overlap two Federal fiscal years. Consequently, bifurcation is not appropriate.

EJR Decision

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 2013 and 2014, but each utilize a FFY 2013 SSI ratio.

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.[32] In case number 16-1623GC, Provider # 5 Methodist Charlton Medical Center (provider number 45-0723) filed its appeal from a Notice of Program Reimbursement (NPR). In case number 16-0326GC, Providers # 3 Huntingdon Hospital (provider number 33-0045) and #8 Lenox Hill Hospital (provider number 33-0119) filed their appeals from NPRs.

The remaining Providers in these cases have not received final determinations for the fiscal years under appeal and filed their appeals under the provisions of 42 C.F.R. §405.1835(c)(1). This regulation permits providers to file appeals where a final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's perfected cost report or amended cost report.[33]

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[32] *See* 42 C.F.R. § 405.1835 (2008).

[33] A number of Providers in case numbers 16-0326GC and 16-1623GC have two or more appeals listed within the Schedule of Providers ("SOP") for the same Provider. The first appeal is based upon the submission of the as-filed cost report and the subsequent appeal(s) is based upon the submission of an amended cost report for the same fiscal year end. As the Medicare contractor did not issue an NPR for most of these cost reports, each provider's accepted amended cost report "supersedes" the early filing, thus the Board has made a jurisdictional determination regarding the EJR request for the amended cost report appeals. The Provider Representative obviously understood this and

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[34] 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.

In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[35] 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 2013 and 2014 but each utilize a FFY 2013 SSI ratio, 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.

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has listed "superseded" in the "Amount of Reimbursement" column on the SOP the original cost report appeals and some of the amended cost report appeals where yet another amended cost report was filed. The Providers listed below submitted amended cost report filings for case numbers 16-0326GC and 16-1623GC.

Case number 16-0326GC:
# 1 Southside Hospital;
# 4, #5 and # 6 North Shore University Hospital;
# 9 Staten Island Hospital;
#11 and #12 Long Island Jewish Medical Center,
# 14 Forest Hills Hospital; and
# 16 Franklin Hospital
Case number 16-1623GC:
# 1 Methodist Dallas Medical Center
# 3 and 4 Methodist Charlton Medical Center

To avoid any confusion, the Board has indicated that the original cost report appeals and later amended cost report appeals that were superseded by a third or fourth amended cost report submission are not included within this EJR Request. This removal is done by striking through the listing for the line numbers referenced above on the SOP.

[34] *See* 42 C.F.R. § 405.1837.

[35] *See* 42 C.F.R. § 405.1837.

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:

L. Sue Andersen, Esq.
Clayton J. Nix, Esq.
Jack Ahern, MBA, CHFP
Gregory H. Ziegler, CPA, CPC-A

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

cc: Pam VanArsdale, NGS (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
1508 Woodlawn Drive, Suite 100
Baltimore, MD 21207
410-786-2671

**Certified Mail**

SEP 07 2017

Maureen O'Brien Griffin
Hall, Render, Killian, Heath & Lyman
500 North Meridian Street
Suite 400
Indianapolis, IN 46204

RE: Expedited Judicial Review Request
Hall Render Part C Days Appeals
FYE: 2006-2008, and 2012-2013
PRRB Case Nos.: 13-2583GC, 13-3072GC, 13-3134GC, 16-1613G and 16-1709G

Dear Ms. Griffin:

On August 11, 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, as explained below.

The issue in these appeals is:

> The improper inclusion by the [Medicare contractor] and the Centers for Medicare & Medicaid Services (CMS) of inpatient days attributable to Medicare Advantage patients in the numerator and [denominator] of the Medicare Proxy when calculating the disproportionate share hospital (DSH) eligibility and payments.[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 11, 2017 EJR Request at 1.
[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.

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"[9] fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

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

The Medicare/SSI fraction is computed annually by CMS, and the Medicare 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) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(l).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] "SSI" stands for "Supplemental Security Income."
[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

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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.

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 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.

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[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.
[19] *Id.*

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, as the providers point out, the Secretary has not acquiesced or taken action to implement the decision[22] and the decision is not binding in actions by other hospitals.

**Providers' Request for EJR**

The underlying issue in this EJR request 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 claim 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 argue that since the Secretary has not acquiesced to the decision in *Allina*, the Board remains bound by the regulation and EJR is appropriate.

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[20] 72 Fed. Reg. 47,130, 47,384 (Aug. 22, 2007).
[21] 746 F. 3d 1102 (D.C. Cir. 2014).
[22] August 11, 2017 EJR Request at 10-12.
[23] 69 Fed. Reg. at 49,099.
[24] *Allina* at 1109.

**Decision of the Board**

Board's Authority

Under the Medicare statute codified at 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1) (2016), the Board is required to grant a provider's EJR request if it determines that (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

Jurisdictional Requirements

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the providers requesting EJR. Pursuant to the pertinent regulations governing Board jurisdiction, 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 $10,000 or more for an individual appeal or $50,000 or more for a group, and the request for hearing was timely filed.[25]

Most of the providers included in this EJR request filed appeals of their original notices of program reimbursement ("NPRs") in which the Medicare contractor settled cost reporting periods ending in 2007, 2008, 2012 or 2013. One group consists of providers with appeals of revised NPRs ("RNPRs") in which the Medicare contractor settled cost reporting periods ending in 2006.

For appeals of original NPRs for 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 by claiming the issue as a "self-disallowed cost" pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen*.[26]

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[25] The regulations governing Board jurisdiction begin at 42 C.F.R. § 405.1835. These regulations are essentially the same for the years covered by the appeals involved with the instant EJR request except for the sub-clause regarding timely filing. 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).

[26] 485 U.S. at 399 (1988). Under the facts of *Bethesda*, the Board initially found that it was without jurisdiction to review the providers' challenge to the Secretary's regulation regarding apportionment of malpractice insurance costs because the providers had "self-disallowed" the costs in their respective cost reports filed with the Medicare contractor. The Supreme Court held that "[t]he Board may not decline to consider a provider's challenge to a regulation of the Secretary on the ground that the provider failed to contest the regulation's validity in the cost report submitted to [the Medicare Contractor]." The Court went on to state 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."

For appeals of original NPRs for cost reporting time periods ending on or after December 31, 2008, the providers preserve their respective 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 cost report for the period where the provider seeks 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.[27]

For appeals of RNPRs for cost reporting periods ending in the 2006 calendar year, the Providers must demonstrate that the issue under review was specifically revisited on reopening.[28]

Jurisdictional Determination for Providers

The Board finds that all 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/self-disallowed 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 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 Its Authority to Consider the Appealed Issue

The providers within this EJR request filed appeals covering cost reporting periods with fiscal years ending 2006-2008, and 2012-2013, thus the cost reporting periods fall squarely within the time frame that covers the Secretary's final rule being challenged.[29] In addition, the Board recognizes that the D.C. Circuit vacated the regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). In addition, within its July 25,

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[27] 42 C.F.R. § 405.1835(a)(1) (2008).

[28] For RNPRs issued prior to August 21, 2008, Board jurisdiction over a provider's RNPR appeal is assessed under the holding in *HCA Health Services v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994). In *HCA Health Services*, the Circuit Court held that when a Medicare contractor reopens its original determination regarding the amounts of reimbursement that a Medicare provider is to receive and the provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening, and does not extend further to all determinations underlying the original NPR.

[29] As stated in the FY 2014 IPPS Final Rule, the Secretary "proposed to readopt the policy of counting the days of patients enrolled in MA plans in the Medicare fraction of the DPP[,]" thus "sought public comments from interested parties . . ." following publication of the FY 2014 IPPS Proposed Rule, 78 Fed. Reg. 27578 (May 10, 2013). Ultimately, the Secretary finalized this DSH policy for FFY 2014 and subsequent years on August 19, 2013, in the FY 2014 IPPS Final Rule. *See* 78 Fed. Reg. 50496, 50615 (Aug. 19, 2013). The provider appeals in the instant EJR request are all based upon FY 2013 cost reporting periods and earlier.

2017 decision in *Allina Health Services v. Price*, the D.C. Circuit Court agreed with the Board's determination to grant EJR for the identical issue involved in the instant 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 the providers in these appeals are entitled to a hearing before the Board;

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

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

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

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

Board Members Participating:

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

FOR THE BOARD:

Board Member

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

cc: Danene Hartley, National Government Services (Certified Mail w/Schedules of Providers)
Laurie Polson, Palmetto GBA c/o NGS (Certified Mail w/Schedules of Providers)
Barb Hinkle, Cahaba GBA c/o National Government Services, Inc. (Certified Mail w/Schedules of Providers)
Wilson Leong, FSS (w/Schedules of Providers)

[30] *See* No. 16-5255, 2017 WL 3137996 (D.C. Cir. July 25, 2017).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

**Certified Mail**

SEP 07 2017

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

RE: Expedited Judicial Review Request
Akin Gump/HCA 2006 DSH Medicare Advantage Days Group
FYE 2006
PRRB Case Nos. 08-0286GC

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' August 18, 2017 request for expedited judicial review (EJR) (received August 21, 2017) for the above-referenced appeal. The Board's determination 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 18, 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 added)

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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. § 412.106(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] August 18, 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 year 2006.

For purposes of Board jurisdiction over a participant's appeals filed from a cost reporting period that 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, 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. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[26] and the appeal was timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

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

[25] For those Providers that have appealed from both original and revised NPRs, 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.

[26] *See* 42 C.F.R. § 405.1837.

Board's Analysis Regarding the Appealed Issue

The group appeal in this EJR request span 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. [27]

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.

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

[27] On August 22, 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.

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

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

cc: Byron Lamprecht, Wisconsin Physician Service (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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SEP 15 2017

**Certified Mail**

Maureen O'Brien Griffin
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RE: Expedited Judicial Review Request
Hall Render Part C Days Appeals
FYE: 2008-2012
PRRB Case Nos.: 13-2056GC, 13-2372GC, 14-1471GC, 14-3291G, 15-1864G and 16-1523G

Dear Ms. Griffin:

On August 22, 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, as explained below.

The issue in these appeals is:

> The improper inclusion by the [Medicare contractor] and the Centers for Medicare & Medicaid Services (CMS) of inpatient days attributable to Medicare Advantage patients in the numerator and [denominator] of the Medicare Proxy when calculating the disproportionate share hospital (DSH) eligibility and payments.[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 22, 2017 EJR Request at 2.
[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.

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"[9] fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

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

The Medicare/SSI fraction is computed annually by CMS, and the Medicare 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) 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] "SSI" stands for "Supplemental Security Income."
[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

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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.

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 Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction.* (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 denotes a requirement to include Medicare Part C inpatient days in the Medicare fraction of the DSH calculation.

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[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.
[19] *Id.*

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, as the providers point out, the Secretary has not acquiesced or taken action to implement the decision[22] and the decision is not binding in actions by other hospitals.

**Providers' Request for EJR**

The underlying issue in this EJR request 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 claim 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 they claim the Board lacks the authority to grant. The providers argue that since the Secretary has not acquiesced to the decision in *Allina*, the Board remains bound by the regulation and EJR is appropriate.

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[20] 72 Fed. Reg. 47,130, 47,384 (Aug. 22, 2007).
[21] 746 F. 3d 1102 (D.C. Cir. 2014).
[22] August 22, 2017 EJR Request at 8.
[23] 69 Fed. Reg. at 49,099.
[24] *Allina* at 1109.

**Decision of the Board**

Board's Authority

Under the Medicare statute codified at 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1) (2016), the Board is required to grant a provider's EJR request if it determines that (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

Jurisdictional Requirements

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the providers requesting EJR. Pursuant to the pertinent regulations governing Board jurisdiction, 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 $10,000 or more for an individual appeal or $50,000 or more for a group, and the request for hearing is filed within 180 days of the date of receipt of the final determination.[25]

All of the providers included in this EJR request filed appeals of their original notices of program reimbursement ("NPRs") in which the Medicare contractor settled cost reporting periods ending between June 30, 2008, and December 31, 2012.

For appeals of original NPRs for 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 by claiming the issue as a "self-disallowed cost" pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[26]

For appeals of original NPRs for cost reporting time periods ending on or after December 31, 2008, the providers preserve their respective 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 cost report for the period where the provider seeks 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.[27]

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[25] 42 C.F.R. § 405.1835(a) (2008).
[26] 485 U.S. at 399 (1988). Under the facts of *Bethesda*, the Board initially found that it was without jurisdiction to review the providers' challenge to the Secretary's regulation regarding apportionment of malpractice insurance costs because the providers had "self-disallowed" the costs in their respective cost reports filed with the Medicare contractor. The Supreme Court held that "[t]he Board may not decline to consider a provider's challenge to a regulation of the Secretary on the ground that the provider failed to contest the regulation's validity in the cost report submitted to [the Medicare Contractor]." The Court went on to state 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."
[27] 42 C.F.R. § 405.1835(a)(1) (2008).

Jurisdictional Determination for Providers

Following review of the providers' jurisdictional documentation, the Board finds that all providers involved with the instant EJR request have had an adjustment to the SSI fraction on their respective NPRs. In addition, the providers' documentation shows that the estimated amount in controversy for each group appeal exceeds $50,000 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 Its Authority to Consider the Appealed Issue

The providers within this EJR request filed appeals covering cost reporting periods with fiscal years ending 2008-2012, thus the cost reporting periods fall squarely within the time frame that covers the Secretary's final rule being challenged.[28] In addition, the Board recognizes that the D.C. Circuit vacated the regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). In addition, within its July 25, 2017 decision in *Allina Health Services v. Price*,[29] the D.C. Circuit Court agreed with the Board's determination to grant EJR for the identical issue involved in the instant 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 the providers in these appeals are entitled to a hearing before the Board;

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[28] As stated in the FY 2014 IPPS Final Rule, the Secretary "proposed to readopt the policy of counting the days of patients enrolled in MA plans in the Medicare fraction of the DPP[,]" thus "sought public comments from interested parties . . ." following publication of the FY 2014 IPPS Proposed Rule, 78 Fed. Reg. 27578 (May 10, 2013). Ultimately, the Secretary finalized this DSH policy for FFY 2014 and subsequent years on August 19, 2013, in the FY 2014 IPPS Final Rule. *See* 78 Fed. Reg. 50496, 50615 (Aug. 19, 2013). The provider appeals in the instant EJR request are all based upon FY 2012 cost reporting periods and earlier.

[29] *See* No. 16-5255, 2017 WL 3137996 (D.C. Cir. July 25, 2017).

[30] On August 28, 2017, one of Medicare contractors, Wisconsin Physicians Service ("WPS"), filed an objection to the EJR request in PRRB Case Nos. 14-3219G and 13-2056GC. 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 providers' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;

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

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

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

Board Members Participating:

L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA, CHFP
Gregory H. Ziegler, CPA, CPC-A

FOR THE BOARD:

Charlotte F Benson

Board Member

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

cc: Danene Hartley, National Government Services (Certified Mail w/Schedules of Providers)
Laurie Polson, Palmetto GBA c/o NGS (Certified Mail w/Schedules of Providers)
Byron Lamprecht, Wisconsin Physicians Service (Certified Mail w/Schedules of Providers)
Wilson Leong, FSS (w/Schedules of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
1508 Woodlawn Drive, Suite 100
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SEP 19 2017

CERTIFIED MAIL

Michael Kruzick
Director of Finance
Norwalk Hospital
24 Stevens Street
Norwalk, CT 06856

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

RE: Jurisdictional Decision
Provider: Norwalk Hospital
Case Number: 13-1864
FYE: 09/30/2008

Dear Mr. Kruzick and Ms. VanArsdale:

**Background:**

Norwalk Hospital, or the Provider, is appealing the amount of Medicare Reimbursement as determined by the Medicare contractor. The following issues are stated in the Model Form A – Individual Appeal Request at Tab 3 – Appeal Issues:

1) Issue No. 1 is entitled "Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific)" (hereinafter "DSH/SSI Percentage Provider Specific issue");

2) Issue No. 2 is entitled "Disproportionate Share Hospital ('DSH')/Supplemental Security Income ('SSI')(Systemic Errors)" (hereinafter "DSH/SSI Systemic Errors issue"); and

3) Issue No. 3 is entitled "Disproportionate Share Hospital Payment – Medicaid Eligible Days" (hereinafter "DSH Medicaid Eligible Days issue").

A jurisdictional review of the appeal reveals an impediment with Issue No. 1, and the Medicare Contractor has filed a jurisdictional challenge with regards to Issue No. 3.

The Provider filed a Model Form D – Request to Transfer an Issue to a Group Appeal regarding Issue No. 2 (DSH/SSI Systemic Errors issue) to Case No. 13-2694G on December 26, 2013.

**Medicare Contractor's Position**

The Medicare Contractor's position regarding Issue No. 3 for DSH Medicaid Eligible Days is that an adjustment is required in order to meet the jurisdictional rules of the Board, and the Medicare Contractor did not adjust Medicaid days on the Provider's submitted cost report. The Medicare Contractor indicates that the number of Total Medicaid days on the submitted amended cost report at Worksheet S-

3, Part I, line 12 equals the Total Medicaid days on the finalized cost report. Because the Medicare Contractor accepted the Medicaid days submitted by the Provider on Worksheet S-3, Part I, on the submitted cost report, the Medicare Contractor argues that the Board lacks jurisdiction over this matter.

**The Provider's Position**

The Provider did not file a response to the Medicare Contractor's August 14, 2015 Jurisdictional Challenge. However, the Provider did file a response to the Board's Alert 10. Through this Board Alert, the Board asked Provider's to brief the DSH Medicaid Eligible Days issue, and to supply the following provider-specific information/documentation to the extent it is not already in the appeal record:

- A detailed description of the process that the provider used to identify and accumulate the actual Medicaid paid and unpaid eligible days that were reported and filed on the Medicare cost report at issue.
- The number of additional Medicaid paid and unpaid eligible days that the provider is requesting to be included in the DSH calculation.
- A detailed explanation why the additional Medicaid paid and unpaid eligible days at issue could not be verified by the state at the time the cost report was filed. If there is more than one explanation/reason, identify how many of these days are associated with each explanation/reason.

*See https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB_Alerts.html*

The Provider states it was unable to include all Medicaid eligible days on its cost report for various reasons such as the State's eligibility vendor provided eligibility verification without including an eligibility code on their reports. The Provider also states that the State of Connecticut Medicaid agency typically fails to verify all Medicaid eligible days at the time of the Provider's submission of its cost report. The Provider contends these issues presented a practical impediment for identification of all Medicaid eligible days as of the date of the filing of the cost report. *See Provider's "Alert 10 Response" (July 18, 2014).*

**Board Decision**

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a hospital 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 $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. 42 U.S.C. §1395oo(a) provides, in relevant part:

> Any provider of services which has filed a required cost report within the time specified in the regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board . . . if –
>
> (1) such provider
>
> (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the

> amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by this report.

Additionally, PRRB Rule 4.5 states that a Provider may not appeal an issue from a final determination in more than one appeal.

Pursuant to 42 C.F.R. 412.106(b)(3), a Provider may request that CMS use its cost reporting period instead of the Federal fiscal year in calculating the SSI percentage of the DSH payment calculation. It must make such a request in writing to its Medicare Contractor.

***Issue No. 1 "DSH/SSI Percentage Provider Specific"***

The Board finds that it has jurisdiction over the portion of Issue No. 1 (DSH/SSI Percentage Provider Specific) challenging the data used to calculate the SSI percentage as there was an adjustment to the SSI percentage (Adj. 2), and the appeal meets the amount in controversy and timely filing requirements. However, the Board also finds that the inaccurate data portion of Issue No. 1 is duplicative of Issue No. 2, the DSH/SSI Systemic Errors issue that was transferred to 13-2694G. The basis of both Issues is that the SSI percentage is improperly calculated, and the Provider does not have the underlying data to determine if the SSI percentage is accurate. The portion of Issue No. 1 challenging the accuracy of the SSI ratio data now resides in Case No. 13-2694G.

Regarding the portion of Issue No. 1 addressing realignment of the DSH calculation to the Provider's fiscal year end, the Board finds that realignment using the Provider's fiscal year end is a Provider election, and there is no evidence in the record that the Medicare Contractor has made a final determination regarding this issue. Therefore, the Board does not have jurisdiction over the DSH/SSI Percentage Provider Specific issue as the Provider cannot meet the "dissatisfaction with a final determination" jurisdictional requirement, and this portion of Issue No. 1 pertaining to realignment of the fiscal year end is dismissed from the appeal.

***Issue No. 3 "DSH Medicaid Eligible Days"***

The Board finds that pursuant to the rationale in *Barberton Citizens Hosp. vs. CGS Administrators*, PRRB Dec. No. 2015-D5 (March 19, 2015)(*"Barberton"),* that it has jurisdiction over the Medicaid Eligible Days issue. Norwalk Hospital has established that there was a practical impediment to capturing every Medicaid eligible day by the deadline for filing this cost report.

In *Barberton* the Board states "pursuant to the concept of futility in *Bethesda*, the Board has jurisdiction of a hospital's appeal of additional Medicaid eligible days for the DSH adjustment calculation if that hospital can establish a "practical impediment" as to why it could not claim these days at the time that it filed its cost report." *Barberton* at 4.

Norwalk Hospital filed a response to Board Alert 10 in this appeal explaining why it was not able to obtain complete Medicaid eligibility verification from Medicaid State agencies at the time this cost report was filed, and it has met the practical impediment standard.

In conclusion, the Board dismisses Issue No. 1 (DSH/SSI Percentage Provider Specific) from the appeal and finds that it has jurisdiction over Issue No. 3 (DSH Medicaid Eligible Days).

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

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, Esq.
Chairperson

cc: Wilson Leong, Esq., FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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SEP 22 2017

**Certified Mail**

Kenneth R. Marcus
Honigman Miller Schwartz & Cohn
660 Woodward Avenue
Suite 2290
Detroit, MI 48226-3506

RE: Expedited Judicial Review Request
Baptist Memorial Health Care Corporation ("BMHCC") 2010 DSH[1] SSI[2]/Medicaid Medicare Advantage Days CIRP[3] Group
FYE: September 30, 2010
PRRB Case No.: 15-2666GC

Dear Mr. Marcus:

On August 17, 2017, in response to BMHCC 2010 DSH SSI/Medicaid Medicare Advantage Days CIRP Group's expedited judicial review ("EJR") request (received on July 21, 2017), the Provider Reimbursement Review Board ("PRRB" or "Board") issued a Development Letter to BMHCC regarding one of its group participants, Baptist Memorial Hospital DeSoto Southaven, Provider No. 25-0141 ("Baptist Memorial"). In its Development Letter, the Board explained that it was unable to make a jurisdictional determination regarding this provider because BMHCC filed an illegible Audit Adjustment Report for Baptist Memorial when it filed the CIRP group's jurisdictional documents.[4] The Board requested that, within 30 days, BMHCC (or the Medicare contractor) provide the Board with a legible copy of the Audit Adjustment Report pertinent to the appeal. On August 28, 2017, BMHCC's representative provided the legible Audit Adjustment Report, as requested.[5] Upon review of the newly furnished document, the Board has

[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] Under 42 C.F.R. § 405.1842(e)(3)(ii) (2016), if the provider (or representative) has not submitted a complete EJR request the Board must, within 30 days of receipt of the incomplete request, issue a written notice to the provider describing in detail the further information that the provider must submit in order to complete the request.
[5] When BMHCC's representative filed the legible Audit Adjustment Report for Baptist Memorial, the representative claimed that the Board had only "four days remain(ing) for the Board to satisfy the [EJR] deadline." Response to Development Letter at 1. However, the representative is incorrect. Under 42 C.F.R. § 405.1842(b)(2) (2016), the 30-day period for the Board to make an EJR determination under section 1878(f)(1) of the Act does not begin to run until the Board finds jurisdiction to conduct a hearing on the matter at issue in the EJR request and notifies the provider that the provider's request is complete. Here, the Board did not receive BMHCC's completed request until it received Baptist Memorial's Audit Adjustment Report on August 28, 2017. Therefore, pursuant to the above-quoted regulation, the 30-day period for the Board to make its EJR determination did not begin until August 28, 2017.

determined that it has jurisdiction to hear Baptist Memorial's appeal as included within the instant CIRP group appeal and that it grants BMHCC's EJR request, as explained below.[6]

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.[7]

**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").[8] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[9]

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[10] 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.[11]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[12] 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.[13] The DPP is defined as the sum of two fractions expressed as percentages.[14] Those

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[6] Under the regulations governing CIRP group appeals, once the Board has determined that a CIRP group is fully formed—such as here when the representative informed the Board that the instant CIRP group was complete in a February 15, 2017 notification—no other provider under common ownership or control may appeal to the Board the issue that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal. 42 C.F.R. § 405.1837(e)(1) (2016). With respect to the instant CIRP group appeal, the Board was unable to make a jurisdictional determination regarding one of the group appeal participants, Baptist Memorial, thus if the Board had granted EJR to the remaining participants in the CIRP group prior to receiving Baptist Memorial's, pursuant to the above-quoted regulation, Baptist Memorial would have lost its ability to appeal the issue at the heart of this group appeal and EJR request. As the representative did not inform the Board that it wished to move forward with the CIRP group EJR request without Baptist Memorial, the Board has not issued its EJR determination for any of the participants involved in the instant CIRP group appeal but does so with this determination.

[7] July 21, 2017 EJR Request at 8.

[8] 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.

[9] *Id.*

[10] 42 U.S.C. § 1395ww(d)(5).

[11] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

[12] 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(l).

[13] 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

[14] 42 U.S.C. § 1395ww(d)(5)(F)(vi).

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.[15]

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.[16]

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

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[15] 42 C.F.R. § 412.106(b)(2)-(3).
[16] 42 C.F.R. § 412.106(b)(4).

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[17] 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].[18]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[19]

With the creation of Medicare Part C in 1997,[20] 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.[21]

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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[17] of Health and Human Services
[18] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).
[19] *Id.*
[20] 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.
[21] 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 Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction.* (emphasis added)[22]

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."[23] 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.[24] (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.[25] 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

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[22] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).
[23] 69 Fed. Reg. at 49,099.
[24] *Id.*
[25] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).

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,*[26] vacated the FFY 2005 IPPS rule. However, the providers point out that the decision is not binding in actions by other hospitals and that the Secretary has not acquiesced to that decision.[27]

**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.[28]

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."[29] 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 providers argue 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.

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[26] 746 F. 3d 1102 (D.C. Cir. 2014).
[27] July 21, 2017 EJR Request at 1.
[28] 69 Fed. Reg. at 49,099.
[29] *Allina* at 1109.

**Jurisdictional Determination for the CIRP Group Providers**

Pursuant to the pertinent sections of the Medicare statute[30] 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 its request for hearing was timely filed.[31]

The CIRP group case involved in the instant EJR request includes providers' appeals of original notices of program reimbursement in which the Medicare contractor settled the cost reporting period ending September 30, 2010.

As such, 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 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 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 the group appeal exceeds $50,000, as required[32] 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 Authority to Consider the Appealed Issue**

The providers' appeals concern the fiscal year ending on September 30, 2010, thus the appealed cost reporting period 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.

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[30] The pertinent section of the Medicare statute may be found at 42 U.S.C. § 1395oo(a).
[31] 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).
[32] 42 C.F.R. § 405.1837.

**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 providers in this group appeal are entitled to a hearing before the Board;

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

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

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 these cases.

Board Members Participating:

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

FOR THE BOARD:

Board Member

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

cc: Barb Hinkle, Cahaba GBA c/o National Government Services, Inc. (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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SEP 22 2017

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

RE: Bristol Hospital
Provider No.: 07-0029
FYE: 9/30/10
PRRB Case No.: 14-4316

Dear Mr. Ravindran and Ms. VanArsdale,

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 September 15, 2014, based on a Notice of Program Reimbursement ("NPR") dated March 19, 2014. The hearing request included eleven issues, nine of which were subsequently transferred to group appeals or withdrawn. Two issues remain in the appeal as follows: Issue 1 – Disproportionate Share Hospital ("DSH") Payment/Supplemental Security Income Percentage (Provider Specific) and Issue 7 – Disproportionate Share Hospital Payment – Medicaid Eligible Days.

The Medicare Contractor submitted a jurisdictional challenge on the DSH SSI% - Provider Specific issue on August 19, 2015. The Provider submitted a responsive brief on September 10, 2015. Subsequently, the Medicare Contractor submitted a jurisdictional challenge on the Medicaid Eligible Days issue on July 6, 2017. The Provider submitted a responsive brief on August 3, 2017.

## Medicare Contractor's Position

*Issue 1- DSH SSI% - Provider Specific*

The Medicare Contractor explains that the Provider appealed DSH SSI% - Provider Specific and DSH SSI% - Systemic Errors. Subsequently, the Provider requested that the DSH SSI% - Systemic Errors issue be transferred to PRRB Case No. 15-2384G – QRS 2010 DSH SSI Percentage Group II on May 26, 2015. The Medicare Contractor contends that the DSH SSI% - Provider Specific and DSH SSI% - Systemic Errors issues are considered the same issue by the

PRRB, and as such, the issue cannot be in two cases at the same time. This Provider is already a member of PRRB Case No. 15-2384G, so the Provider cannot also have this issue in an individual open case for the same fiscal year.[1]

*Issue 7- DSH - Medicaid Eligible Days*

The Medicare Contractor explains that it accepted an amended cost report from the Provider on July 26, 2011. On its amended cost report, the Provider included 1,300 Medicaid paid days and 2,762 Medicaid unpaid days.[2]

The Medicare Contractor goes on to explain that it adjusted cost report Worksheets S-3, Part I, column 5, lines 1 and 2 to deduct 136 Medicaid paid days and 276 Medicaid eligible days respectively. The adjustment to Medicaid eligible days resulted from a detailed review of the days. Of the 276 days disallowed, 263 related to the psychiatric excluded unit and 13 days related to lack of remittance advices, having active Medicare Part A coverage at the time of service, or the services were not rendered in the inpatient area of the hospital. The adjustment to the Medicaid paid days was entirely related to the psychiatric excluded unit.[3]

The Medicare Contractor contends that the Provider is now claiming an additional 4,227 Medicaid days. The Provider did not include this amount on Worksheet E Part A, line 30, protested amounts, on the amended cost report. The Medicare Contractor contends that the Medicaid eligible days issue in this case should be dismissed from the appeal as there were no protested items filed on the amended cost report and the Provider has failed to prove the Medicare Contractor's adjustment to Worksheet S-3 adjusted the days currently sought by the Provider. Since the additional days were not claimed in the cost report, it follows that the Medicare Contractor made no adverse adjustment. Therefore, there is no dissatisfaction for the Provider to base its appeal on this issue.[4]

**Provider's Position**

*Issue 1- DSH SSI% - Provider Specific*

The Provider contends that the SSI (Provider Specific) and SSI (Systemic Errors) are separate and distinct. The Provider argues that Board Rule 8.1 states "Some issues may have multiple components. To comply with the regularity requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible..." The SSI Systemic and SSI Provider Specific issues represent different components of the SSI issue, which was specifically adjusted during the audit. Since these specific appeal issues represent different aspects/components of the SSI issue, the Provider

[1] Medicare Contractor's August 19, 2015 jurisdictional challenge at 1-2.
[2] Medicare Contractor's July 6, 2017 jurisdictional challenge at 3.
[3] Medicare Contractor's July 6, 2017 jurisdictional challenge at 3.
[4] Medicare Contractor's July 6, 2017 jurisdictional challenge at 3-4.

contends the Board should find jurisdiction over both the SSI Systemic and SSI Provider Specific issue.[5]

The Provider contends that the SSI Systemic issue covers more in-depth aspects of the MedPar data but more importantly the treatment of Medicare Advantage, Medicare Managed Care, Medicare+Choice and/or Part C Days. The SSI Systemic issue also covers CMS Ruling 1498-R. The Provider contends that the Medicare Contractor's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1695ww(d)(5)(F)(i).[6]

Under the SSI (Provider Specific) issue the Provider is addressing the various errors of omission and commission that do not fit into the "systemic errors" category. The Provider argues that, accordingly, 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 2010 as a result of its understated SSI percentage.[7]

*Issue 7- DSH - Medicaid Eligible Days*

The Provider contends that the Board does have jurisdiction over this issue pursuant to Board Rule 7.2(B) and under the provisions of 42 U.S.C. § 1395oo(a)(1)(B). The issuance of a Notice of Program Reimbursement and timely appeal properly triggers the Board's jurisdiction over this Provider. Further, in this case there were, in fact, adjustments to DSH and such adjustments may be enough to warrant Board jurisdiction over this appeal issue. However, the Provider contends that the adjustments are not required, as DSH is not an item that has to be adjusted or claimed on a cost report. Accordingly, the presentment requirement does not apply, but should the Board determine it does apply, the Provider contends this requirement is not valid.[8]

The Provider argues that the documentation necessary to pursue DSH is often not available from the State in time to include all DSH/Medicaid Eligible Days, even those days for patients who have Part C and Medicaid coverage on the cost report, and the information, as to what days are included in the Medicare fraction, is not readily available from the CMS prior to the cost report filing deadline. As a result, the Provider also self-disallowed DSH in the cost report in accordance with Board Rule 7.2(B).[9]

**Board's Decision**

*Issue 1- DSH SSI% - Provider Specific*

Two of the issues that the Provider included in its hearing request were the DSH SSI % - Provider Specific and DSH SSI % - Systemic Errors issues. The Provider requested that the DSH SSI% - Systemic Errors issue be transferred to PRRB Case No. 13-2584G - QRS 2010 DSH SSI

[5] Provider's September 10, 2015 responsive brief at 1.
[6] Provider's September 10, 2015 responsive brief at 1-2.
[7] Provider's September 10, 2015 responsive brief at 2.
[8] Provider's August 3, 2017 responsive brief at 1.
[9] Provider's August 3, 2017 responsive brief at 4.

Percentage Group II by a request dated May 26, 2015. The Board has considered the DSH SSI % - Provider Specific and DSH SSI% - Systemic Errors issues to be the same issue as both are based on SSI data. As such, the issue cannot be in two cases at the same time.

The Board finds that Board Rule 4.5 states that a Provider may not appeal an issue from a final determination in more than one appeal. As such, the Board concludes that it does not have jurisdiction over Issue 1 – DSH SSI% - Provider Specific, and dismisses it from the appeal, as it is the same issue that the Provider is appealing in PRRB Case No. 13-2584G – QRS 2010 DSH SSI Percentage Group II.

*Issue 7 – DSH - Medicaid Eligible Days*

The Provider is appealing from a 9/30/2010 cost report, which means that it either had to claim the cost at issue or it is subject to the protest requirement in order for the Board to have jurisdiction.

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

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 notwithstanding the fact that it knew the State would have additional days at a later point in time. Therefore, the Board could only have jurisdiction over those days if the Provider included a claim for the specific items on its cost report, as required by 42 C.F.R. § 405.1835(a).

The Board finds that the Provider did not include a claim for the specific days at issue in this appeal on its cost report, therefore it does not have jurisdiction over the days. The Board acknowledges that Bristol filed Medicaid days on various lines on its as-filed cost report, to which the Medicare Contractor made an adjustment. However, Bristol has presented no evidence that the days at issue were part of the days adjusted off. Therefore, the Board finds that Bristol has not met the dissatisfaction requirement of including a specific claim on the cost report, or protesting the specific Medicaid eligible days at issue, concludes that it does not have jurisdiction over the issue, and dismisses the issue from the appeal.

As there are no issues remain remaining in the appeal, the Board hereby closes the case and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

[10] 42 C.F.R. § 405.1835(a) (emphasis added).

Board Members Participating:
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Charlotte F. Benson, CPA
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FOR THE BOARD

L. Sue Andersen, Esq.
Chairperson

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

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SEP 25 2017

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Pam VanArsdale
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National Government Services, Inc.
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

RE: Jurisdictional Decision
Provider: Norwalk Hospital
Case Number: 13-1006
FYE: 09/30/2007

Dear Mr. Kruzick and Ms. VanArsdale:

**Background:**

Norwalk Hospital, or the Provider, is appealing the amount of Medicare Reimbursement as determined by the Medicare contractor. The Provider titles Issue No. 1 in its request for appeal as the "Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific)" issue (hereinafter "DSH/SSI Percentage Provider Specific issue"). *Model Form A – Individual Appeal Request (Mar. 4, 2013), Tab 3 – Appeal Issues at 1.* The Provider titles Issue No. 2 as the "Disproportionate Share Hospital ('DSH')/Supplemental Security Income ('SSI') (Systemic Errors)" issue (hereinafter "DSH/SSI Systemic Errors issue"). *Id.*

The Provider describes the DSH/SSI Percentage Provider Specific issue as the "SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation." *Id.* The Provider further states

> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that that CMS failed to include in their determination of the SSI percentage. The Provider hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period…

*Id.*

The Provider describes the DSH/SSI Systemic Errors issue as their SSI percentage was incorrectly computed for a variety of reasons, including "the DSH payment do not accurately represent patient days

in the numerator and denominator used to calculate the percentage." *Id at 3.* The Provider has filed request to transfer the DSH/SSI Systemic Errors issue to Case No. 13-2679G. *Model Form D – Request to Transfer an Issue to a Group Appeal (Oct. 24, 2013).*

**Medicare Contractor's Position**

The Medicare Contractor's position is that Issue No. 1 addressing the DSH/SSI Percentage Provider Specific issue is duplicated by Issue No. 2, and duplicative issues are prohibited by PRRB Rule 4.5. The Medicare Contractor asserts the Provider is arguing the same thing in both issues - that the SSI percentage is understated and that it needs the underlying data to determine what records were not included, if any.

**The Provider's Position**

The Provider did not file a response to the Medicare Contractor's August 28, 2017 Jurisdictional Challenge.

**Board Decision**

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a hospital 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 $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. 42 U.S.C. §1395oo(a) provides, in relevant part:

> Any provider of services which has filed a required cost report within the time specified in the regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board . . . if –
>
> (1) such provider
>
> (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by this report.

Additionally, PRRB Rule 4.5 states that a Provider may not appeal an issue from a final determination in more than one appeal.

Pursuant to 42 C.F.R. 412.106(b)(3), a Provider may request that CMS use its cost reporting period instead of the Federal fiscal year in calculating the SSI percentage of the DSH payment calculation. It must make such a request in writing to its Medicare Contractor.

The Board finds that it has jurisdiction over the portion of Issue No. 1 (DSH/SSI Percentage Provider Specific) challenging the data used to calculate the SSI percentage as there was an adjustment to the SSI

percentage (Adj. 37), and the appeal meets the amount in controversy and timely filing requirements. However, the Board also finds that the inaccurate data portion of Issue No. 1 is duplicative of Issue No. 2, the DSH/SSI Systemic Errors issue that was transferred to 13-2679G. The basis of both Issues is that the SSI percentage is improperly calculated, and the Provider does not have the underlying data to determine if the SSI percentage is accurate. The portion of Issue No. 1 challenging the accuracy of the SSI ratio data now resides in Case No. 13-2679G.

Regarding the portion of Issue No. 1 addressing realignment of the DSH calculation to the Provider's fiscal year end, the Board finds that realignment using the Provider's fiscal year end is a Provider election, and there is no evidence in the record that the Medicare Contractor has made a final determination regarding this issue. Because the DSH/SSI Percentage Provider Specific issue is duplicative and there was no final determination regarding this issue, the Board does not have jurisdiction over this issue and and it is dismissed from the appeal.

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

Board Members

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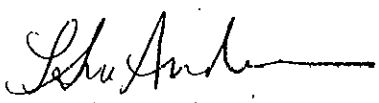
FOR THE BOARD



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Chairperson

cc: Wilson Leong, Esq., FSS

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RE: **PRRB Own Motion Expedited Judicial Review Determination**
Puerto Rico DSH SSI Group Appeals
Case Nos. 14-4129GC; 14-4161GC; 15-0021GC; 15-0245GC & 15-0777GC

Dear Mr. Roth and Mr. Pike:

The Provider Reimbursement Review Board ("Board") has reviewed the parties' responses regarding the suitability of these appeals for Expedited Judicial Review ("EJR") filed in response to the Board's May 19, 2017 notice that it was considering EJR on its own motion. The Board's decision regarding EJR on its own motion is set forth below.

## Issue under Appeal

Whether the hospitals' Medicare DSH payments for the fiscal years at issue were unlawfully low because they were based on improperly low SSI percentages that were calculated in violation of the DSH statute and other applicable statutes?[1]

## Statutory and Regulatory Background

The Disproportionate Share Hospital ("DSH") payment is based on an Inpatient Prospective Payment System ("IPPS") hospital's "disproportionate patient percentage," which is defined as follows in 42 U.S.C. § 1395ww(d)(5)(F)(vi):

> In this subparagraph, the term "disproportionate patient percentage" means, with respect to a cost reporting period of a hospital, the sum of—
>
> (I) 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 title and were entitled to supplemental security income benefits (excluding any State supplementation) under title XVI of this Act, and the denominator of which is the number of such

[1] Transcript at 7.

> 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 title, and
>
> (II) 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 title XIX, but who were not entitled to benefits under part A of this title, and the denominator of which is the total number of the hospital's patient days for such period.

The first fraction is commonly known as the "Medicare/SSI Fraction." The second fraction is commonly known as the "Medicaid Fraction." The Centers for Medicare and Medicaid Services ("CMS")[2] derives the numerator of the Medicare/SSI Fraction by counting inpatient days for inpatients who are entitled both to (a) Medicare Part A and (b) SSI program benefits under Title XVI of the Social Security Act ("the Act").

Although the Medicare DSH regulation has changed over the years, it generally states that (a) the numerator of the Medicare/SSI Fraction includes inpatient days for patients who "were entitled to both Medicare Part A and SSI" and (b) the denominator of the Medicare/SSI Fraction includes inpatient days for "patients entitled to Medicare Part A."

Puerto Rico hospitals were not included under the IPPS when it began on October 1, 1983. Effective October 1, 1987, however, Congress extended the IPPS program to hospitals in Puerto Rico. This change was enacted by § 9304 of the Omnibus Budget Reconciliation Act of 1986 ("OBRA 1986"). As enacted in OBRA 1986, 42 U.S.C. § 1395ww(d)(9)(D)(iii) requires Medicare DSH payments to be made to Puerto Rico hospitals, as follows:

> The following provisions of paragraph (5) shall apply to subsection (d) Puerto Rico hospitals receiving payment under this paragraph ***in the same manner and to the extent as they apply to subsection (d) hospitals receiving payment under this subsection:***
>
> (i) Subparagraph (A) (relating to outlier payments).
> (ii) Subparagraph (B) (relating to payments for indirect medical education costs), except that for this purpose the sum of the amount determined under subparagraph (A) of this paragraph and the amount paid to the hospital under clause (i) of this subparagraph shall be substituted for the sum referred to in paragraph (5)(B)(i)(I).
> (iii) Subparagraph (F) (relating to disproportionate share payments), except that for this purpose the sum described in clause (ii) of this subparagraph shall be substituted for the sum referred to in paragraph (5)(F)(ii)(I).
> (iv) Subparagraph (H) (relating to exceptions and adjustments).

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[2] Before June 14, 2001, CMS was known as the Health Care Financing Administration ("HCFA"). The Board generally refers to the agency as CMS, even for events before June 14, 2001.

CMS implemented the Puerto Rico IPPS provisions as part of the FY 1988 final rule by promulgating regulations at Subpart K of Part 412 of Chapter 42 of the Code of Federal Regulations which is entitled "PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT OPERATING COSTS FOR HOSPITALS LOCATED IN PUERTO RICO."[3] Subpart K includes 42 C.F.R. § 412.200, the first two sentences of which state: "Beginning with discharges occurring on or after October 1, 1987, hospitals located in Puerto Rico are subject to rules governing the Prospective Payment System for inpatient operating costs. Except as provided in this subpart, the provisions of subparts A, B, C, F, G and H apply to hospitals located in Puerto Rico." Subpart G is of particular interest in this case because it includes the DSH regulation: 42 C.F.R. § 412.106.

The parties stipulated that Puerto Rico does not now sponsor, and has never sponsored, a Title XVI SSI program. In 1974, the scope of Title XVI of the Act was expanded to provide for SSI benefits in the fifty States and the District of Columbia ("the States"), going beyond the previous Title XVI cash assistance programs for the needy aged, blind, and disabled. In Puerto Rico and a few other territories, however, the old provisions of Title XVI (providing cash assistance) continue to be used. The Title XVI SSI program provisions do not apply in Puerto Rico and these other territories even though anyone eligible for cash assistance under Titles I, X, XIV, and XVI also would qualify for benefits under the Title XVI SSI program eligibility criteria. In fact, certain individuals who do not meet the cash assistance qualification criteria under Titles I, X, XIV, and XVI, nevertheless meet the Title XVI SSI program qualification criteria.

The parties also stipulated that under CMS' implementation of 42 U.S.C. § 1395ww(d)(9)(D)(iii), the only inpatient hospital days for those entitled to Medicare Part A counted by CMS in the Medicare/SSI fraction for DSH purposes for hospitals in Puerto Rico are the days relating to Medicare beneficiary residents of the States entitled to Title XVI benefits at the time of their inpatient stay who happen to receive inpatient services at a Puerto Rico hospital. No days related to Puerto Rico resident Medicare beneficiary inpatients are counted (who were not entitled to SSI), even if these inpatients met the Title XVI SSI program eligibility criteria. CMS' non-inclusion of these days significantly reduced, and in some cases totally eliminated, DSH payments to which Puerto Rico hospitals would have been entitled if these days had been included.

**Providers' Position**

The Providers state that the idea of EJR in these appeals has come up numerous times over the years, including an own-motion request issued by the Board in 2005 (under old, pre-consolidation case numbers). Each time, the Providers have taken the position that EJR is not appropriate because the Board is not bound by the "implementation" of the Puerto Rico DSH statute, as the agency has never presented its interpretation of that statute in regulation.

The Providers argue that the Board has the authority to grant the relief sought, which they believe is one of two options: "1.) remand the appeals to the MAC for determination of the correct amount due in light of the Board's interpretation of the statute, or 2.) calculate the amount due, using the

[3] 52 Fed. Reg. 33034, 33058 (Sept. 1, 1987).

Hospital's methodology of including inpatient days for which the patient would have been entitled to SSI payments if the patient had been a resident of one of the States, or using a methodology developed by the Board."[4]

In its post hearing brief, the Providers covered why EJR is not appropriate and summarized those points in its own motion EJR response:

1.) EJR is required when a provider is challenging the constitutionality of a statute or the substantive or procedural validity of a regulation or ruling. The providers in this case claim neither is happening, as they believe that CMS has not issued a regulation relating to the controlling statutory provision.
2.) The Hospitals in this case are challenging the constitutionality of the implementation of a statute, not the statute itself, therefore EJR is not required.
3.) Conversely, if the Hospitals are not challenging the constitutionality of the statute, nor the regulation, EJR would not be required, and therefore the Board would have the authority to decide the issue.
4.) At the hearing, there was testimony that CMS calculated the DSH payments at issue for the Puerto Rico hospitals using the same methodology for calculating SSI percentages that CMS used for calculating DSH payments for hospitals in the States. The Providers argue that using the same methodology violates the statute's requirement for the payments to be made in "the same manner" and "to the extent" that hospitals in the states received payments.
5.) EJR would only be appropriate if CMS had issued a regulation through notice and comment, but it has not done so.
6.) CMS has unlawfully given guidance in preambles of non-applicable rulemaking regarding its position on how Puerto Rico SSI percentages should be calculated.

The Providers argue that the only situation in which EJR is appropriate would be if the Board concludes that the Puerto Rico DSH Statute does not address the issue in the appeal and determines it is bound by CMS' implementation of the statute.[5] The Providers conclude that this is not the situation currently before the Board, therefore EJR is not appropriate.

**Medicare Contractor/Federal Specialized Services Position**

The Medicare Contractor acknowledges that EJR has been discussed in relation to these appeal throughout their long history at the Board, but based on the post hearing briefs, the hearing transcript, etc., the Medicare Contractor is requesting a decision pursuant to 42 C.F.R. § 405.1871, and not an EJR determination under 42 C.F.R § 405.1842.

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[4] Providers' Consolidated Post Hearing Brief at 59.
[5] Providers' Consolidated Response to Notice of Board's Own-Motion Consideration of Whether EJR is Appropriate at 8.

The Medicare Contractor summarized its recommendation using the following points:

A.) Puerto Rico Residents are not entitled to receive SSI payments;
B.) Regulation 42 C.F.R. § 412.106(b)(2) limits the DSH Medicare proxy numeration to patients entitled to receive SI payments when hospitalized;
C.) The regulation does not permit the development of a surrogate to identify low income Puerto Rico residents who meet the SSI requirements applicable to the 50 US States/DC to enlarge the Medicare proxy for a Puerto Rico SSI hospital;
D.) If the appealing Providers had agreed with C.), EJR might have been appropriate much earlier;
E.) The Providers developed a complex argument citing first 42 U.S.C. § 1395(ww)(d)(9)(D)(iii) and incorporating a review of the creation of the DSH, Puerto Rico Hospitals inclusion into IPPS, Administrative Procedure Act deficiencies, and Affordable Care Act DSH reform to create a gap between the statute and 42 C.F.R. § 412.106(b)(2), that the Board can fill and order additional DSH payments based on an enlarged Medicare proxy;
F.) The Medicare Contractor argued that the Providers arguments summarized in E.) above DO NOT support an increased Medicare proxy.

The Medicare Contractor is requesting that the Board make a decision relating to the points expressed in E.) above. It further argues that if the Board grants EJR now, it would be unclear whether the Board could even consider the Provider's arguments on an "authority" basis or on a "merits" basis.

**Decision of the Board**

In the preamble of the FY 1988 proposed IPPS rule, CMS (then known as HCFA) outlined its proposal to begin paying Puerto Rico hospitals under the IPPS system. CMS stated that 42 U.S.C. § 1395ww(d)(9)(A) specifies that a hospital is subject to the prospective payment system if it is located in Puerto Rico and otherwise would be subject to that system if it were located in one of the 50 states.[6] Further, CMS stated that § 1395ww(d)(9)(D) specifies that § 1395ww(d)(5)(F), which authorized additional payments for hospitals that serve a disproportionate share of low-income patients, would apply to Puerto Rico hospitals. CMS proposed 42 C.F.R. § 412.200, which stated:

> Beginning with discharges occurring on or after October 1, 1987, hospitals located in Puerto Rico are subject to the rules governing the prospective payment system. Except as provided in this subpart, the provisions of Subparts A, B, C, F, ***G*** and H of this part apply to hospitals located in Puerto Rico.[7]

[6] 52 Fed. Reg. 22080, 22088 (June 10, 1987).
[7] (Emphasis added.)

Significantly 42 C.F.R. Part 412, Subpart G governs DSH adjustment calculations. In the FY 1988 final IPPS rule, CMS further addressed the application of Subpart G to Puerto Rico hospitals.[8] In response to a comment that states, "the same cost outlier thresholds applicable to prospective payment hospitals located outside of Puerto Rico are not appropriate for Puerto Rico hospitals given the fact that hospital costs are lower in Puerto Rico," CMS cited the statute that states, "certain provisions . . . applicable to subsection (d) hospitals shall apply to subsection (d) Puerto Rico hospitals . . . in the same manner and to the extent as they apply to subsection (d) hospitals . . . Therefore, we are using the same day and cost outlier thresholds for Puerto Rico hospitals and all other hospitals." CMS went on to say, "Congress also incorporated features that are identical to the features applicable to the prospective payment system for all hospitals outside of Puerto Rico. In fact Congress, provided that Puerto Rico hospitals will be entitled to additional payments for the indirect costs of medical education and as disproportionate share hospitals, even though the formulas for computing these adjustments would be different (and perhaps result in lower adjustments) if they were based solely on Puerto Rico data and circumstances." Therefore, CMS considered revising payment formulas for specific Puerto Rico "data and circumstances" and decided against it.[9]

CMS also responded to a comment in the final rule in which there was a concern that not all Puerto Rico hospitals that would qualify for a disproportionate share adjustment were identified as certain hospitals would qualify under § 412.106(b)(2). CMS stated, "The determination of whether a hospital is entitled to receive additional payments as a disproportionate share hospital is made by fiscal intermediary based on the latest data available."[10]

CMS's methodology for calculating the standardized rates (*i.e.*, initial base federal rate) to be used in the IPPS for Puerto Rico hospitals further confirms that 42 C.F.R. Part 412, Subsection G applies to Puerto Rico hospitals in the exact same manner and extent it applied to all subsection (d) hospitals. The statutory requirements for the standardized amount is set forth at 42 U.S.C. § 1395ww(d)(9)(B) and, in particular, the standardized amount must "exclude[e] an estimate of the add-on DHS payments that are to be made under IPPS to Puerto Rico hospitals pursuant to § 1395ww(d)(9)(D)(iii). In section III of the addendum to both the FY 1988 proposed and final IPPS rules, CMS set forth its methodology for calculating the standardized amount[11] and provided the following detail on its calculation of the estimate for the DSH add-on payments to be excluded from the standardized amount:

> us[ing] available data on the percentage of Medicaid days from FY 1984 Medicare cost reports and the percentage of SSI/Medicare days for FY 1985 derived *from matching FY 1985 SSI eligibility files* to Medicare FY 1985 PATBILL records.[12]

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[8] 52 Fed. Reg. 33034, 33043-33045, (Sept. 1, 1987).
[9] *Id.* at 33044.
[10] *Id.* at 33045.
[11] 52 Fed. Reg. at 22089; 52 Fed. Reg. at 33044.
[12] 52 Fed. Reg. at 22107 (emphasis added); 52 Fed. Reg. at 33067 (emphasis added).

Thus, CMS has consistently used the SSI eligibility files as specified in 42 C.F.R. Part 412, Subpart G both in setting up the IPPS standardized amounts for Puerto Rico hospitals and for calculating hospital-specific DSH add-on payments for Puerto Rico hospitals.

In summary, CMS' discussion of the Puerto Rico DSH payments in both the FY 1988 proposed and final IPPS rules supports its promulgation of 42 C.F.R. § 412.200 which strictly states that Puerto Rico hospitals will be subject to Subpart G, which includes the regulatory provisions implementing the disproportionate share hospital payment at § 412.106. 42 C.F.R § 412.200 clearly states that those identified Subparts would apply to all Puerto Rico hospital discharges, except as provided in this subpart. CMS failed to implement additional regulations for Puerto Rico hospitals, therefore the DSH regulations as they relate to all other subsection (d) hospitals would apply to Puerto Rico hospitals as well.

Therefore, the Board finds that it is bound by 42 C.F.R § 412.200, which through notice and comment implemented 42 U.S.C. § 1395ww(d)(9)(D)(iii) and applied 42 C.F.R §412.106 to all Puerto Rico hospitals as written. The Board has no authority to challenge CMS' promulgation of the implementing regulation and demand that they use another calculation besides 42 C.F.R § 412.106 to calculation the Puerto Rico hospital DSH payment, or to provide for revisions to the DSH regulations specifically for Puerto Rico hospitals.

The Board finds that:

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

2) based upon the Provider's assertions, 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. § 412.200; 42 U.S.C. § 1395ww(d)(9)(D)(iii) and 42 C.F.R> § 412.106); and

4) it is without the authority to decide the legal question of whether the hospitals' Medicare DSH payments for the fiscal years at issue were unlawfully low because they were based on improperly low SSI percentages that were calculated in violation of the DSH statute and other applicable statutes.

Accordingly, the Board finds on its own motion that the legal question of whether the hospitals' Medicare DSH payments for the fiscal years at issue were unlawfully low because they were based on improperly low SSI percentages that were calculated in violation of the DSH statute and other applicable statutes properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants expedited judicial review on its own motion for the issue and the subject years. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review.

As each group appeal only included the issue over which the Board has granted EJR on its own motion, PRRB Cases Numbers 14-4129GC; 14-4161GC; 15-0021GC; 15-0245GC & 15-0777GC are hereby closed.

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

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

Enclosures: 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877

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RE: Hendrick Medical Center
Provider No. 45-0224
FFY 2015
PRRB Case No. 15-1081

Dear Messrs. Roth and Leong:

The Provider Reimbursement Review Board (Board) has reviewed the record in the above-referenced appeal. The Board's jurisdictional determination with respect to appeal is set forth below.

**Issue Under Appeal**

The issue under appeal in this case is:

> Whether the Medicare Inpatient Prospective Payment System [IPPS] wage index assigned to the Abilene, Texas Core-Based Statistical Area for [F]ederal fiscal year ("FFY) 2015 was incorrectly low, thereby causing the Providers' 2015 Medicare payments to be understated.[1]

**Factual Background**

The statute, 42 U.S.C. § 1395ww(d)(3)(E), requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary adjust the standardized amounts "for area differences in the hospital wage level which reflects the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level."[2] The wage index is calculated and assigned to hospitals on the basis of the labor market area in which the hospital is located. Pursuant to 42 U.S.C. § 1395ww(d)(3)(E), beginning in 2005, the delineation of hospital labor market areas is based on the Core-Based Statistical Areas (CBSAs) established by the Office of Management and Budget.[3]

The Federal Fiscal (FFY) wage index for 2015 information was made available through the Hospital Open Door forum on the internet. Hospitals were encouraged to sign up for automatic notifications of information and scheduling of the Open Door Forums. In addition, the Centers for Medicare & Medicaid Services sent out a memorandum on September 16, 2013, in which the Medicare Administrative Contractors (MACs) were instructed to inform all inpatient prospective payment hospitals of the

[1] Providers' February 28, 2017 cover letter to the position paper.
[2] 79 Fed. Reg. 27,978, 28,054 (May 15, 2014).
[3] *Id.*

availability of the wage data files and the process and timeframe for requesting revisions.[4] A timetable for the FFY 2015 wage index was also publish on the internet.[5]

Hendrick Medical Center (the Provider or Hendrick) noted that the average hourly wage (AHW) and other wage dated in its 2012 unaudited cost report was not correct. The Provider contacted the MAC and supplied the correct information. The result of this submission was an increase in the Provider's AHW. This corrected dated was reflected in the revised FFY 2015 Public Use File (PUF) published on February 20, 2014. This was the data used to calculate the wage indices published in the FFY 2015 IPPS Proposed Rule in the May 15, 2014 Federal Register.[6] The Provider notes that the Proposed Rule included the correctly calculated wage index for the Abilene, Texas CBSA,[7] the area where this Provider is located.

On May 2, 2014, just before the IPPS Proposed Rule was published, and in accordance with the FY 2015 Hospital Wage Index Time Table, CMS added the FYE 2015 wage index and occupational mix PUF to its website. Hendrick's wage data in this PUF was incorrect, resulting in a lower AHW. This contradicted the March 24, 2014 approval the MAC had given Hendrick Medical Center when it submitted corrected wage data.

The Provider believes that the MAC was to notify hospitals of the release of the May 2, 2014 PUF in April of 2014. This notice was to inform providers to review the PUF and that this will be their last opportunity to request corrections to errors in the final data. Hendrick asserts that it received no communication from the MAC after the March 24, 2014 email from the MAC.[8] The Providers realized that the incorrect wage index for Hendrick was used when the Secretary published the FFY 2015 IPPS Final Rule on August 22, 2014. The wage data error effects not only Hendrick, but the other facilities in the CBSA because the wage index is calculated and assigned to hospitals on the basis of the labor market area in which the hospital is located.

In its position paper, the MAC explained that when it transmitted the final wage index data to CMS, the original, unrevised data was mistakenly transmitted. As a result, this data was incorporated into the PUF that was release May 2, 2014.[9]

**Board's Jurisdictional Determination**

The Board concludes that it lacks jurisdiction over Hendrick Medical Center because it failed to exhaust its administrative remedies when it failed to check the May 2, 2014 PUF which contained the incorrect wage data for FFY 2015. Although the Provider argues that it lacked notice of the issuance of the PUF, the Secretary advised providers to review the file in the May 15, 2014 Federal Register. In that notice the Secretary advised that:

> The final wage index data public use files are posted on May 2, 2014 on the Internet at: *http://www.cms.gov/Medicare/ Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/FY-2015-Wage-Index-Home-Page.html*. The May 2014 public use files are made

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[4] *Id. at 28,080.*
[5] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2015-WI-Timeline.pdf.
[6] 79 Fed. Reg. 27,978 (May 15, 2014).
[7] Providers' February 28, 2017 Position Paper at 4.
[8] *Id. at 6. See also* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2015-WI-Timeline.pdf.
[9] MAC's March 27, 2017 Position Paper at 6.

> available solely for the limited purpose of identifying any potential errors made by CMS or the MAC in the entry of the final wage index data that resulted from the correction process described above (revisions submitted to CMS by the MACs by April 9, 2014).
>
> After the release of the May 2014 wage index data files, changes to the wage and occupational mix data will only be made in those very limited situations involving an error by the MAC or CMS that the hospital could not have known about before its review of the final wage index data files.
>
> **********
>
> The final wage index data public use files are posted on May 2, 2014 on the Internet at: *http://www.cms.gov/ Medicare/ Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/FY-2015-Wage-Index-Home-Page.html*. The May 2014 public use files are made available solely for the limited purpose of identifying any potential errors made by CMS or the MAC in the entry of the final wage index data that resulted from the correction process described above (revisions submitted to CMS by the MACs by April 9, 2014). After the release of the May 2014 wage index data files, changes to the wage and occupational mix data will only be made in those very limited situations involving an error by the MAC or CMS that the hospital could not have known about before its review of the final wage index data files.
>
> ******
>
> If, after reviewing the May 2014 final public use files, a hospital believes that its wage or occupational mix data are incorrect due to a MAC or CMS error in the entry or tabulation of the final data, the hospital should notify both its MAC and CMS regarding why the hospital believes an error exists and provide all supporting information, including relevant dates (for example, when it first became aware of the error). The hospital is required to send its request to CMS and to the MAC no later than June 2, 2014.[10]

Providers are deemed to have notice of the contents of the Federal Register. The regulation, 44 C.F.R. § 1507 states that notice by publication in the Federal Register "is sufficient to give notice of the contents of the document to a person subject to or affected by it." In the case of Hendrick, it is clear that the Provider had availed itself of the procedures for correcting its wage data as set forth in FY 2015 Hospital Wage Index Development Timetable. However, the Provider failed to review the May 2, 2014 PUF file. The Secretary reminded providers to check their wage index calculations in the May 15, 2014 IPPS Proposed Rules and noted that they had until June 2, 2014 to advise CMS and the MAC of any error. All of these deadlines were set forth in Wage Index Development Timetable which the Provider had been aware of as evidenced by its request to correct its wage data.

The Provider is deemed to have knowledge of information published in the Federal Register and there is no requirement that the MAC provide notice other than identified in proposed rule where on September 16, 2013, MACs were instructed to advise IPPS of the availability of wage data and the timeframe for requesting revisions.[11] Since the Provider failed to review the May 2nd PUF and did not request a

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[10] 79 Fed. Reg. 27, 978, 28,081 (May 15, 2014).
[11] *Id.* at 28,080.

correction to its wage index data, it failed to exhaust its administrative remedies and its appeal is dismissed and the case closed.

Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877.

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Chairperson

Enclosures: 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1875 and 405.1877.

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RE: **Expedited Judicial Review Determination**
13-1741GC Good Shepard Health System 2007 DSH Part C Days Group
13-2192GC Franciscan Alliance 2006 DSH Part C Days Group
14-4220GC Centegra Health 2010 DSH Medicare Advantage Group
15-1867G Hall Render 2013 DSH Medicare/Medicaid Part C Days Optional Group
15-2642G Hall Render 2012 DSH Medicare/Medicaid Part C Days Optional Group

Dear Ms. Griffin:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' September 5, 2017 request for expedited judicial review (EJR), (received September 6, 2017). The Board's determination is set forth below.

The issue for which EJR has been requested is:

> The improper inclusion by the [Medicare Contractor] and the Centers for Medicare & Medicaid Services (CMS) of inpatient days attributable to Medicare Advantage patients in the numerator and [denominator] of the Medicare Proxy when calculating the disproportionate share hospital (DSH) eligibility and payments.[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] September 5, 2017 EJR Request at 2.
[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"[9] fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

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

The Medicare/SSI fraction is computed annually by CMS, and the Medicare 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)(F)(i)(I); 42 C.F.R. § 412.106.
[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] "SSI" stands for "Supplemental Security Income."
[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

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

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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.

[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.

> 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, as the Providers point out, the Secretary has not acquiesced or taken action to implement the decision[22] and the decision is not binding in actions by other hospitals.

**Providers' Request for EJR**

The underlying issue in this EJR request 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 claim 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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[19] *Id.*
[20] 72 Fed. Reg. 47,130, 47,384 (Aug. 22, 2007).
[21] 746 F. 3d 1102 (D.C. Cir. 2014).
[22] September 5, 2017 EJR Request at 8-9.
[23] 69 Fed. Reg. at 49,099.
[24] *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 argue that since the Secretary has not acquiesced to the decision in *Allina*, the Board remains bound by the regulation and EJR is appropriate.

**Decision of the Board**

Board's Authority

Under the Medicare statute codified at 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1) (2016), the Board is required to grant a provider's EJR request if it determines that (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

Jurisdictional Requirements

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the providers requesting EJR. Pursuant to the pertinent regulations governing Board jurisdiction, 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 $10,000 or more for an individual appeal or $50,000 or more for a group, and the request for hearing was timely filed.[25]

Most of the Providers included in this EJR request filed appeals of their original notices of program reimbursement ("NPRs") in which the Medicare contractor settled cost reporting periods ending in 2007, 2010, 2012 or 2013. One group consists of Providers with appeals of revised NPRs (NPRs) in which the Medicare contractor settled cost reporting periods ending in 2006.

For appeals of original NPRs for cost reporting periods ending before December 31, 2008, the providers may demonstrate dissatisfaction with the amount of Medicare reimbursement of the

[25] The regulations governing Board jurisdiction begin at 42 C.F.R. § 405.1835. These regulations are essentially the same for the years covered by the appeals involved with the instant EJR request except for the sub-clause regarding timely filing. 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).

Part C days issue by claiming the issue as a "self-disallowed cost" pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[26]

For appeals of original NPRs for cost reporting time periods ending on or after December 31, 2008, the providers preserve their respective 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 cost report for the period where the provider seeks 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.[27]

For appeals of RNPRs for cost reporting periods ending in the 2006 calendar year, the Providers must demonstrate that the issue under review was specifically revisited on reopening.[28]

Jurisdictional Determination for Providers

The Board finds that all Providers involved with the instant EJR request have either had Part C days excluded from the Medicaid fraction, have had a specific adjustment to the SSI fraction, or have properly protested/self-disallowed 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 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 Its Authority to Consider the Appealed Issue

The Providers within this EJR request filed appeals covering cost reporting periods with fiscal years ending 2006, 2007, 2010, 2012 and 2013, thus the cost reporting periods fall squarely within the time frame that covers the Secretary's final rule being challenged.[29] In addition, the

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[26] 485 U.S. at 399 (1988). Under the facts of *Bethesda*, the Board initially found that it was without jurisdiction to review the providers' challenge to the Secretary's regulation regarding apportionment of malpractice insurance costs because the providers had "self-disallowed" the costs in their respective cost reports filed with the Medicare contractor. The Supreme Court held that "[t]he Board may not decline to consider a provider's challenge to a regulation of the Secretary on the ground that the provider failed to contest the regulation's validity in the cost report submitted to [the Medicare Contractor]." The Court went on to state 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."

[27] 42 C.F.R. § 405.1835(a)(1) (2008).

[28] For RNPRs issued prior to August 21, 2008, Board jurisdiction over a provider's RNPR appeal is assessed under the holding in *HCA Health Services v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994). In *HCA Health Services*, the Circuit Court held that when a Medicare contractor reopens its original determination regarding the amounts of reimbursement that a Medicare provider is to receive and the provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening, and does not extend further to all determinations underlying the original NPR.

[29] As stated in the FY 2014 IPPS Final Rule, the Secretary "proposed to readopt the policy of counting the days of patients enrolled in MA plans in the Medicare fraction of the DPP[,]" thus "sought public comments from interested parties . . ." following publication of the FY 2014 IPPS Proposed Rule, 78 Fed. Reg. 27578 (May 10, 2013).

Board recognizes that the D.C. Circuit vacated the regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit or the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). In addition, within its July 25, 2017 decision in *Allina Health Services v. Price*, the D.C. Circuit Court agreed with the Board's determination to grant EJR for the identical issue involved in the instant EJR request.[30,31]

**Board's Decision Regarding the EJR Request**

The Board finds that:

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

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

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

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.

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Ultimately, the Secretary finalized this DSH policy for FFY 2014 and subsequent years on August 19, 2013, in the FY 2014 IPPS Final Rule. *See* 78 Fed. Reg. 50496, 50615 (Aug. 19, 2013). The Provider appeals in the instant EJR request are all based upon FY 2013 cost reporting periods and earlier.

[30] *See* 2017 WL 3137996 (D.C. Cir. July 25, 2017).

[31] On September 6, 2017, one of the Medicare contractors, Wisconsin Physicians Service ("WPS"), filed an objection to the EJR request in case number 13-2192GC. 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

Board Members Participating:

L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA, CHFP
Gregory H. Ziegler, CPA, CPC-A

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

cc: Danene Hartley, National Government Services (Certified Mail w/Schedules of Providers)
Laurie Polson, Palmetto GBA c/o NGS (Certified Mail w/Schedules of Providers)
Bill Tisdale, Novitas (Certified Mail w/Schedules of Providers)
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DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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SEP 28 2017

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RE: Second Request for Board Reconsideration on Dual-Eligible Part C Days
CHW 2003 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 07-0096GC

Dear Mr. Knight and Ms. Alcantara:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the CHW 2003 Disproportionate Share Hospital ("DSH") Dual Eligible Days Common Issue Related Party ("CIRP") Group's ("CHW") request that the Board reconsider its January 5, 2016 ("Decision") with respect to Northridge Hospital Medical Center, Provider No. 05-0116, and St. Mary's Regional Medical Center – Reno, Provider No. 29-0009. The Board's decision is set forth below.

## BACKGROUND

On May 22, 2015, the Board issued a decision in which it denied jurisdiction over Participant 13 on the Schedule of Providers and denied the Providers' request for bifurcation of the dual eligible Part A and Part C days issues.

Toyon submitted a request for reconsideration of the bifurcation denial on July 16, 2015. In response to the reconsideration request, the Board once again reviewed the file and on January 5, 2016, issued a decision in which it granted bifurcation of the dual eligible Part A and Part C days issues for all but two Providers that remained pending in the group: Participants 10 and 24 (Northridge Hospital – Roscoe Campus and St., Mary's Regional Medical Center – Reno).

On February 18, 2016, Toyon submitted another reconsideration request in which it has asked the Board to reconsider its decision to deny bifurcation of the dual eligible Part A and Part C days issues for Participants 10 and 24. Toyon also argues that if the Board determines that the Providers only appealed one part of the dual eligible days issue, then the Providers should be able to determine which type of dual eligible day it appealed – in this case the Providers argue that they have appealed Part C days.

**BOARD'S DECISION**

The Board denies the reconsideration request and reaffirms its denial of bifurcation of the dual eligible and Part C issues for Northridge Hospital, Participant 10 on the Schedule of Providers. Based on its issue statement in its appeal request, Northridge only appealed those dual eligible days that were adjusted off by the Medicare Contractor in adjustment numbers 35 and 36.[1] There is insufficient evidence to reverse the Board's original decision as there is no evidence that any of the days adjusted off included Part C days, therefore the Board denies the reconsideration request with respect to Northridge Hospital.

The Board grants the reconsideration request and grants bifurcation of the dual eligible and Part C issues for St. Mary's Regional Medical Center – Reno, Participant 24 on the Schedule of Providers. This Provider is appealing from fiscal year end ("FYE") 12/31/2003, therefore this fiscal year was prior to the 2004 final rule discussing how to count Part C days.[2] Further, the 2004 proposed rule indicates that Part C days were included in the Medicaid fraction pre-2004.[3] Based on this, the Board finds that the Provider appealed both the dual eligible and Part C days issues. The Board hereby reopens this appeal and transfers the Part C days issue for St. Mary's Regional Medical Center – Reno to PRRB Case No. 16-0566GC, CHW 2003 DSH Part C Days CIRP Group. PRRB Case No. 07-0096GC is once again closed.

The Board also denies the Providers' request to elect which issue they appealed if the Board finds that bifurcation is not appropriate, as it has here. As discussed above, there is no evidence that any of the days the Provider has challenged in its issue statement are Medicare Part C days, therefore the Provider cannot elect to appeal that issue instead of the dual eligible days issue.

Board Members
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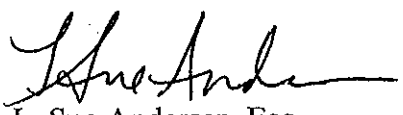
FOR THE BOARD



L. Sue Andersen, Esq.
Chairperson

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

[1] The original issue in the appeal request was: "Issue #4: Whether the intermediary's adjustment number 35 & 36 for dual eligible days to be excluded from Medicaid Eligible days is correct. The Provider will be transferring this issue to a CHW group appeal. Effect on Title XVIII Reimbursement: $296,676."
[2] 69 Fed. Reg. 48916 (Aug. 11, 2004).
[3] *See Allina Health Servs. V. Sebelius*, 746 F.3d 1102, 1106 (D.C. Cir. 2014) (citing to *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 16-17 (D.C. Cir. 2011)).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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SEP 2 8 2017

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Pam VanArsdale
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RE: Jurisdictional Decision
Provider: Norwalk Hospital
Case Number: 14-0820
FYE: 09/30/2010

Dear Mr. Kruzick and Ms. VanArsdale:

**Background:**

Norwalk Hospital, or the Provider, is appealing the amount of Medicare Reimbursement as determined by the Medicare contractor. The Provider listed seven issues in its Model Form A – Individual Appeal Request at Tab 3. Four of those issues are relevant to this jurisdictional decision.

Issue No. 1 is entitled "Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific)" (hereinafter "DSH/SSI Percentage Realignment issue"), and the Provider describes the issue as whether the Medicare Contractor used the correct SSI percentage in the DSH calculation. The Provider also adds in its description that the Provider preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See Model Form A – Individual Appeal Request (Nov. 13, 2013), Tab 3 at 1.*

Issue No. 2 is entitled "Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific)" (hereinafter "DSH/SSI Percentage Provider Specific issue"), and the Provider also describes this issue as whether the Medicare Contractor used the correct SSI percentage in its DSH calculation. More specifically, the Provider states it is seeking SSI data from the Centers for Medicare & Medicaid in order to reconcile its records with CMS data and identify records that CMS failed to include in their calculation of the SSI percentage, and that CMS did not account for all patient days in the Medicare fraction. *See Model Form A – Individual Appeal Request (Nov. 13, 2013), Tab 3 at 1-2.*

Issue No. 3 is entitled "Disproportionate Share Hospital ('DSH')/Supplemental Security Income ('SSI')(Systemic Errors)" (hereinafter "DSH/SSI Systemic Errors issue"), and the Provider describes this issue as whether the DSH/SSI percentage was properly calculated. More specifically and relevant to this

jurisdictional decision, the Provider describes problems with the underlying SSI data that is used to calculate the DSH SSI percentage, referring to the U.S. District Court decision *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008). *See Model Form A – Individual Appeal Request (Nov. 13, 2013), Tab 3 at 2-10.* The Provider filed a Model Form D – Request to Transfer an Issue to a Group Appeal regarding Issue No. 3 (DSH/SSI Systemic Errors issue) to Case No. 14-1815G on August 29, 2014.

Issue No. 4 is entitled "Disproportionate Share Hospital Payment – Medicaid Eligible Days" (hereinafter "DSH Medicaid Eligible Days issue"), and the Provider contends that the Medicare Contractor failed to include all Medicaid eligible days in the DSH calculation. *See Model Form A – Individual Appeal Request (Nov. 13, 2013), Tab 3 at 10.*

The Medicare Contractor has filed a jurisdictional challenge with regards to Issue Nos. 1, 2 and 4 in this appeal.[1]

**Medicare Contractor's Position**

The Medicare Contractor is challenging jurisdiction over Issue No. 1 (DSH/SSI Percentage Realignment), Issue No. 2 (DSH/SSI Percentage Provider Specific) and Issue No. 4 (Medicaid Eligible Days). Regarding Issue No. 1, the Medicare Contractor states that the Provider's fiscal year end is already September 30th, which is the same as the federal fiscal year end. Therefore, any request for realignment of the DSH calculation to the federal fiscal year end is not applicable. Also, the Medicare Contractor states that the Provider abandoned this issue as it is not addressed in the Provider's position paper.

Regarding Issue No. 2, the Medicare Contractor asserts this issue is duplicative of Issue No. 3, the DSH/SSI Systemic Errors issue that was transferred to Case No. 14-1815G. The Medicare Contractor alleges that the basis of both issues is that the DSH/SSI percentage is understated and the Provider needs the underlying data to determine what records were not included, if any. The Medicare Contractor points to PRRB Rule 4.5 which prohibits the appeal of an issue from a final determination in more than one appeal.

Regarding Issue No. 4, the Medicaid Eligible Days issue, the Medicare Contractor contends that the Board does not have jurisdiction over the additional days the Provider now seeks because the Medicare Contractor did not make an adjustment to the disputed days, nor did the Provider include a protested amount on its amended cost report for the disputed days as required. The Medicare Contractor states it accepted the Medicaid days submitted by the Provider on Worksheet S-3, Part I, on the submitted cost report which was filed on July 18, 2012.

[1] The Medicare Contractor has filed two separate jurisdictional challenges regarding Medicaid Eligible Days in this appeal, one dated February 6, 2015 and the other dated August 21, 2017. The August 21, 2017 challenge addresses additional issues as stated more fully below.

**The Provider's Position**

The Provider did not file a response to the Medicare Contractor's August 14, 2015 Jurisdictional Challenge. However, the Provider did file a response to the Board's Alert 10. Through this Board Alert, the Board asked Provider's to brief the DSH Medicaid Eligible Days issue, and to supply the following provider-specific information/documentation to the extent it is not already in the appeal record:

- A detailed description of the process that the provider used to identify and accumulate the actual Medicaid paid and unpaid eligible days that were reported and filed on the Medicare cost report at issue.
- The number of additional Medicaid paid and unpaid eligible days that the provider is requesting to be included in the DSH calculation.
- A detailed explanation why the additional Medicaid paid and unpaid eligible days at issue could not be verified by the state at the time the cost report was filed. If there is more than one explanation/reason, identify how many of these days are associated with each explanation/reason.

*See https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB_Alerts.html*

The Provider contends that the State of Connecticut Medicaid agency typically fails to verify all Medicaid eligible days at the time of the Provider's submission of its cost report. The Provider argues these issues presented a practical impediment for identification of all Medicaid eligible days as of the date of the filing of the cost report. *See Provider's "Alert 10 Response" (July 18, 2014).*

**Board Decision**

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2009), 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.[2]

Additionally, PRRB Rule 4.5 states that a Provider may not appeal an issue from a final determination in more than one appeal.

[2] 42 C.F.R. § 405.1835(a) (emphasis added).

Pursuant to 42 C.F.R. 412.106(b)(3), a Provider may request that CMS use its cost reporting period instead of the Federal fiscal year in calculating the SSI percentage of the DSH payment calculation. It must make such a request in writing to its Medicare Contractor.

*Issue No. 1 "DSH/SSI Percentage Realignment"*

The Board finds that it has jurisdiction over the portion of Issue No. 1 (DSH/SSI Percentage Provider Specific) challenging the data used to calculate the SSI percentage as there was an adjustment to the SSI percentage (Adj. 15), and the appeal meets the amount in controversy and timely filing requirements. However, the Board also finds that the inaccurate data portion of Issue No. 1 is duplicative of Issue No. 3, the DSH/SSI Systemic Errors issue that was transferred to 14-1815G. The basis of both Issues is that the SSI percentage is improperly calculated, and the Provider does not have the underlying data to determine if the SSI percentage is accurate. The portion of Issue No. 1 challenging the accuracy of the SSI ratio data now resides in Case No. 14-1815G.

Regarding the portion of Issue No. 1 addressing realignment of the DSH calculation to the Provider's fiscal year end, the Board finds that realignment using the Provider's fiscal year end is a Provider election, and there is no evidence in the record that the Medicare Contractor has made a final determination regarding this issue. Therefore, the Board does not have jurisdiction over Issue No. 1 (DSH/SSI Percentage Realignment) issue and it is dismissed from the appeal.

*Issue No. 2 "DSH/SSI Percentage Provider Specific"*

The Board finds that Issue No. 2 is duplicative of Issue No. 3. The basis of both issues is that the DSH SSI percentage is improperly calculated, and the Provider does not have the underlying data to determine if the SSI percentage is accurate. Issue No. 2 regarding the DSH/SSI Percentage Provider Specific is therefore dismissed from the appeal as it is duplicative and it resides in Case No. 14-1815G.

*Issue No. 4 "DSH Medicaid Eligible Days"*

The Provider is appealing from a 09/30/2010 cost report, which means that it either had to claim the cost at issue or it is subject to the protest requirement in order for the Board to have jurisdiction.

The Board finds that it does not have jurisdiction over the Medicaid eligible days issue in this appeal. The Provider did not protest the Medicaid eligible days currently under appeal on its cost report notwithstanding the fact that it knew Connecticut would have additional days at a later point in time. Therefore, the Board could only have jurisdiction over those days if the Provider included a claim for the specific items on its cost report, as required by 42 C.F.R. § 405.1835(a). Because the Board does not have jurisdiction over Issue No. 4, this issue is dismissed from the appeal.

In conclusion, the Board dismisses Issue Nos. 1 (DSH/SSI Percentage Realignment), 2 (DSH/SSI Percentage Provider Specific), and 4 (DSH Medicaid Eligible Days) from this appeal. This appeal is now closed as there are no remaining issues.

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

Board Members

L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA, CHFP

FOR THE BOARD

L. Sue Andersen, Esq.
Chairperson

cc: Wilson Leong, Esq., FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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SEP 28 2017

**Certified Mail**

Akin Gump Strauss Hauer & Feld, LLP
Stephanie A. Webster
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Washington, DC 20036 1564

RE: Expedited Judicial Review Request
Akin Gump Part C Days Group Appeals
FYEs: 2007 and 2009
PRRB Case Nos.: 14-0485GC, 14-0486GC, 17-1953GC and 17-1989GC

Dear Ms. Webster:

On September 19, 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, as explained below.

The issue in these appeals is:

> . . . [W]hether "enrollees in 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 be instead be included in the Medicaid fraction" of the DSH adjustment.[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] September 18, 2017 EJR Request at 4.
[2] *See* 42 U.S.C. § 1395ww(d)(I)-(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.

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"[9] fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

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

The Medicare/SSI fraction is computed annually by CMS, and the Medicare 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) 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] "SSI" stands for "Supplemental Security Income."
[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

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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.

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 Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction.*(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 denotes a requirement to include Medicare Part C inpatient days in the Medicare fraction of the DSH calculation.

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[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.
[19] *Id.*

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, as the providers point out, the Secretary has not acquiesced or taken action to implement the decision[22] and the decision is not binding in actions by other hospitals.

**Providers' Request for EJR**

The underlying issue in this EJR request 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 claim 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 they claim the Board lacks the authority to grant. The providers argue that since the Secretary has not acquiesced to the decision in *Allina*, the Board remains bound by the regulation and EJR is appropriate.

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[20] 72 Fed. Reg. 47,130, 47,384 (Aug. 22, 2007).
[21] 746 F. 3d 1102 (D.C. Cir. 2014).
[22] September 18, 2017 EJR Request at 8.
[23] 69 Fed. Reg. at 49,099.
[24] *Allina* at 1109.

**Decision of the Board**

Under the Medicare statute codified at 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1) (2016), the Board is required to grant a provider's EJR request if it determines that (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

Jurisdictional Determination for Providers

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the providers requesting EJR. Pursuant to the pertinent regulations governing Board jurisdiction, 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 $10,000 or more for an individual appeal or $50,000 or more for a group, and the request for hearing is filed within 180 days of the date of receipt of the final determination.[25]

Three of the participants in all of the groups appealed from original NPRs and all of those were for the cost reporting period ending June 30, 2009. For appeals of original NPRs for cost reporting time periods ending on or after December 31, 2008, the Providers preserve their respective 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 cost report for the period where the Provider seeks 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 majority of providers included in this EJR request filed appeals of their revised notices of program reimbursement ("RNPRs") in which the Medicare contractor issued RNPR's in 2012-2017. For any provider that files an appeal from a revised NPR ("RNPR") issued after August 21, 2008, the Board only has jurisdiction to hear that provider's appeal of matters that the Medicare contractor specifically revised within the RNPR. *See* 42 C.F.R. § 405.1889(b)(1) (2008).

Each of the Providers involved with the instant EJR request, both from NPR's and RNPR's, all have a specific adjustment to the SSI fraction/dual-eligible Part C days 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 and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor.

[25] 42 C.F.R. § 405.1835(a) (2008).

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

The providers within this EJR request filed appeals covering cost reporting periods with fiscal years ending 2007 and 2009, thus the cost reporting periods fall squarely within the time frame that covers the Secretary's final rule being challenged.[26] 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 the providers in these appeals are entitled to a hearing before the Board;

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

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

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.

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[26] As stated in the FY 2014 IPPS Final Rule, the Secretary "proposed to readopt the policy of counting the days of patients enrolled in MA plans in the Medicare fraction of the DPP[,]" thus "sought public comments from interested parties . . ." following publication of the FY 2014 IPPS Proposed Rule, 78 Fed. Reg. 27578 (May 10, 2013). Ultimately, the Secretary finalized this DSH policy for FFY 2014 and subsequent years on August 19, 2013, in the FY 2014 IPPS Final Rule. *See* 78 Fed. Reg. 50496, 50615 (Aug. 19, 2013). The provider appeals in the instant EJR request are all based upon earlier FYs.

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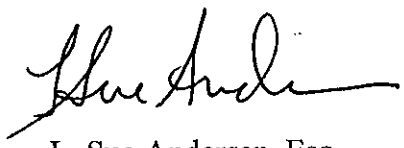
FOR THE BOARD:



L. Sue Andersen, Esq.
Chairperson

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

cc: Bill Tisdale, Novitas Solutions, Inc. (Certified Mail w/Schedules of Providers)
Wilson Leong, FSS (w/Schedules of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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SEP 28 2017

Refer to: 13-3706GC

CERTIFIED MAIL

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| | |
|---|---|
| RE: | LifePoint 2009 Medicare DSH Labor & Delivery Days CIRP Group Jurisdictional Challenge |
| PN: | Various |
| FYE: | 2009 |
| CASE NO.: | 13-3706GC |

Dear Ms. Elias and Mr. Tisdale,

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

**BACKGROUND FACTS**

The Board established a group appeal on September 13, 2013 for the LifePoint 2009 Medicare DSH Labor & Delivery Days CIRP Group. The group issue statement reads, in part, as follows:

> "The common issue relates to the treatment of patient days that were identified as Labor and Delivery Room ("LDR") days in the calculation of Providers' DSH payments. Specifically, the Provider challenge the Intermediaries' exclusion of Labor and Delivery Room days for Medicaid eligible beneficiaries from the numerator of the Medicaid fraction. Also, where applicable, Provider challenge the exclusion of LDR Days from the Medicare numerator. ... The Providers seek inclusion of LDR days in the Medicaid fraction of the DDP, or Medicare fraction as appropriate, in accordance with the FFY 2010 IPPS final Rule and CMS Ruling 1498-R."

The Medicare Contractor filed a jurisdictional challenge on June 6, 2017 regarding participants #2, 3 & 4.[1] On July 5, 2017, the Providers filed their Jurisdictional Brief.

## ARGUMENTS

*Medicare Contractor's Arguments in Jurisdictional Challenge*

The Medicare Contractor contends that it did not render a final determination to exclude LDR days from the DSH calculation for the participants in dispute. Furthermore, none of the providers have preserved its right to claim dissatisfaction for the LDR days issue as they did not self-disallow the LDR days in accordance with 42 C.F.R. § 405.1835(a)(1)(ii).[2]

The regulations at 42 C.F.R. § 405.1835(a)(1)(ii) establish the requirements that providers must follow in order to preserve the right to claim dissatisfaction for self-disallowed items.

*Providers' Response to Jurisdictional Challenge*

The Providers contend that they, submitted their cost reports in accordance to governing authority. It was CMS's policy to count LDR inpatient days only if the patient occupied a routine care bed prior to occupying an ancillary LDR bed before the census taking hour. The CMS 1498-R was issued on April 28, 2010 to resolve pending cases and avoid potential appeals from cost reports which were not settled by an initial NPR at the time CMS1498-R was issued. The Provider states that these participants fall into the latter category.[3] The Provider points out that since the cost reports were open(NPR not issued) with the Medicare Contactor, when the 1498 ruling was issued( April 28, 2010) and the cost reports were a pre October 1, 2009 cost report, the Medicare Contractor should have ensured that appropriate LDR days were included in the NPR. The Provider asserts; exactly like the Provider in *Bethesda,* the Participants here were barred from including LDR days on their cost reports.

Accordingly, the Providers appealed, not an adjustment to their cost reports, but the failure of the Medicare Contractor to include the LDR days in the DSH calculation according to CMS Ruling 1498-R. The Providers argue that the Board has the authority to grant the relief that the Providers are seeking, to enforce CMS ruling.

The Providers maintain the Medicare Contractor failed to follow the clear and explicit instructions of CMS Ruling 1498-R. The Providers could not have included such a challenge or protest on their cost report because 1498-R was not issued until April 28, 2010 which was after the Providers filed their cost reports. As to the protesting requirement, the Providers contend the only exhaustion requirement available to them, was to file this appeal for the Medicare Contractor's failure to follow the requirements of CMS Ruling 1498-R.

## BOARD DECISION

Pursuant to 42 C.F.R. § 405.1835(a)(i) –(ii) (2009), "[a] provider . . . has a right to a Board hearing . . . only if— (1) [t]he 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

[1] The Provider withdrew participant #3 on July 21, 2017. Therefore, the Board need not address this Provider.
[2] *See* Medicare Administrative Contractor's Jurisdictional Challenge at 2 (June 6, 2017).
[3] CMS 1498 R P. 16. (Exhibit P-3).

item(s) by . . . filing a cost report under protest . . . ." 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). Thus, when 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."[4]

The Board finds that it does not have jurisdiction over participants #2 (Memorial Medical Center Las Cruces) and #4 (Danville Regional Medical Center) regarding the Labor Delivery Room days issue, because the Providers did not comply with the requirements of 42 C.F.R. § 405.1835(a)(1)(i)–(ii) (2009). The Providers' cost reports were for Fiscal Year End (FYE) 06/30/2009 and 09/30/2009, therefore the Providers were required to either claim the days, ie. make a specific claim on their cost report, or file a cost report with a protested amount for items the provider deemed to be self-disallowed costs.

The Board concludes that Adjustment 32 for Participant #2 (Memorial Medical Center Las Cruces) was solely to adjust total days. This adjustment does not relate to the specific issue under dispute which is the inclusion of the LDR days in the DSH calculation. The Board concludes that participant # 4(Danville Regional Medical Center) self-disallowed LDR days. Without a claim for the issue as a reimbursable cost and specific audit adjustment to the issue under appeal, the Board lacks jurisdiction under §405.1835(a)(1)(i).

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 Participant #2 and #4 cost reports were after December 31, 2008; therefore, any self-disallowed items are required to be protested. Therefore, the Board finds that the Providers failed to preserve its rights, and lacks any legal basis to appeal the item to the Board under §405.1835(a)(1)(ii) for self-disallowed costs. In considering jurisdiction over the LDR day's issue, the Board acknowledges the recent United States District Court for the District of Columbia in *Banner Heart Hosp. v. Burwell* (DDC August 19, 2016).[5]

As the Board finds that it lacks jurisdiction over the LDR days issue for Memorial Medical Center Las Cruces (Prov. No. 32-0018, 09/30/2009) and Danville Regional Medical Center (Prov. No. 49-0075, 06/30/2009) (Participant #2 and Participant #4) under 42 C.F.R. §

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[4] 42 C.F.R. § 405.1835(a)(1)(ii) (2009).

[5] 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. Here, the Provider has not documented that it would have been futile to claim these items. Therefore, the Provider would stand on "separate" ground than those in *Bethesda*, as it was not futile (i.e., the provider was barred by neither statute nor regulation) to make the claim. Under the 2008 regulation, the Board is not able to grant jurisdiction over these items without the specific claims, but under the *Bethesda* test, the Providers still fail.

405.1835(a)(1)(i) (2009) or 42 C.F.R. § 405.1835(a)(1)(ii) (2009), the Board hereby dismisses these participants from Case No. 13-3706GC. It is also noted that the Provider withdrew participant #1, Andalusia Regional Hospital, on September 12, 2017. Therefore, there are no Providers pending in Case No. 13-3706GC and 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.

Board Members Participating
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA
Gregory H. Ziegler, CPA, CPC-A

FOR THE BOARD

L. Sue Andersen, Esq.
Chairperson

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

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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SEP 28 2017

CERTIFIED MAIL

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Evaline Alcantara
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RE: Delano Regional Medical Center
Provider No.: 05-0608
FYE: 12/31/09
PRRB Case No.: 14-0802

Dear Mr. Knight 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 15, 2013, based on a Notice of Program Reimbursement ("NPR") dated May 24, 2013. The hearing request included eight issues. Five issues have been transferred to group appeals and one issue was withdrawn. One issue was resolved in a Partial Administrative Resolution that was submitted to the Board on September 15, 2017. One issue remains in the appeal is as follows: Issue No. 7 – Medicare Disproportionate Share Hospital (DSH) Payments – SSI Ratio Alignment to Provider's Cost Reporting Year. The Medicare Contractor submitted a jurisdictional challenge on this issue and Issue No. 1 – Medicare Settlement Data – Outlier Fixed Loss Threshold on March 27, 2015.[1] The Provider submitted a responsive brief on April 22, 2015.

## Medicare Contractor's Position

The Medicare Contractor contends that this issue is suitable for reopening, but is not an appealable issue. The decision to realign a hospital's SSI percentage is a hospital election, not a Medicare Contractor determination. The Hospital must make a formal request to CMS, through its Medicare Contractor, in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.[2]

[1] The Provider submitted a request dated September 24, 2014 to transfer Issue No. 1 to PPRB Case No. 14-4384G - Toyon 2009 Understatement of Outlier Payments Group. The jurisdictional challenge will be addressed in the group appeal.

[2] Medicare Contractor's jurisdictional challenge at 9.

The Medicare Contractor argues that the regulations at 42 C.F.R. § 405.1835 specify the criteria for a provider's right to a PRRB hearing. The regulations specify that the Provider has a right to a PRRB hearing for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination which affect a provider's reimbursement. A determination is defined at 42 C.F.R. § 405.1801(a) as "...a determination of the amount of total amount of payment due to the hospital, pursuant to § 405.1803 following the close of the hospital's cost reporting period...".[3]

The Medicare Contractor contends that it did not and cannot make a determination in terms of the Provider's SSI percentage realignment. The only party that can make the election regarding the fiscal year end for the SSI percentage is the Provider. Since there is not a Medicare Contractor determination for the Provider to contest, the Board does not have jurisdiction over this issue, pursuant to 42 C.F.R. § 405.1803. It is the Medicare Contractor's position that realignment is not an appropriate issue to include as an appeal issue.[4]

**Provider's Position:**

The Provider contends that the NPR and all audit adjustments within meet the criteria of a final determination by the Contractor. Specifically, audit adjustment 45 was implemented in the Contractor's own words "To adjust SSI% and Disproportionate Share Amount based on the latest SSI% update, March 2012".[5]

The Provider explains that the SSI ratio was adjusted by the Contractor from 29.54% to a value of 33.90% that is developed by CMS on a federal fiscal year basis. The Provider contends the final SSI ratio value of 33.90% should be higher. The Provider argues that it has a right to be dissatisfied with any aspect of the Contractor audit adjustments, including the aspect of the Contractor's adjustment implementing a SSI ratio that has been developed on a federal fiscal year basis because all other DSH payment elements for this Provider are developed upon a cost reporting period basis. The Provider states that there is nothing in the DSH statute or the Medicare regulations that preclude an appeal of this nature.[6]

The Provider contends that the regulation concerning the "Contents of Request for a Board Hearing"[7] requires the Provider to describe their dispute[8] and provide a remedy describing how and why the Provider believes Medicare payment must be determined differently.[9] The Provider contends that it performed both of these tasks, including identifying two remedies: 1) Request CMS to realign the Provider's SSI percentage to the Provider's cost reporting year, or 2) Use the Provider's own data to seek a resolution to the issue. The Provider explains that it sought a

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[3] Medicare Contractor's jurisdictional challenge at 9.
[4] Medicare Contractor's jurisdictional challenge at 9-11.
[5] Provider's responsive brief at 6.
[6] Provider's responsive brief at 6 (emphasis included).
[7] 42 C.F.R. § 45.1835(b).
[8] 42 C.F.R. § 45.1835(b)(2)(i).
[9] 42 C.F.R. § 45.1835(b)(2)(ii).

remedy to the issue by submitting a DSH Ratio Realignment Request to the Contractor on February 28, 2013.[10]

**Staff Recommendation:**

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

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

As the SSI Ratio Realignment issue was the last issue remaining in the appeal, the Board hereby closes the appeal and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
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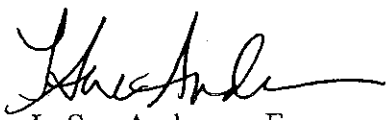
FOR THE BOARD



L. Sue Andersen, Esq.
Chairperson

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

cc: Federal Specialized Services
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[10] Provider's responsive brief at 6-7.

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SEP 29 2017

**Certified Mail**

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RE: **Expedited Judicial Review Request Determination**[1]
VHS 2007 DSH Medicare Non-Covered Days Group
FYE 2007
PRRB Case No. 09-1742GC

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 appeal, along with the Providers' September 5, 2017 response to the Board's August 22, 2017 request for additional information (received September 6, 2017). On September 14, 2017 Federal Specialized Services filed a jurisdictional objection to which the Provider responded on September 20, 2017. The Board's determination with respect to jurisdiction and the request for EJR 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 Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[6]

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[1] The EJR request included case numbers 08-2109GC, 13-1096GC, 14-2942GC, 15-1758GC, 08-1621 and 08-2731. The Board issued an EJR determination under separate cover on August 22, 2017.
[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.*
[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.

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]

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.

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[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).

§ 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:

> . . . 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*

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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).

> *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.

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]

**FSS' Jurisdictional Challenge and the Providers' Response**

FSS challenges the Board's jurisdiction over the Part C days issue because FSS alleges that the issue was not included in the Request for Hearing filed by the Providers. FSS asserts that the hearing request addressed only inclusion of dual eligible Medicare non-covered days that were previously paid by third

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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).
[21] 746 F. 3d 1102 (D.C. Cir. 2014).
[22] July 28, 2017 EJR Request at 1.

party payors or denied by the Medicare Administrative Contractor (MAC) in the DSH calculation. FSS points out that the regulation, 42 C.F.R. § 405.1837(c), requires that providers must specifically include an explanation of the providers' dissatisfaction and why the Providers believe that the Medicare payment is incorrect. Since the statement of the issue was not in accordance with the requirements of the regulation, FSS does not believe the Board has jurisdiction over the appeal.

The Providers responded by stating that they believe the terminology utilized by the MAC (dual eligible days) to deny Part C days, and the terminology used by the Providers, "Specifically, whether those Medicare non-covered days that were previous paid by other third party pay[ors] or denied payment by the [MAC], due to their belief they were dual eligible" to describe these Part C days has created some confusion. They note that this was the result of the MAC instructing the Providers to remove patients, which appeared to be dual eligible, as identified on the Medicare Common Working File (CWF) from the Medicaid fraction of the DSH calculation. These patients included managed care third party paid patients, as well as Part A exhausted days. The Provider maintains that those Medicare managed care plans (other third parties) which paid the non-Part A claims (Medicare Part C) were included in the May 19, 2009 hearing request. The Providers equate "DSH dual eligible days" with DSH Part C days.

**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 this case, 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, the Provider's believe 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

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[23] 69 Fed. Reg. at 49,099.
[24] *Allina* at 1109.

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 this group appeal have filed appeals involving fiscal year June 30, 2007.

For purposes of Board jurisdiction over a participant's appeals filed from a cost reporting period that ends prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[25,26]

The Board concludes that the Providers included Part C days in this appeal as demonstrated by Tab 1E of Hemet Valley Medical Center's (Hemet Valley) jurisdictional documents.[27,28] The Provider listed the categories of days under appeal and included Part C days as a category. The total of the days found under Tab 1E, Medicare non-covered days of 965 includes Medicaid HMO days, exhausted days, and Part C days. The Board finds that Hemet Valley clearly included Medicaid HMO days as issue #5, exhausted days as issue # 6, and Part C days as issue #2 in its individual appeal. Hemet Valley transferred issue #2 from its individual appeal to the current case and the remaining Providers were directly added to the appeal subsequent to the issuance of their Notices of Program Reimbursement.

The Board has determined that participants involved with the instant EJR request have had Part C days excluded from the Medicaid fraction and the issue is a self-disallowed cost under *Bethesda,* as such 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.[29] The appeal was timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeals in this EJR request involve the fiscal year June 30, 2007, thus the appealed cost reporting period 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

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[25] 108 S.Ct. 1255 (1988).

[26] For Hemet Valley that appealed from both an original and revised NPR, the Board will not issue a jurisdictional determination for the revised NPR appeal. The Board has determined that the Provider has jurisdictionally valid appeal pending for the same fiscal year end from the original NPRs; therefore reaching a decision on the revised NPR appeal is futile as the outcome for this Provider will not be affected.

[27] *See* Board Rule 16 (A Provider may request to join an existing group by transferring the relevant issue from the Provider's individual appeal to that group. In the case of Hemet Valley, the Provider transferred the issue under appeal in the current group from its individual appeal, case number 09-0733.)

[28] The entire original hearing request for Hemet Valley can be found under Tab 3 of the Provider's September 5, 2017 response to the Board's request for additional information.

[29] *See* 42 C.F.R. § 405.1837.

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 appeal 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 receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes these cases.

Board Members Participating:

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

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

cc: Geoff Pike, First Coast Services Options (Certified Mail w/ Schedules of Providers)
Wilson Leong, (w/Schedules of Providers)