DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Refer to: 17-2152GC

OCT 0 6 2017

CERTIFIED MAIL

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CGS Administrators
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RE: St. Elizabeth Medical Center, *as a participant in*
Southwest Consulting SEH 2011 DSH SSI Fraction Part C Days CIRP Group II
Provider No.: 18-0001
FYE: 12/31/2011
PRRB Case No.: 17-2152GC

Dear Mr. Newell and Ms. Cummings,

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

Background:

On April 5, 2017, the Provider was issued a revised Notice of Program Reimbursement (NPR) for fiscal year end (FYE) 12/31/2011. The revised NPR stated that it was "To update the SSI% in accordance with CMS' SSI realignment calculation." On August 25, 2017, the Provider representative filed a common issue related party (CIRP) group appeal request with the Board to appeal the DSH SSI fraction Part C Days issue. The CIRP group appeal request included one Provider – St. Elizabeth Medical Center (provider no. 18-0001, FYE 12/31/2011).

The Board acknowledged this group appeal request and named it Group II because there is a previous SEH 2011 DSH SSI Fraction part C Days appeal, case no. 14-3869GC. The Board granted Expedited Judicial Review in case no. 14-3869GC; St. Elizabeth Medical Center was a participant in case no. 14-3869GC.

Board's Decision:

The Board finds that it does not have jurisdiction over the SSI Fraction Part C Days issue for St. Elizabeth Medical Center that was appealed from its April 5, 2017 revised NPR. The Board

finds that the Provider's revised NPR did not adjust SSI Fraction Part C Days. Adjustment no. 1 on the Provider's audit adjustment report related to the revised NPR was to revise the SSI percentage to be calculated on the Provider's cost reporting year, known as SSI realignment, based on its request to CMS. This realigned SSI percentage only adjusted the total number of SSI days from being calculated based on the federal fiscal year to being calculated based on the cost reporting fiscal year. Whether or not Part C should be included in the SSI fraction was not part of the cost report revision.

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2011) provides, in relevant part:

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

42 C.F.R. § 405.1889 (2011) explains the effect of a cost report revision:

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

These regulations make clear that a Provider can only appeal items that are specifically adjusted from a revised NPR. The Provider has appealed the Part C issue, which was not adjusted in the revised NPR. As part of its appeal request the Provider submitted a copy of the letter sent to the Medicare Contractor requesting the realignment of the SSI percentage. The letter stated:

> If the recalculation completed at this time *continues* to include the Medicare Advantage days, St. Elizabeth's Fort Thomas reserves the right to request a recalculation excluding Medicare Advantage days at a later date."[1]

[1] Emphasis added.

Based on this statement, the Board finds that the Provider has acknowledged that Part C Days[2] were already in the SSI percentage prior to the realignment, therefore the inclusion of these days was not part of the revised NPR realignment adjustment.

Additionally, the same Provider for the same FYE has previously appealed the SSI Fraction Part C Days issue from its original NPR in case no. 14-3869GC. The original NPR did adjustment Part C Days in the SSI Fraction. The Board granted Expedited Judicial Review in case no. 14-3869GC.

The Board finds that it does not have jurisdiction over the SSI Fraction Part C Days issue appealed from the revised NPR issued for St. Elizabeth Medical Center for FYE 12/31/2011 because the issue was not specifically adjusted in the revised NPR. As St. Elizabeth Medical Center is the only participant in case no. 17-2152GC, the appeal is hereby closed and removed from the Board's docket.

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

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

FOR THE BOARD

L. Sue Andersen
Chairperson

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

cc: Wilson Leong, FSS

[2] Part C Days and Medicare Advantage Days refer to the same kind of day at issue in this group appeal.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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OCT 10 2017

Certified Mail

Maureen O'Brien Griffin
Hall, Render, Killian, Heath & Lyman
500 North Meridian Street
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RE: Expedited Judicial Review Request
Hall Render Part C Days Appeals
FYE: 2006-2008, and 2011
PRRB Case Nos.: 13-0626GC, 13-0629GC, 13-0632GC, 13-1856GC and 15-1525GC

Dear Ms. Griffin:

On September 18, 2017, the Provider Reimbursement Review Board ("PRRB" or "Board") received a request for expedited judicial review ("EJR") for the above-referenced group 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] September 18, 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, then is used to determine the amount of the DSH payment due to the qualifying hospital.[7] The DPP is defined as the sum of two fractions expressed as percentages.[8] Those two fractions are the "Medicare" or "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 utilized by the Medicare contractors to compute a qualifying 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)

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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.*

Consequently, within the Secretary's response to the commenter, the Secretary announced that CMS would include 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 substantive regulatory change had in fact occurred but that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule.[21] As a result, the pertinent regulatory language was "technically corrected" to reflect that Part C days were required to be included in the Medicare fraction of the DPP 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, as the providers point out, the Secretary has not acquiesced or taken action to implement the decision[23] 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.[24]

In *Allina*, the Court affirmed the district court's decision "that the Secretary's final rule was not a logical outgrowth of the proposed rule."[25] 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

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

validity of the 2004 rule that the providers 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.

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.[26]

The providers included in this EJR request filed appeals of either original notices of program reimbursement ("NPRs") or revised NPRS ("RNPRs") in which the Medicare contractor settled cost reporting periods ending between December 31, 2006, and June 30, 2011.

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*.[27]

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[26] 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).

[27] 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 RNPRs issued prior to August 21, 2008, providers must demonstrate that the issue under review was specifically revisited on reopening.[28]

For appeals of original NPRs for cost reporting time periods ending on or after December 31, 2008, 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 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 cost reports under protest.[29]

Jurisdictional Determination for Providers

The Board finds that all providers involved with the instant EJR request have had an adjustment to the SSI%[30] on their respective NPRs/RNPRs 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 ending in 2006-2008 and 2011, thus the cost reporting periods fall squarely within the time frame covered by the Secretary's final rule being challenged in this EJR request.[31] 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

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[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] 42 C.F.R. § 405.1835(a)(1) (2008).

[30] The terms "SSI fraction," "SSI%," and "Medicare fraction" are synonymous and used interchangeably within this decision

[31] 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.

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*,[32] the D.C. Circuit Court agreed with the Board's decision to grant EJR for the identical issue involved in the instant EJR request.[33]

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.
Charlotte F. Benson, CPA
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

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

[33] On September 20, 2017, one of Medicare contractors, Wisconsin Physicians Service ("WPS"), filed an objection to the EJR request in PRRB Case Nos. 15-1525GC. 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.

cc: Danene Hartley, National Government Services (Certified Mail w/Schedules of Providers)
Pam VanArsdale, National Government Services (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

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CERTIFIED MAIL

OCT 16 2017

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

RE: Cape Fear Valley Medical Center, Provider No. 34-0028, FYE 9/30/2006,
PRRB Case No. 13-3632

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeal prior to scheduling a hearing date. Upon review, the Board notes that the Medicare Contractor has objected to a number of the issues in dispute. A timeline of the pertinent facts in the case, the Parties Contentions, and the Board's determination are set forth below.

Timeline/Pertinent Facts

The Medicare Contractor issued the Provider its Notice of Program Reimbursement ("NPR") for fiscal year ending ("FYE") 9/30/2006 on October 20, 2010. An Amended Notice of Amount of Medicare Program Reimbursement was issued on March 6, 2013 - This was the third reopening.

On September 3, 2013, the Provider filed an Individual Appeal from its revised NPR (RNPR). The Provider listed five issues on appeal.

- Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") Percentage (Provider Specific)
- DSH/SSI (Systemic Errors)
- DSH payment – Medicare Managed Care Part C Days
- DSH payment – Dual Eligible Days
- Rural Floor Budget Neutrality Adjustment ("RFBNA")

Subsequently, on April 7, 2014, the Provider requested to transfer the following issues to relevant group appeals:

- DSH/SSI Percentage (Systemic Errors)
- DSH SSI Fraction Dual Eligible Days*
- DSH Medicaid Fraction Dual Eligible Days*
- DSH SSI Fraction Part C Days*
- DSH Medicaid Fraction Part C Days*

*The Provider referred to the Dual Eligible Days and Part C Days issues (originally listed as two issues) from both the SSI Fraction and the Medicaid Fraction (creating four distinct issues).

In an April 14, 2014 letter accompanying the Preliminary Position Paper, the Provider advised that only the SSI Percentage (Provider Specific) and Rural Budget Neutrality Adjustment issues remained pending in the appeal.[1]

The Medicare Contractor filed a Jurisdictional Challenge, on May 6, 2014, alleging that the Board lacked jurisdiction over the issues in this appeal because no final determination or adjustment had been made, to which the Provider replied in a brief filed on May 30, 2014.

In a letter dated June 16, 2014, the Board denied the Provider's Request to Transfer the Medicaid Fraction Part C days to a group appeal because the issue was not timely raised or added to the appeal and therefore the Board lacked jurisdiction.

Medicare Contractor's Contentions

The Medicare Contractor contends that the Board does not have jurisdiction over six of the seven issues originally raised on appeal. According to the Medicare Contractor, it only reopened the cost report to report previous settlement payments and report the proper SSI percentage based on the Federal Register and contends that the Board does not have jurisdiction over the following issues which were not adjusted:

- DSH/SSI Percentage (Provider Specific)
- DSH/SSI Percentage (Systemic Errors)
- DSH/SSI Payment – Medicare Managed Care Part C days *Medicaid fraction*
- DSH/SSI Payment – Dual Eligible Days SSI fraction
- DSH/SSI Payment - Dual Eligible Days Medicaid fraction

First, the Medicare Contractor argues that the SSI (Systemic Errors) issue has been resolved through CMS recalculation and re-issuance of the SSI percentage that was incorporated into the Provider's cost report under appeal.

Second, the Medicare Contractor contends that the Board does not have jurisdiction over any issues appealed from the Medicaid fraction. As noted, the cost report was reopened for the third time "to revise the Medicare-SSI fraction in the DSH calculation to ensure the accurate inclusion of Medicare Advantage data submitted by Providers, which will be included in the revised SSI ratios to be published by CMS."[2] The Medicare Contractor also maintains that the two issues the Provider has appealed (Dual Eligible days and Medicare Advantage days) are actually four distinct issues (*Medicare-SSI fraction* Dual Eligible days and Medicare Advantage Days and *Medicaid fraction* Dual Eligible days and Medicare Advantage days).

The Medicare Contractor contends that while the Provider can appeal adjustments to the Medicare Advantage days in the Medicare fraction, the Provider cannot appeal Medicare Advantage days in the Medicaid fraction (or any issue in the Medicaid fraction) because there were no adjustments made to the Medicaid fraction. Further, the Medicare Contractor argues

[1] On March 2, 2015, the Provider withdrew the RFBNA issue. Both the MAC and Provider previously addressed jurisdiction over the RFBNA issue. As this issue has been withdrawn, those arguments are now moot.
[2] Medicare Contractor's Notice of Intent to Reopen Cost Report dated April 22, 2011.

that, although it revised the Medicare-SSI fraction to report the proper SSI percentage, the revision to the SSI fraction did not include changes to the Dual Eligible days or Provider Specific SSI percentage.[3]

Because the Medicare Contractor made no adjustment to the Medicaid fraction on the revised cost report and the SSI Percentage issued by CMS included no changes to the Dual Eligible days or the Provider Specific SSI percentage in the Medicare fraction, The Medicare Contractor argues that the only appealable issue in this case is the inclusion of the Medicare Advantage Part C days in the SSI fraction.

Provider's Contentions

The Provider contends that the Board has jurisdiction under the provisions of 42 U.S.C. § 1395oo(a)(1)(B) and, in this case, there were adjustments to DSH. However, the Provider contends that these adjustments are not required, as DSH is not an item that has to be claimed or adjusted and, therefore, the presentment requirement does not apply. Although the Provider maintains that the presentment requirement does not apply, it contends that if the Board does find it applies, the Provider argues that the requirement is not valid and the Board should find that it has jurisdiction over this appeal.

First, the Provider maintains that DSH does not need to be claimed or adjusted because the Medicare Contractor could determine DSH eligibility from readily available data. Specifically, the Medicare Contractor could base its' decision to make a DSH adjustment on the published SSI information supplied by Centers for Medicare and Medicaid Services (CMS). The Provider continues that the delay in obtaining access to state data in order to verify is comparable to the practical impediment for claiming dissatisfaction found in *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988), which the Supreme Court found sufficient for Board jurisdiction.

Second, the Provider contends that the presentment requirement is not valid because it is inconsistent with the plain language of the governing statute. The Provider maintains that, pursuant to *Bethesda*, 42 C.F.R. § 405.1835(a) does not require a Provider to submit a claim to the Medicare Contractor to preserve its right to a hearing before the Board in connection with that item. The Provider does not believe a presentment requirement would have changed the Supreme Court's analysis.

Third, the Provider contends that it is not addressing a realignment of the SSI percentage, rather it is addressing the various errors of omission and commission that do not fit into the "systemic errors" category. Accordingly, the Provider maintains that this is an appealable item because the Medicare Contractor specifically adjusted the Provider's SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year 2006 as a result of its' understated SSI percentage. In addition, the Provider believes that it can specifically identify

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[3] The Medicare Contractor states in its jurisdictional challenge that it is unable to determine if the Provider ever submitted a request to have its SSI percentage recomputed based on its own fiscal year end, rather than the Federal fiscal year end. However, as the Provider's cost report year end is 09/30/2006, its cost report year end is the Federal fiscal year end.

patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS.

Lastly, the Provider contends that the documentation necessary to pursue DSH is often not available from the State in time to include all DSH/Medicaid Eligible days, on the cost report and it is not readily available from CMS prior to the cost report filing deadline, or even at the time of the audit. However, because the Medicare Contractor adjusted the Medicare fraction, which included a revised SSI ratio made up of, not only SSI patients, but also patients with Part C and patients with dual coverage, the Board has jurisdiction over these days. The Provider is dissatisfied with these days being in the Medicare fraction and maintains that they belong in the Medicaid fraction.

Board Determination

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.

In this case, the Provider filed its appeal from a revised NPR. The Code of Federal Regulations at 42 C.F.R. § 405.1885 (2008) provides for an opportunity for a revised NPR, stating in relevant part:

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

Further, in accordance with 42 C.F.R. § 405.1889 (2008), a revised NPR is considered a separate and distinct determination from which the provider may appeal. The regulation provides:

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in § 405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of § 405.1811, § 405.1834, § 405.1835, § 405.1837, § 405.1875, § 405.1877 and § 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.

(2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

Transfers of DSH issues

In this case, the NPR was reopened for a third time to revise the DSH Medicare-SSI fraction to include the new data matching process set forth in the FY 2011 proposed and final rule which includes dually eligible Part A and Part C Medicare beneficiaries in the SSI fraction. The Provider appealed the following DSH issues from the revised NPR:

1. DSH payment/SSI percentage (Provider specific)
2. DSH payment/SSI percentage (Systemic errors)
3. DSH payment – Medicare Managed Part C days
4. DSH payment – Dual Eligible Days

The Provider requested to transfer the issues as follows:

Iss. #	Group	Case No.
2	QRS 2006 DSH SSI Fraction Numerator/Baystate Errors/§951 Group	13-1439G
3*	QRS 2006 DSH SSI Fraction Denominator/Part C Days Group	13-1436G and
3*	QRS 2006 DSH Medicaid Fraction/Part C Days Group	13-1442G
4*	QRS 2006 DSH SSI Fraction Denominator/Dual Eligible Group	13-1419G and
4*	QRS 2006 DSH Medicaid Fraction/Dual Eligible Group	13-1440G

*Specifically, the Provider requested to bifurcate issues 3 and 4 into four issues and transfer them to the relevant Medicaid Fraction and SSI-Medicare Fraction group appeals.

The Board previously decided, in a letter dated June 16, 2014, that the Provider failed to appeal the Medicaid fraction of Medicare Managed Care Part C days in the appeal request and denied jurisdiction over the issue and its transfer to Case No. 13-1436G. At that time, the Board did not make a determination on the Provider's request to transfer the Medicaid ratio Dual Eligible days issue to Case No. 13-1419G or over the requests to transfer the SSI ratio challenges of both Dual Eligible and Part C days, nor the SSI systemic issues, to group appeals.

In this case, the RNPR revised the SSI Ratio to the newly published ratio based on the updated data matching published in the 2010 Federal Register. The Board, therefore, finds that it has jurisdiction over the SSI systemic, SSI ratio Medicare Managed Care and SSI ratio Dual Eligible days issues. Consequently, the Board grants the requests to transfer these issues to the respective groups (Case Nos. 13-1439G, 13-1436G and 13-1419G). The Board notes that Case No. 13-1436G was later closed on June 8, 2017 as the Board consolidated both Case Nos. 13-1436G and 13-1442G into the QRS 2006 DSH Medicare Managed Care Part C Days Group (2), Case No. 13-1383G.[4] Therefore, the Medicaid Fraction Part C days issue for Cape Fear (FYE 9/30/06) would not reside in 13-1383G as it was previously dismissed.

[4] The Board found that these cases were duplicative since both Medicare and Medicaid Fraction Part C days are now considered one issue.

Finally, as the RNPR did not adjust the Medicaid Fraction, no adjustment was made to remove Dual Eligible days from the Medicaid Fraction. Consequently, the Board denies the transfer of Medicaid Dual Eligible days issue to Case No. 13-1440G and dismisses it from the case as the Board lacks jurisdiction over the issue pursuant to 42 C.F.R. § 405.1889.

DSH Payment/SSI Percentage (Provider Specific) Issue

With regard to the SSI Provider Specific issue, 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 1), 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 to the DSH/SSI Systemic Errors issue (1 sub-issue of Issue#1) that was transferred to 13-1439G. 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. 13-1439G.

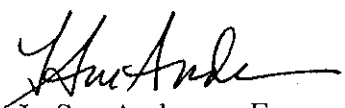
Regarding the portion of Issue No. 1 addressing realignment of the DSH calculation to the Provider's fiscal year end, the Board finds that realignment using the Provider's fiscal year end is a Provider election, and there is no evidence in the record that the Medicare Contractor has made a final determination regarding this issue (in fact, the Provider's cost report year end is 9/30/2006, which is the Federal fiscal year end.) Therefore, the Board does not have jurisdiction over the sub-issue of Issue No. 1 related to the DSH/SSI Percentage Realignment, and it is dismissed from the appeal.

After the noted transfers and the dismissal of the Medicaid Fraction Dual Eligible days and SSI Provider Specific issues, there are no remaining issues in the case. Therefore, Case No. 13-3632 is hereby closed.

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
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 .1877

cc: Laurie Polson, Palmetto GBA c/o National Government Services (J-M)
Pam VanArsdale, National Government Services, Inc. (J-K) (MAC for groups)
Wilson C. Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

OCT 16 2017

CERTIFIED MAIL

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

RE: Request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal
Regarding DSH Part C Days issue
Blumberg Ribner 96/98 Dual Eligible Days Group
Provider Nos.: Various
FYEs: Various
PRRB Case No.: 06-0092G

Dear Mr. Blumberg:

The Provider Reimbursement Review Board (PRRB or Board) has reviewed your May 23, 2016 Request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal Regarding DSH Part C Days Issue for the Blumberg Ribner 96/98 Dual Eligible Days Group. The Board grants the Providers' Request for Reinstatement of the Part C days issue and Bifurcation of the Group Appeal Regarding the DSH Part C days issues.

Background

On August 17, 2015, the dual eligible Part A days issue was remanded to the Medicare Contractor in case number 06-0092G, Blumberg Ribner 96/98 Dual Eligible Days Group, pursuant to the Centers for Medicare & Medicaid Services (CMS) Ruling 1498-R[1] and the case was closed. On May 23, 2016, the Providers filed a Request for Rule 41.1 [sic] Reinstatement and Bifurcation of Group Appeal Regarding Disproportionate Share Hospital (DSH) Part C (or HMO) Days Issue[2] for the dual eligible days issue. The Providers argue that the Board remanded their appeal of the dual eligible days issue, however, the appeal included two issues (the Part A days issue addressed

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

[2] Any individual who was enrolled on December 31, 1998, with an eligible organization under section 1876 of the Social Security Act was considered to be enrolled under Part C as of January 1, 1999. 42 U.S.C. § 1395w-21. For the periods before January 1, 1999, the issue was referred to as HMO days.

by Ruling1498-R and the Part C/HMO days issue). The Providers maintain their appeal of the dual eligible days issue was intended to refer to persons eligible for Medicare Parts A and C; the Medicare Part C days issue did not come within the scope of Ruling 1498-R. The Providers request that the Board reinstate their appeal of the Part C days issue.[3]

Decision of the Board

PRRB Rule 46.1 (effective July 1, 2015), provides "[a] Provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case." In the instant case, the Providers are requesting reinstatement of the Part C/HMO days issue. The Part C/HMO days issue was *not* remanded to the Medicare Contractor as the Providers assert; the dual eligible Part A days issue *solely* was remanded to the Medicare Contractor.[4] The Medicare Part C/HMO days issue does not come within the scope of Ruling 1498-R.

The Board grants the Providers Request for Reinstatement of the Part C days issue and Request for Bifurcation of the dual eligible Part A days and Part C days issues. The Board acknowledges that at the time that the Providers' individual appeals and group appeal were filed (2006 and prior), the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or Part C/HMO days. Federal courts later ruled differently on the dual eligibility related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the Providers' individual appeals and group appeal added the dual eligible days issue using a broad issue statement that encompassed both dual eligible Part A days and Part C/HMO days.

Accordingly, the Board finds that there are two issues pending within case number 06-0092G in violation of 42 C.F.R. § 405.1837(a)(2) and PRRB Rule 13.[5] The Board reopens case number 06-0092G and reinstates the Part C/HMO days issue. As the Part C days issues spans before and after 1/1/1999, the time periods will need to be bifurcated as different legal issues are present for HMO days prior to 1/1/1999 and for Part C days after 1/1/1999. The HMO days issue which covers the fiscal year ends (FYE) prior to January 1, 1999, is now within newly formed case number 17-2283G. The Part C days issue which covers the fiscal year ending on or after January 1, 1999, is now within newly formed case number 17-2284G. The Board's Acknowledgment Letters for case numbers 17-2283G and 17-2284G are included as enclosures along with this

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[3] Providers' Request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal Regarding DSH Part C Days Issue at 1.

[4] The Board made it clear in its August 17, 2015 remand letter that it was remanding the Medicare dual eligible Part A days issue. The Board stated " the . . . appeal includes a challenge to the exclusion of Medicare dual eligible days *(where the patient was entitled to Part A benefits but the inpatient hospital stay was not covered under part A or the patient's Part A hospital benefits were exhausted)* from the calculation of the disproportionate share (DSH) percentage for patient discharges before October 1, 2004. This issue is to be remanded to the Intermediary under the terms of the Centers for Medicare & Medicaid Services (CMS) Ruling CMS-1498-R." (Emphasis added).

[5] 42 C.F.R. 405.1837(a)(2) provides that a provider has a right to a Board hearing as part of a group appeal if "[t]he matter at issue in the group appeal involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group." PRRB Rule 13 states "[t]he matter at issue must involve a single common question of fact or interpretation of law, regulation or CMS policy or ruling." Both the regulation and Board Rule make it clear that a group appeal can only contain one issue.

determination. The dual eligible Part A days issue was previously remanded from case 06-0092G by the Board on August 17, 2015, therefore case number 06-0092G will be re-closed.

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

Board Members Participating:
L. Sue Andersen, Esq.
Charlotte Benson, C.P.A.
Gregory Ziegler

For the Board

L. Sue Andersen
Chairperson

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Schedule of Providers, Acknowledgement of Optional Group Appeal & Scheduling Due Dates for case numbers 17-2283G and 17-2284G

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

CERTIFIED MAIL

OCT 16 2017

Corinna Goron, President
Healthcare Reimbursement Services, Inc.
c/o Appeals Department
17101 Preston Road, Suite 220
Dallas, TC 75248 1372

RE: Sonoma Valley District
Provider No. 05-0090
FYE 6/30/2007
Case No.: 13-2098

Dear Ms. Goron:

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above-referenced appeal. The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

The Provider submitted a request for hearing on May 15, 2013, based on a Notice of Program Reimbursement ("NPR") dated November 15, 2012. The hearing request included five issues, two of which related to the SSI percentage. The first issue, SSI Systemic errors, and three other issues were transferred to group appeals, leaving only the SSI percentage (Provider Specific) issue. The Provider filed its preliminary positon paper on December 20, 2013 and confirmed that the only issue briefed was the SSI percentage (Provider Specific) issue.

Board Determination:

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

The Board finds that it has jurisdiction over the portion of the SSI percentage (Provider Specific) issue challenging the data used to calculate the SSI percentage as there was an adjustment to the SSI percentage (Adj. 4), and the appeal meets the amount in controversy and timely filing requirements. However, the Board also finds that the inaccurate data portion of this issue is duplicative of the DSH/SSI Systemic Errors issue that was transferred to Case No. 14-0365G. The Provider contends in the SSI percentage (Provider Specific) issue statement that the "Medicare Contractor did not determine Medicare DSH reimbursement in accordance with the

Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[1] The SSI Systemic Errors issue statement also argues that "the SSI percentages calculated by the Centers for Medicare and Medicaid Services and used by the Lead Medicare Contractor to settle their Cost Report was incorrectly computed."[2] The 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. Therefore, the portion of the SSI percentage (Provider Specific) challenging the accuracy of the SSI ratio data now resides in Case No. 14-0365G.

Regarding the portion of the SSI percentage (Provider Specific) addressing realignment of the DSH calculation to the Provider's fiscal year end, the Board finds that realignment issue is premature. 42 C.F.R. § 405.1835 (2012) states

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

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

Therefore because the DSH SSI (Provider Specific) issue is duplicative of the Systemic Errors issue and the Medicare Contractor has not made a final determination from which Sonoma Valley Hospital could appeal, the Board finds that it lacks jurisdiction over the DSH/SSI percentage (Provider Specific) issue and dismisses it from Case No. 13-2098.

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.

As there are no remaining issues in the appeal, the Board hereby closes Case No. 13-2098.

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

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

For the Board:

Chairperson

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

cc: Evaline Alcantara, Noridian Healthcare Solutions (J-E)
Wilson C. Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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CERTIFIED MAIL

OCT 17 2017

Richard Webster
Thomas Jefferson University Hospital
111 South 11th Street
Suite 2210 Gibbon
Philadelphia, PA 19107 5096

RE: Thomas Jefferson University Hospital (39-T174), FYE 9/30/2017
PRRB Case No. 18-0023

Dear Mr. Webster:

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

Pertinent Facts:

On September 21, 2016, Thomas Jefferson University Hospital ("the Provider") received a Reconsideration Determination of its earlier CMS determination regarding reduction to the annual update for failure to meet the IRF Quality Reporting Program (QRP) requirements. The Reconsideration Determination directs the Provider to 42 C.F.R. Part 45, Subpart R and the PRRB Review Instructions for guidance on filing an appeal of the determination.

The Provider filed an individual appeal with the Medicare Contractor, Novitas Solutions, Inc., on February 6, 2017 using the Board's Model Form A.[1] The appeal was not filed with the Board.

On September 27, 2017, the Provider emailed the Office of Hearings to inquire about the status of the appeal, of which it included a copy. In response, Board staff contacted the Provider and advised that it had no record of the appeal. Board staff also emailed the Provider with the mailing address of the Board and advised that a copy of the appeal, proof of delivery of the original request and a letter of explanation for the late filing must be submitted for consideration.

The Provider filed a copy of the appeal, with a copy of a Fed Ex receipt and a cover letter requesting that good cause be found for the late filing.[2] The appeal was received by the Board on October 5, 2017 – more than a year (379 days) after the issuance of the final determination.

The Provider asserts that it attempted to follow the regulation at 42 C.F.R. Part 405 to understand the appeals process, but that it submitted the appeal to the wrong agency. The Provider requests

[1] Federal Express (Fed Ex) Tracking Receipt 785504063848 – shows Ship Date of February 3, 2017 and Delivery Date of February 6, 2017.
[2] Provider's letter to the Board dated October 2, 2017.

leniency because it had never been through the appeals process before and navigated the system incorrectly.[3]

Board Determination:

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 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, and the request for hearing is received by the Board within 180 days of the date of receipt of the final the determination. Before the Board can make a determination over all matters covered by the cost report, it must first determine that the Provider has filed a jurisdictionally valid appeal.

The Board finds that it does not have jurisdiction over this appeal because the Provider did not timely file its appeal and does not qualify for a good cause extension. Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. § 405.1835(a)(3), unless the Provider qualifies for a good cause extension, the Board must receive a Provider's hearing request no later than 180 days after the date of receipt of the final determination, with a five-day presumption for mailing.

In this case, the Provider's Reconsideration Determination was issued on September 21, 2016. An appeal of the Reconsideration Determination was due to be filed with the Board within 180 days after issuance, including a five-day mailing presumption, i.e., on or before March 27, 2017.[4] However, the Provider allegedly timely filed its appeal with the Medicare Contractor on February 6, 2017, but concedes that it did not file with the Board until October 5, 2017.[5]

The Board finds that the Provider failed to meet the good cause extension standard enunciated in 42 C.F.R. § 405.1836(b), which states that "[t]he Board may find good cause to extend the time limit only if the provider demonstrates in writing it could not reasonably be expected to file timely due to extraordinary circumstances beyond its control (such as a natural or other catastrophe, fire, or strike) ...."[6] Although the Provider asserts that it tried to comply with the regulations and that it was due to its inexperience having never filed an appeal that caused the missed deadline, the fact remains that, the appeal was not filed with the correct organization.[7] Unfortunately, the Provider's explanation for the late filing does not rise to the level of the good cause criteria cited above. Although the Provider may be new to filing appeals, the Reconsideration Determination referred the Provider to the Board's website. The Provider

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[3] *Id.*

[4] Per 42 C.F.R § 405.1801(d)(3), if the last day of the designated time period is a Saturday, a Sunday, a Federal legal holiday (as enumerated in Rule 6(a) of the Federal Rules of Civil Procedure), or a day on which the reviewing entity is unable to conduct business in the usual manner, the deadline becomes the next day that is not one of the aforementioned days.

[5] It should be noted that the Board did not receive any inquiries from the Medicare Contractor when it did not receive the Board's Acknowledgement of the case. Generally, when the Medicare Contractor receives an appeal, it will set up a "place holder" until it is able to match up the case with the Board's Acknowledgement.

[6] 42 C.F.R. § 405.1836(b)(2008)(emphasis added).

[7] Provider's letter to Board dated October 5, 2017.

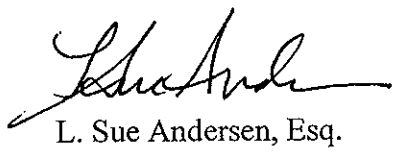
obtained the Model Form from the Board's website and filed it with the Medicare Contractor, but did not follow Board Rules regarding mailing correspondence (specifically Rule 3.1: PRRB Mailing Address; Rule 3.2: Delivery of Materials to the Board; and Rule 3.3: Service on Opposing Parties.)[8]

Finally, the Provider delayed in following up on the status of its case, waiting more than 7 months after it was filed. After considering all the facts in this case, the Board finds that the Provider failed to demonstrate that it could not reasonably be expected to file timely due to extraordinary circumstances beyond its control. Consequently, the Board hereby dismisses the appeal and case number 18-0023 is closed.

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

Board Members:
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
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: Bruce Snyder, Novitas Solutions, Inc. (J-L)
Wilson C. Leong, Esq., CPA, Federal Specialized Services

[8] All of the Board's Model Forms contain the Board's address information in the header, including the Board's phone number, yet the appeal was not sent to the Board.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

OCT 18 2017

Certified Mail

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: 2008-2009
PRRB Case Nos.: 13-1380G, 13-3081GC, 13-3642GC and 13-3664GC

Dear Ms. Griffin:

On September 21, 2017, the Provider Reimbursement Review Board ("PRRB" or "Board") received a request for expedited judicial review ("EJR") for the above-referenced group appeals (dated September 20, 2017). The Board has reviewed 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] The instant cases involve the hospital-specific DSH adjustment, which requires

[1] September 20, 2017 EJR Request at 1-2.
[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).

the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[5]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[6] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, then is used to determine the amount of the DSH payment due to the qualifying hospital.[7] The DPP is defined as the sum of two fractions expressed as percentages.[8] Those two fractions are the "Medicare" or "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 utilized by the Medicare contractors to compute a hospital's DSH eligibility and 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 Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered

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

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

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

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

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

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

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

> associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[19] (emphasis added)

Consequently, within the Secretary's response to the commenter, the Secretary announced that CMS would include 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 substantive regulatory change had in fact occurred but that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule.[21] As a result, the pertinent regulatory language was "technically corrected" to reflect that Part C days were required to be included in the Medicare fraction of the DPP 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, as the providers point out, the Secretary has not acquiesced or taken action to implement the decision[23] 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.[24]

In *Allina*, the Court affirmed the district court's decision "that the Secretary's final rule was not a logical outgrowth of the proposed rule."[25] 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] *Id.*
[22] 746 F. 3d 1102 (D.C. Cir. 2014).
[23] September 20, 2017 EJR Request at 8.
[24] 69 Fed. Reg. at 49,099.
[25] *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 providers 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.

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.[26]

The providers included in this EJR request filed appeals of either original notices of program reimbursement ("NPRs") or revised NPRS ("RNPRs") in which the Medicare contractor settled cost reporting periods ending between March 31, 2008, and December 31, 2009.

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*.[27]

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[26] 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).

[27] 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

For providers appealing from revised NPRs ("RNPRs"), the providers must demonstrate that the issue under review was specifically revisited/revised in the appealed RNPR.[28]

For appeals of original NPRs for cost reporting time periods ending on or after December 31, 2008, 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 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 cost reports under protest.[29]

Jurisdictional Determination for Providers

The Board finds that all providers involved with the instant EJR request have had an adjustment to the SSI%[30] on their respective NPRs/RNPRs 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 ending in 2008-2009, thus the cost reporting periods fall squarely within the time frame covered by the Secretary's final rule being challenged in this EJR request.[31] 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

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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."

[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. For RNPRs issued on or after August 21, 2008, the regulation at 42 C.F.R. § 405.1889(b)(1) (2008) states that only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.

[29] 42 C.F.R. § 405.1835(a)(1) (2008).

[30] The terms "SSI fraction," "SSI%," and "Medicare fraction" are synonymous and used interchangeably within this decision

[31] 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.

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,*[32] the D.C. Circuit Court agreed with the Board's decision to grant EJR for the identical issue involved in the instant 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.

Board Members Participating:

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

FOR THE BOARD:

Board Member

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

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

cc: Danene Hartley, National Government Services (Certified Mail w/Schedules of Providers)
Pam VanArsdale, National Government Services (Certified Mail w/Schedules of Providers)
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DEPARTMENT OF HEALTH & HUMAN SERVICES

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OCT 19 2017

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Palmetto GBA c/o National Government Services
Laurie Polson, Appeals Lead
MP: INA 101-AF42
P. O. Box 6474
Indianapolis, IN 46206-6474

RE: Presbyterian Hospital Mathews
Juris. Challenge DSH – SSI (Provider Specific) and Medicaid Eligible Days
PN: 34-0171
FYE: 12/31/2009
PRRB Case Number: 14-2332

Dear Mr. Kramer and Ms. Polson,

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

Background

Presbyterian Hospital Mathews ("Presbyterian" or "Provider") filed a timely appeal on February 7, 2014 from its August 14, 2013 Notice of Program Reimbursement ("NPR"). The issues initially raised included:

(1) Disproportionate Share Hospital Payment ("DSH") – Supplemental Security Income ("SSI") (Provider Specific-Realignment)
(2) DSH – Medicaid Eligible Days
(3) DSH – Labor Room Days
(4) Rural Floor Budget Neutrality Adjustment ("RFBNA")

After withdrawal of DSH-Labor Room Days and RFBNA issue, only Issue #1, and 2 remain in this case.[1]

The Medicare Contractor filed a jurisdictional challenge on January 30, 2015 regarding Issue #1, DSH – SSI (Provider Specific) and Issue #2 DSH-Medicaid Eligible Days. Presbyterian filed their jurisdictional responsive brief on February 24, 2015.

[1] *See* Provider's Preliminary Position and Medicare Contractor's Final Position Paper at 3.

Medicare Contractor's Position

Provider Specific SSI
The Medicare Contractor contends neither the Medicare Contractor nor the Secretary have issued a determination that is contrary to the Provider's request for a recalculation of the SSI percentage based on the Provider Specific FYE, thus no dissatisfaction with the final determination exists under 42 U.S.C § 1395oo(a) and therefore the Provider Reimbursement Review Board ("Board") lacks jurisdiction. The Medicare Contractor further contends the Presbyterian is entitled to a recalculation of the SSI under 42 C.F.R. § 412.106 (b)(3), if the Provider adheres to the requirements of making this type of request. However the Medicare Contractor states Provider is not entitled to appeal an action that it has not yet taken.[2]

Medicaid Eligible Days
The Medicare Contractor contends the Board doesn't have jurisdiction over the additional Medicaid eligible days under 42 C.F.R. §405.1835, since the Medicare Contractor did not make an adjustment to disallow the disputed days. The Medicare Contractor contends the sole DSH adjustment made included to report the proper SSI% based on the Federal Register. The Medicare Contractor further contends Presbyterian did not conform to the Board's Alert 10 in which the Board instructed Providers to supplement their record with additional arguments and/or documentation that would be relevant to the Board making a jurisdictional determination on the issue relating to the DSH paid/unpaid Medicaid eligible days. The Medicare Contractor also contends that Presbyterian has failed to demonstrate that it is dissatisfied with the Medicare Contractor's determination but instead its dissatisfaction is with its own reporting.3

Provider's Contentions

Provider Specific SSI
Presbyterian contends that the Board has jurisdiction over the SSI Provider Specific issue, since the Medicare Contractor specifically adjusted the Providers SSI percentage and the Provider is dissatisfied with the amount of DSH payment it received for the cost report fiscal year of 2009. Presbyterian further contends it will analyze the Medicare Part A records and will be able to identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS. The Provider believes that the SSI percentage determined by CMS is incorrect due to understated days in the SSI ratio. Presbyterian contends it is addressing not only the realignment issue but also the various errors of omission and commission that do not fit into the "systematic errors" category.4

Medicaid Eligible Days
Presbyterian states that Adjustment #16 relates to Provider's DSH calculation and this adjustment is enough to warrant Board jurisdiction over DSH/Medicaid Eligible day's issue. Presbyterian also argues that an adjustment is not required, as DSH is an issue that does not have to be adjusted or claimed on the cost report therefore the Presentment requirement should not apply. Presbyterian further questions the

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[2] *See* Jurisdictional challenge dated January 29, 2015 (Received January 30, 2015).
[3] *See* Jurisdictional challenge dated January 29, 2015 (Received January 30, 2015).
[4] *See* Provider's Jurisdictional Response dated February 20, 2015.

validity of applying the Presentment rule. Presbyterian also contends they self-disallowed Medicaid Eligible Days in accordance with Board Rule 7.2(B), as they did not have the documentation necessary to identify all days at the time of the cost report filing.

The Provider also states they responded to the Board's Alert 10 under separate cover in terms of jurisdiction on the DSH/Medicaid Eligible Day issue. [5]

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 - 405.1840 (2014), 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 (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the notice of the final determination.

Provider Specific SSI
The Provider filed in its original appeal request, Issues # 1 as "Whether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation" with the contentions that the SSI percentage was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits so the SSI percentage issued by CMS is flawed. The Provider stated that it was seeking data from CMS in order to reconcile its records and identify the data that CMS failed to include. For issue #1, it went on to state 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."[6]

Presbyterian filed its Final Position paper on July 28, 2017 briefing the SSI provider specific issue. The provider fails to mention the recalculation of the SSI% based on its cost reporting period in the paper, and states that when it receives data from SSA it will identify patients that were not included in the SSI percentage based on the "Federal Fiscal Year End" ("FFY").[7]

The Board therefore finds that it lacks jurisdiction over the Provider Specific issue as it relates to realignment from the FFY to Cost Report Year. The issue was abandoned by the Provider in its Final Position Paper. The Board finds that it has jurisdiction over the portion DSH-SSI (Provider) Specific issue as it relates to the "errors of omission and commission" as there was an adjustment to the SSI percentage (Adj.15). However, the Board finds that this issue is duplicative of the SSI Systemic Errors issue appealed in Group Case No. Case No. 14-2215GC. Since the remaining "provider specific" arguments put forth in this appeal request are categories of the same argument (not separate issues) related to the accuracy of the SSI fraction within the DSH adjustment (Provider has not identified how the two issues are different, and as it's been 4 years since the NPR, they should have requested the data to identify by now).

Accordingly, the Board dismisses Issue #1 DSH – SSI (Provider Specific-Realignment), from this appeal.

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[5] Provider's Jurisdictional Response dated February 20, 2015.
[6] See Providers Individual Appeal Request dated February 5, 2014.
[7] *See* Provider's Final Position Paper, page 9.

Medicaid Eligible Days
After reviewing Presbyterian's Individual Appeal Request and the Position Papers the Board finds that the Provider did not submit any supporting documentation that indicates that the Medicare Contractor made an adjustment to disallow the disputed days or that the days the Provider is making a claim for were filed under Protest on the Medicare Cost Report. The Provider further acknowledges they submitted a fiscal year 2009 cost report that does not reflect an accurate number of Medicaid Eligible days as the documentation is often not available from the State in time to include all DSH/Medicaid Eligible days on the cost report.[8]

The regulation at 42 C.F.R. § 405.1835(a)(1) provides, in relevant part:

> (a) A provider . . . has a right to a Board hearing . . . for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination, only if --
> (1) The provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue, by either –
>
> (i) Including a claim for specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or
>
> (ii) Effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item(s) by following the applicable procedures for filing a cost report under protest, where the provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy (for example, if the intermediary lacks discretion to award the reimbursement the provider seeks for the item(s)).

Per Board Rule 7.2 C :

> "Effective for cost reporting periods ending on or after December 31, 2008, items not being claimed under subsection A above must be adjusted through the protested cost report process. The Provider must follow the applicable procedures for filing a cost report under protest as contained in CMS Pub. 15-2, Section 115. See 42 C.F.R. § 405.1835(a)(1)(ii)".

Although Presbyterian did include a protested amount on W/S E Part A, they did not document that claim included a request for additional Medicaid Eligible Days. The Board finds that Presbyterian failed to claim the Medicaid eligible days nor did they provide documentation that the protested amount on the cost report included a claim for additional Medicaid Eligible Days. The Provider also acknowledged that it was standard that additional Medicaid Eligible Days were identified after the cost report was filed, therefore they had knowledge prior to the submission of the cost report that they should have included a protested amount for costs they could not identify on the as-filed report. Therefore the appealed issue of Medicaid Eligible Days in this instance does not meet the jurisdictional requirements of the 42 C.F.R.

[8] See Provider's Jurisdictional Response dated February 20, 2015 and Position Paper.

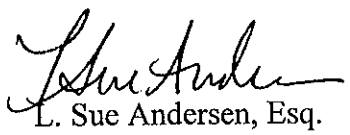
§ 405.1835(a)(1) and Board Rule 7.2(C). Since there are no remaining issues remaining in this appeal the case will be closed.

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
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
1508 Woodlawn Drive, Suite 100
Baltimore, MD 21207
410-786-2671

CERTIFIED MAIL

OCT 19 2017

Corinna Goron, President
Healthcare Reimbursement Services, Inc.
c/o Appeals Department
17101 Preston Road, Suite 220
Dallas, TX 75248 1372

RE: Our Lady of Lourdes Regional Medical Center
Provider No. 19-0102
FYE 6/30/2008
Case No.: 13-3206

Dear Ms. Goron:

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above-referenced appeal. The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

The Provider submitted a request for hearing on August 27, 2013, based on a Notice of Program Reimbursement ("NPR") dated February 27, 2013. The hearing request included two issues, one of which was labeled SSI percentage (Provider Specific). The Provider filed its preliminary positon paper on May 1, 2014. The cover letter to the position paper indicates that the Medicaid Eligible Days issue was withdrawn so that the only issue being briefed was the SSI percentage (Provider Specific) issue.

Board Determination:

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

The Board finds that it has jurisdiction over the portion of the SSI percentage (Provider Specific) issue challenging the data used to calculate the SSI percentage as there was an adjustment to the SSI percentage (Adj. 6), and the appeal meets the amount in controversy and timely filing requirements. However, the Board also finds that the inaccurate data portion of this issue is duplicative of the DSH/SSI Systemic Errors issue which the Provider directly added to Case No. 13-3117GC. The Provider contends in the SSI percentage (Provider Specific) issue statement that the "Medicare Contractor did not determine Medicare DSH reimbursement in accordance

with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[1] The SSI Systemic Errors issue statement also argues that "the SSI percentages published by the Centers for Medicare and Medicaid Services (CMS) was incorrectly computed . . .".[2] 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. Therefore, the portion of the SSI percentage (Provider Specific) challenging the accuracy of the SSI ratio data resides in Case No. 13-3117GC.

Regarding the portion of the SSI percentage (Provider Specific) addressing realignment of the DSH calculation to the Provider's fiscal year end, the Board finds that realignment issue is premature. 42 C.F.R. § 405.1835 (2012) states

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

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

Therefore because the DSH SSI (Provider Specific) issue is duplicative of the Systemic Errors issue which is pending in a group appeal (13-3117GC) and the Medicare Contractor has not made a final determination with regard to the realignment from which Our Lady of the Lourdes Regional Medical Center could appeal, the Board finds that it lacks jurisdiction over the DSH/SSI percentage (Provider Specific) issue and dismisses it from Case No. 13-3206.

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.

As there are no remaining issues in the appeal, the Board hereby closes Case No. 13-3206.

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

[2] *Id.* at Issue 2.

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

For the Board:

Chairperson

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

OCT 19 2017

CERTIFIED MAIL

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

RE: Navarro Regional Hospital, Provider No. 45-0447, FYE 12/31/2014
PRRB Case No. 17-2111

Dear Ms. O'Brien Griffin:

The Provider Reimbursement Review Board (the Board) has reviewed your October 6, 2017 request to add an issue to the subject individual appeal, as well as your request to transfer that issue to a common issue related party (CIRP) group for Navarro Regional Hospital. The Board notes that the Provider's individual appeal was dismissed on September 11, 2017. Although the CHS requested reinstatement of the appeal by letter dated September 14, 2017, the Board denied the reinstatement by letter dated October 16, 2017. Therefore, since the individual appeal is in a closed status, the Board hereby denies your request to add the Post 1498R Data Match issue and denies your request to transfer the added issue to the CHS 2014 DSH Post 1498R SSI Data Match Group, Case No. 16-1192GC.

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:
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
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 .1877

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

CERTIFIED MAIL OCT 19 2017

Marvin Reso, RN
Corporate Secretary/DPCS
Always Care Hospice, Inc.
5252 Orange Avenue, Suite 212
Cypress, CA 90630

RE: Always Care Hospice, Inc., Provider No.: 75-1526, FYE 9/30/2018
PRRB Case No. 17-2323

Dear Mr. Reso:

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced appeal. The pertinent facts of the case and the jurisdictional determination of the Board are set forth below.

Pertinent Facts:

According to the Provider's appeal request, it received a letter from CMS dated July 13, 2017 (of which it did not submit a copy) advising the Provider to submit a Reconsideration Request by August 13, 2017. The Provider asserts that, "[d]ue to the emergency leave of one of our employees who handles the quality data reporting, the company failed to submit the Reconsideration Request . . .". Therefore, the Provider requests that the Board accept the late submission of the Reconsideration Request.

Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2011), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if **it is dissatisfied with the final determination of the intermediary** (now referred to as 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 (emphasis added).

Hospices are covered under 42 C.F.R. § 418.312(h)(1) which says

> **(1)** A hospice may request reconsideration of a decision by CMS that the hospice has not met the requirements of the Hospice Quality Reporting Program for a particular reporting period. A hospice must submit a reconsideration request to CMS no later than 30 days from the date identified on the annual payment update notification provided to the hospice.

In this case, the Provider admits that it did not timely submit the request for reconsideration to CMS. 42 C.F.R. § 418.312(h)(3) discusses the Provider's appeal rights before the Board:

> (3) A hospice that is dissatisfied with a decision made by CMS on its reconsideration request may file an appeal with the Provider Reimbursement Review Board under part 405, subpart R of this chapter.

The Board finds that the Provider has not exhausted its administrative remedies by requesting a reconsideration as set forth in the regulations. Thus, the Medicare Contractor has not made a final determination which would have triggered appeal rights before the Board. Consequently, the Board finds that it lacks jurisdiction over this appeal pursuant to 42 C.F.R. §§ 405.1835 – 405.1840 and § 418.312(h)(3) and hereby dismisses the appeal.

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
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 .1877

cc: Danene Hartley, National Government Services (J-6)
Wilson C. Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

CERTIFIED MAIL OCT 19 2017

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

RE: Methodist Sugar Land Hospital, Provider No. 45-0820, FYE 12/31/2008,
PRRB Case No. 14-0811

Dear Ms. Chi:

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above-referenced appeal. The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

Houston Methodist Hospital System (Houston Methodist) filed an appeal on behalf of the Provider on November 18, 2013, which included the following issues:

- DSH SSI (Provider Specific) (two issues: one involving the SSI calculation & one involving errors of omission when CMS did not account for all patient days in the Medicare fraction)
- DSH SSI (Systemic Errors)
- Medicaid Eligible Days
- Managed Care Part C Days (both fractions)
- Dual Eligible/Exhausted Part A Days (both fractions)

The Board assigned case number 14-0811 to the individual appeal in an Acknowledgement letter dated December 15, 2013.

The Medicare Contractor objected to the Board's jurisdiction over the Medicaid Eligible Days and Dual Eligible Days issues – contending that it did not make an adjustment.

On August 27, 2014, Houston Methodist filed "Requests to Transfer Issue to A Group Appeal" (Model Form D's) for the following issues:

- DSH SSI (Systemic) to case number 14-4116GC
- SSI Fraction Medicare Managed Care Part C Days to case number 14-4119GC
- Medicaid Fraction Medicare Managed Care Part C Days to case number 14-4127GC
- Medicaid Fraction Dual Eligible/Exhausted Part A Days to case number 14-4097GC
- SSI Fraction Dual Eligible/Exhausted Part A Days to case number 14-4098GC

Subsequently, on September 14, 2016 Methodist Health withdrew the Medicaid Eligible Days

issue from the appeal.

Board Determination:

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.

The Board finds that it has jurisdiction over Issue Nos. 1 and 2, the DSH SSI Provider Specific issues, as they relate to the flawed SSI percentage used by CMS and "errors of omission" as there were adjustments to the SSI percentage (Adj. #s 15 & 22), and the appeal meets the amount in controversy and timely filing requirements.

However, the Board also finds that omission issues raised in Nos. 1 & 2 are duplicative of Issue No. 3, the DSH SSI Percentage (Systemic Errors) issue that was transferred to a group case. The "systemic" arguments and the "provider specific" arguments put forth in the appeal request are categories of the same argument (not separate issues) related to the accuracy of the SSI fraction within the DSH adjustment. The basis of all three issues is that the SSI percentage is improperly calculated due to errors in accumulating the underlying data and the inability to obtain the data. PRRB Rule 4.5 states that a Provider may not appeal an issue from a final determination in more than one appeal. Because the underlying data issues are duplicative of the SSI Accuracy issue, which has already been transferred to case number 14-4116GC, it cannot be pursued in the individual appeal.

Regarding the portion of the SSI percentage (Provider Specific) addressing realignment of the DSH calculation to the Provider's fiscal year end, the Board finds that realignment issue is premature. 42 C.F.R. § 405.1835 (2012) states

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

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

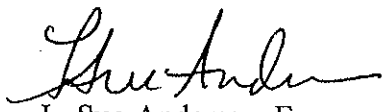
Therefore because the DSH SSI (Provider Specific) issue is duplicative of the Systemic Errors issue which is pending in a group appeal (14-4116GC) and the Medicare Contractor has not made a final determination with regard to the realignment from which Methodist Sugar Land Hospital could appeal, the Board finds that it lacks jurisdiction over the DSH/SSI percentage (Provider Specific) issue and dismisses it from Case No. 14-0811.

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.

As there are no remaining issues in the appeal, the Board hereby closes Case No. 14-0811.

Board Members Participating:
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
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 .1877

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

CERTIFIED MAIL OCT 19 2017

Corinna Goron, President
Healthcare Reimbursement Services, Inc.
c/o Appeals Department
17101 Preston Road, Suite 220
Dallas, TX 75248 1372

RE: Our Lady of the Lake Ascension Community Hospital
Provider No. 19-0242
FYE 6/30/2010
Case No.: 14-1247

Dear Ms. Goron:

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above-referenced appeal. The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

The Provider submitted a request for hearing on December 3, 2013, based on a Notice of Program Reimbursement ("NPR") dated September 6, 2013. The hearing request included two issues, one of which was labeled SSI percentage (Provider Specific). The Provider filed its preliminary positon paper on August 28, 2014. The cover letter to the position paper indicates that the Medicaid Eligible Days issue was withdrawn so that the only issue being briefed was the SSI percentage (Provider Specific) issue.

Board Determination:

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

The Board finds that it has jurisdiction over the portion of the SSI percentage (Provider Specific) issue 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 this issue is duplicative of the DSH/SSI Systemic Errors issue which the Provider directly added to Case No. 14-0857GC. The Provider contends in the SSI percentage (Provider Specific) issue statement that the "Medicare Contractor did not determine Medicare DSH reimbursement in accordance

with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[1] The SSI Systemic Errors issue statement also argues that "the SSI percentages published by the Centers for Medicare and Medicaid Services (CMS) was incorrectly computed . . .".[2] 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. Therefore, the portion of the SSI percentage (Provider Specific) challenging the accuracy of the SSI ratio data resides in Case No. 14-0857GC.

Regarding the portion of the SSI percentage (Provider Specific) addressing realignment of the DSH calculation to the Provider's fiscal year end, the Board finds that realignment issue is premature. 42 C.F.R. § 405.1835 (2012) states

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

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

Therefore because the DSH SSI (Provider Specific) issue is duplicative of the Systemic Errors issue which is pending in a group appeal (14-0857GC) and the Medicare Contractor has not made a final determination with regard to the realignment from which Our Lady of the Lourdes Regional Medical Center could appeal, the Board finds that it lacks jurisdiction over the DSH/SSI percentage (Provider Specific) issue and dismisses it from Case No. 14-1247.

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.

As there are no remaining issues in the appeal, the Board hereby closes Case No. 14-1247.

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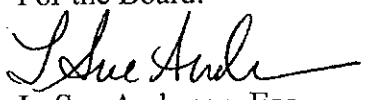
[1] *See* Provider's Individual Appeal Request at Tab 3, Issue 1.
[2] *Id.* at Issue 2.

Board Members Participating:
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
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 .1877

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Refer to: 16-1084

OCT 19 2017

CERTIFIED MAIL

Catholic Community Hospice
Howard Cassidy-Moffatt
Executive Director Healthcare Services
425 West 85th Street
Kansas City, MO 64114

CGS Administrators
Judith E. Cummings
Accounting Manager
CGS Audit & Reimbursement
P.O. Box 20020
Nashville, TN 37202

RE: Catholic Community Hospice
Provider No.: 26-1644
FYE: 9/30/2016
PRRB Case No.: 16-1084

Dear Mr. Cassidy-Moffatt and Ms. Cummings,

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

Background:

On June 9, 2015, the Medicare Contractor informed Catholic Community Hospice ("the Hospice") of a two percent payment reduction citing a failure to meet the Hospice Quality Reporting requirements. The letter was addressed to:

Ms. Judith Walker, Executive Director
Catholic Community Hospice
405 NE 70th Street
Kansas City, MO 64118

The Hospice alleges that it did not receive the notification of payment reduction letter as it was sent to the wrong address, "even though the proper address had been updated with CMS."

On January 20, 2016, the Medicare Contractor faxed a copy of the June 9, 2015 notification letter to the Hospice. On January 27, 2016, the HCIS Help desk sent an email to the Hospice stating that the time for a reconsideration request had passed, but that it could still file an appeal with the Board. The Board received the Hospice's appeal request on February 23, 2016.

Board's Decision:

The Board finds that it does not have jurisdiction over Catholic Community Hospice's appeal because it was not timely filed and the Hospice did not establish by a preponderance of the evidence that it did not receive notice until January 26, 2017.

42 C.F.R. § 405.1835(a) sets out the requirements for Board jurisdiction and states:

> (a) A provider . . . has a right to a Board hearing . . . for specific items claimed for a cost reporting period covered by a final contractor or Secretary determination if –
>
> (1) The Provider has preserved its right to claim dissatisfaction . . .
> (2) The amount in controversy . . . is $10,000 or more; and
> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request is no later than 180 days after receipt by the provider of the final contractor or Secretary determination.

Here, CMS imposed a two percent reduction to the Hospice's Annual Payment Update because it failed to report quality data via the Hospice Item Set in 2014. The two percent reduction notice letter was dated June 9, 2015. However, the Provider argues that it did not receive this notification until it was faxed by the Medicare Contractor on January 27, 2016. The Board finds that the record does not contain sufficient evidence to establish, by a preponderance of the evidence, that the Provider did not receive notice until January 27, 2016. The Provider makes that argument, but does not include any evidence to prove its argument; therefore, the Board finds that the Provider did not timely file its appeal request. PRRB Case No. 16-1084 is hereby closed and removed from the Board's docket.

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

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

FOR THE BOARD

L. Sue Andersen, Esq.
Chairperson

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

cc: Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Refer to: 13-2879GC

OCT 2 4 2017

CERTIFIED MAIL

Hall, Render, Killian, Heath &Lyman
Elizabeth A. Elias
500 North Meridian Street
Suite 400
Indianapolis, IN 46204

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

RE: Mercy General Health Partners, *as a participant in*
Trinity Health 2007 DSH Labor and Delivery Room Days CIRP Group
Provider No.: 23-0004
FYE: 6/30/2007
PRRB Case No.: 13-2879GC

Dear Ms. Elias and Ms. Hartley,

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

Background:

On February 15, 2013, Mercy General Health Partners ("Mercy General") was issued a revised Notice of Program Reimbursement ("NPR") for fiscal year end 6/30/2007. The group representative filed a group appeal request with the Board for three Providers, including Mercy General. The group representative has since withdrawn two Providers, so Mercy General is the only Provider that remains in the appeal.

On July 19, 2017, the Medicare Contractor submitted a jurisdictional review in which it argues that the Board does not have jurisdiction over Mercy General. The group representative responded to this jurisdictional review and argues that the Board does have jurisdiction over the Provider.

Medicare Contractor's Position:

In its jurisdictional review, the Medicare Contractor argues that the Board does not have jurisdiction over Mercy General, because it appealed from a revised NPR and does not have dissatisfaction with labor and delivery days.

Provider's Position

The Provider begins by arguing that the Medicare Contractor mischaracterized its issue statement. According to the Provider, "the Group Appeal issue is the determination or calculation of the Provider's DSH payment, which as defined by statute, encompasses both the Medicare and Medicaid fractions."[1]

The Provider next contends that CMS Ruling 1498-R mandates that the labor and delivery room days at issue should have been included in the appealed cost report. Finally, the Provider argues that the adjustment to DSH at adjustment no. 5 is sufficient to give rise to jurisdiction over the labor and delivery room days from its revised NPR.

Board's Decision:

The Board finds that it does not have jurisdiction over Mercy General because it has appealed from a revised NPR that did not specifically adjust labor and delivery room days.

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2013) provides in relevant part:

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

42 C.F.R. § 405.1889 (2013) explains the effect of a cost report revision:

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

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[1] Providers' Jurisdictional Response.

These regulations make clear that a Provider can only appeal items that are specifically adjusted from a revised NPR. Here, the Provider's revised NPR has only adjusted the SSI percentage. As labor and delivery room days were not specifically adjusted, the Board finds that it does not have jurisdiction over Mercy General.

Mercy General is the last Provider that remains in this group appeal, therefore PRRB Case No. 13-2879GC is hereby closed and removed from the Board's docket.

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

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

FOR THE BOARD

L. Sue Andersen, Esq.
Chairperson

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

cc: Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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OCT 24 2017

Certified Mail

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Expedited Judicial Review Determination

RE: Shands HealthCare 2014 Post-Allina Decision Medicare Part C Days Group
PRRB Case No. 16-1761GC[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) and the Providers' October 5, 2017 response to the Board's September 7, 2017 request for additional information requesting missing jurisdictional information for one of the Providers (received October 6, 2017). 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

[1] The August 8, 2017 EJR included case numbers 16-0326GC and 16-1623GC. The Board decided the question of whether EJR as appropriate in early correspondence.
[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.

prospective payment system ("PPS").[5] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[6]

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

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

> 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.[13]

Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary[14] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[15]

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

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

With the creation of Medicare Part C in 1997,[17] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004. [18]

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicare fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction* . . . (emphasis added)[19]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[20] In response to a comment regarding this change, the Secretary explained that:

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

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

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

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

[20] 69 Fed. Reg. at 49,099.

> *adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[21] (emphasis added)

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

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

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius,*[23] vacated the FFY 2005 IPPS rule. However, the Providers point out, the decision is not binding in actions by other hospitals. Further, the Secretary has not acquiesced to that decision.[24]

Providers' Request for EJR

Bifurcation

In the cover letter to the EJR request, the Providers point out that the issue in this appeal 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 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 while the periods prior to be EJR'd.

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

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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.

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.[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 1, 2013.

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

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 appeal within this EJR request have filed appeals involving fiscal year 2014.

The Providers in this case have not received final determinations for the fiscal year 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.[32]

The Board has determined that participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[33] 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 appeal in this EJR request involves the June 30, 2014 fiscal year which began July 1, 2013. Consequently, each of the providers in the appeal utilizes a FFY 2013 SSI percentage, thus the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only federal 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 federal court in either the D.C. Circuit *or* the federal 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;

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[32] One of Providers, Shands Hospital at the University of Florida, has two 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 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, the 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. 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.

[33] *See* 42 C.F.R. § 405.1837.

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

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

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

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

Board Members Participating:

L. Sue Anderson, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A

FOR THE BOARD:

L. Sue Andersen
Chairperson

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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OCT 2 6 2017

Refer to: 14-0739

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Bill Tisdale
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RE: Denver Health Medical Center
Jurisdictional Challenge
PN: 06-0011
FYE: 12/31/2008
CASE NO.: 14-0739

Dear Mr. Springston and Mr. Tisdale,

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

Background:

The Provider submitted a request for hearing on November 13, 2013, based on a Notice of Program Reimbursement ("NPR") dated May 15, 2013. The hearing request included three issues. One issue was subsequently withdrawn by the Provider via Provider's preliminary position paper dated July 30, 2014.[1] Two issues remain in the appeal as follows: Issue No. 1 – Medicare Disproportionate Share Hospital (DSH) Payments – Additional Medicaid Eligible Days and Issue No.2 – Bad Debts. The Provider references adjustments number 57 and 68 for the DSH – Medicaid Eligible Days issue. The Medicare Contractor submitted a jurisdictional challenge on Issue No. 1 on August 23, 2017. The Provider did not file a responsive brief.

Medicare Contractor's Position

The Medicare Contractor contends that this issue does not meet the jurisdictional requirements, as an adjustment was not made to the additional Medicaid eligible patient days in question. The Medicare Contractor's adjustments to the as-filed numbers reflected an adjustment to Medicaid

[1] Medicare Contractor's jurisdictional challenge, footnote 2. (August 23, 2017)

Labor and Delivery Days (adjustment 57) and an adjustment to the SSI Percentage (adjustment 68). The Provider cannot demonstrate dissatisfaction with the Medicare Contractor's final determination, as there was no Medicare Contractor final determination for the days in contention.[2]

The Medicare Contractor argues that in the case at issue it did not make an adjustment for the additional Medicaid eligible days in question. The Provider is not able to demonstrate that it meets the dissatisfaction requirement. The Provider did not preserve its right to claim dissatisfaction as it did not include a claim for the specific additional Medicaid eligible days now in question. The Medicare Contractor contends that the Provider has not shown how the associated days were claimed on the cost report (or presented) and then disallowed by the Medicare Contractor. The days at were not claimed by the Provider and therefore the Medicare Contractor did not render a final determination.[3]

The Medicare Contractor explains that effective with cost report periods that end on or after December 31, 2008, CMS amended the regulations governing cost report appeals to incorporate PRM 15-2 § 115 *et seq.* into the regulations at 42 C.F.R. § 405.1835(a)(1)(ii) 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." The Medicare Contractor contends that the Provider has failed to preserve its right to claim dissatisfaction by properly filing the reimbursement impact of the additional Medicaid eligible days in question as a Protested Amount.[4]

Under the 2008 regulation, the Medicare Contractor contends that the Board lacks jurisdiction over the disputed days because they were neither claimed nor self-disallowed. In 2008, CMS amended 42 C.F.R. § 405.1811(a)(1) and 42 C.F.R. § 405.1835(a)(1) to require, as a condition to filing a valid appeal, the provider to have either claimed an item or included that item as a protested amount when filing its cost report.[5]

Provider's Position

No Response received from the Provider.

Board Determination:

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

[2] Medicare Contractor's jurisdictional challenge at 3. (August 23, 2017)
[3] *Id.* at 5.
[4] *Id.* at 6.
[5] *Id.* at 6.

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.....[6]

The Provider is appealing from a 12/31/2008 cost report, which means that it either had to claim the cost at issue or it is subject to the protest requirement in order for the Board to have jurisdiction.

The Board finds that it does not have jurisdiction over the DSH - Medicaid eligible days issue in this appeal. The Provider did not protest the Medicaid eligible days currently under appeal on its cost report notwithstanding the fact that it knew Colorado 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 or if it filed the days it could not document as a protested amount as required by 42 C.F.R. § 405.1835(a)(1). The Board finds that the Provider did neither, and therefore, the Board concludes that Denver Health Medical Center has not met the dissatisfaction requirement of including a specific claim on the cost report, or protesting the specific Medicaid eligible days at issue. As the Board lacks jurisdiction over the issue, it hereby dismisses the issue from the appeal.

The Medicare Bad Debt issue remains in the appeal, the case remains open.

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

Board Members Participating
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
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

[6] 42 C.F.R. § 405.1835(a).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: 17-2146

OCT 26 2017

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Washington, DC 20006-4706

RE: SSM Health St. Mary's Hospital - St. Louis
Provider No.: 26-0091
FYE - 12/31/2013
PRRB Case No.: 17-2146

Dear Mr. Hettich:

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

PERTINENT FACTS:

By letter dated August 31, 2017, King & Spalding filed a Form A - Individual Appeal Request on behalf of SSM Health St. Mary's Hospital - St.Louis, Provider No.: 26-0091, FYE - 12/31/2013 based on the Notice of Program Reimbursement ("NPR") dated February 23, 2017.

The appeal request was received in the Board's offices on September 1, 2017. The Board established case number 17-2146 and issued an Acknowledgment and Critical Due Dates notice on September 5, 2017.

By letter dated September 12, 2017, Federal Specialized Services challenged the Board's jurisdiction over the appeal stating that the appeal was not timely filed.

BOARD DETERMINATION:

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.

Board Rule 4.3 – Date of Receipt Presumption/Calculating Filing Deadlines states:

> The date of receipt of a final determination is presumed to be 5 days after the date of issuance. This presumption, which is otherwise conclusive, may be overcome if it is established by a preponderance of the evidence that such materials were actually received on a later date. *See* 42 C.F.R. § 405.1801(a)(1)(iii).

The date of receipt of documents is presumed to be the date:

- stamped "received" by the Board on documents submitted by regular mail, hand or non-nationally recognized next-day courier.
- of delivery to the Board on documents transmitted by a nationally-recognized next-day courier as evidenced by the courier's tracking bill. It is the responsibility of the provider to maintain record of delivery. [*July 1, 2009*]

See 42 C.F.R. § 405.1801(a)(2).

Board Rule 9 also addresses the acknowledgement of an appeal and issuance of critical due dates:

> The Board will send an acknowledgement via email indicating that the appeal request has been received and identifying the case number assigned. If the appeal request does not comply with the filing requirements, the Board may dismiss the appeal or take other remedial action. An acknowledgement does not limit the Board's authority to require more information or dismiss the appeal if it is later found to be jurisdictionally deficient.

The final determination used to establish the subject appeal is the Notice of Program Reimbursement dated February 23, 2017, thus the presumed date of receipt of the NPR is February 28, 2017. Accordingly, the filing deadline for the appeal request, 180 days from the date of receipt, including the five-day mailing presumption, was Sunday, August 27, 2017.

Per 42 C.F.R. § 405.1801(d)(3), if the last day of the designated time period is a Saturday, a Sunday, a Federal legal holiday (as enumerated in Rule 6(a) of the Federal Rules of Civil Procedure), or a day in which the reviewing entity is unable to conduct business in the usual manner, the deadline becomes the next day that is not one of the aforementioned days.

Because August 27, 2017 fell on a Sunday, the deadline for filing the appeal (based on the February 23, 2017 date of the NPR) was Monday, August 28, 2017. The Provider's appeal request was not received in the Board's office until September 1, 2017, 189 days following the date of issuance of the NPR. The Board, therefore, concludes that the appeal was not timely filed and dismisses case number 17-2146 pursuant to the regulations cited above and the Board Rules.

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
Gregory H. Ziegler, CPA, CPC-A

FOR THE BOARD:

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Chairperson

cc: Byron Lamprecht
Wisconsin Physicians Service
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OCT 2 6 2017

CERTIFIED MAIL

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Wisconsin Physicians Service
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RE: Trinity Health 2007 DSH SSI Post 1498-R Data Match CIRP Group
Common Issue Related Parties Group (CIRP) –Juris Review
PN: Various
FYE: 2007
PRRB Case Number: 13-2281GC

Dear Ms. Griffin and Ms. Lamprecht,

The Provider Reimbursement Review Board ("Board") has reviewed the May 24th, 2017 Joint Stipulation and Motion. The Joint Stipulation and Motion requests that because the issues presented in the present appeal is the same as that presented in the appeals that were the subject of the Board's March 27, 2017 decision, 2017-D11, that the decision in 2017-D11 should be applied to these appeals.[1] The Board's decision is outlined below.

Background

On June 5, 2013 the Board received Trinity Health's[2] request to establish a Common Issue Related Party (CIRP) group appeal based on the following summary issue statement:

> The failure of the Fiscal Intermediary and the Centers for Medicare and Medicaid Services (CMS) to properly determine the ratio of patient days for patients entitled to Medicare Part A and Supplemental Security Income (SSI) benefits (excluding any State supplementation) to patient days for patients entitled to Medicare Part A (Medicare Proxy or Fraction) for the Provider in its Disproportionate Share Hospital (DSH) eligibility determination and payment calculation, including any related impact on capital DSH. The Provider asserts that the Medicare Proxy is improperly understated due to a number of factors, including CMS's inaccurate and improper matching or use of data along with policy changes to determine both the number of Medicare Part A SSI patient days in the numerator of the fraction and the total Medicare Part A patient days in the denominator, as utilized in the calculation of the Medicare percentage of

[1] May 24th, 2017 Joint Stipulation and Motion, at 2.
[2] Trinity Health 2007 DSH SSI Post 1498-R Data Match CIRP Group ("Trinity Health").

> low income patients for DSH purposes and/or low income patient (LIP) adjustment for Inpatient Rehabilitation Facilities (IRFs) and/or IRF units....

Case 13-2281GC was established. On November 20, 2015 Trinity Heath informed the Board that the CIRP group was complete and on January 19, 2016 the Board issued the CIRP group critical due dates letter. Subsequently, Trinity Health requested that additional related providers be transferred into the group appeal. Trinity Health informed the Board that this was necessary to meet the CIRP requirements. The Board granted those transfers as CIRP groups are required to raise common issues together.

In August of 2016, the Board scheduled the case for a hearing on June 22, 2017. By Letter dated April 28, 2017, the Provider Representative requested a hearing on the Record pursuant to Rule 32.3, the Request stated:

> The issues presented in this Group Appeal are identical to those presented for a large number of Group Appeals, referred to as the Hall Render Optional and CIRP, DSH Dual/SSI Eligible Group Appeals-Medicare Fraction, Case No. 13-1862GC et.al ("Hall Render Dual/SSI Eligible Appeals") that were the subject of a board hearing on September 15, 2015. Pursuant to correspondence dated February 28, 2017, the Provider has requested that the decision in the related Hall Render Dual/SSI Eligible Appeals that was subsequently issued on March 27, 2017 should be applied to this case and agrees to an on-record review of this case. ....

On May 25, 2017 both parties (Medicare Contractor and Provider) submitted a Joint Stipulation and Motion requesting that the Board rely upon the submitted Stipulation of factual and legal matters for purposes of issuing its decision for this group appeal.

The pertinent Stipulations stated:

> The issues presented in the Hall Render Dual/SSI Eligible Appeals is whether the Providers' Medicare Disproportionate Share Hospital ("DSH") reimbursement calculations were understated due to the Centers for Medicare and Medicaid Services' ("CMS" or "Agency") and the MACs' failure to include all SSI Eligible Patient days in the numerator of the Medicare fraction of the DSH percentage, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi).
>
> Because the issues presented in this group appeal and the Hall Render Dual/SSI Eligible Appeals is the same, and because the relevant legal authorities, supporting documentation and evidence with respect to this group appeal is also the same as that presented in the appeals that were the subject of the Board's March 27, 2017 decision (2017-Dl1), the Providers and the MACs agree that the decision in the related Hall Render Dual/SSI Eligible Appeals issued on March 27, 2017 should be applied to these appeals. Accordingly, the parties jointly agree to an on-record review and

determination of this group appeal pursuant to Board Rule 32.3.[3]

Analysis

Hall Render[4] has stipulated that the issue in the present appeal, the Trinity Health 2007 DSH SSI Post 1498-R Data Match CIRP Group, is the same issued adjudicated in 2017-D11. Upon review of the Schedule of Providers for 2017-D11, it is evident that Case #13-2276GC, Trinity Health 2007 DSH Medicare Fraction Dual Eligible Days CIRP Group, was adjudicated as one of the many CIRP groups consolidated at hearing and as part of that decision. Also, 2017-D12, the "sister" Hall Render Dual Eligible decision, included 09-1039GC Trinity 2007 Dual Eligible Days group appeal as part of its decision. From the review of Board's case tracking system it appears that Trinity Health had previously requested two separate Trinity Health 2007 Dual Eligible Days CIRP groups for the same issue/year, as some of the chain providers were 209B hospitals and other were not. Hall Render believed that the fact could potentially make a difference in the adjudication of the cases and therefore requested that they be distinct appeals.

There are seven providers included on the Final Schedule of Providers for the current case, 13-2218GC. When comparing that schedule of providers to the 2017-D11 decision for 13-2276GC, it is noted that there were six Trinity providers for 2007 included on the final schedule of providers attached to the decision[5] It is also noted that there were three Trinity providers included on the schedule of providers for 09-1039GC, (2017 D-12) one of which was a duplicate provider from 13-2276GC, but was from an Original NPR whereas the provider in 13-2276GC was from a revised NPR. There are two providers in the current 13-2281GC SSI Data Match group for 2007 that were not included in either 13-2276GC or 09-1039GC. They are Provider #1 (05-0093 St Agnes Hospital, 6/30/07) and #6 (36-0012 Mount Caramel Saint 6/30/07).

Therefore, Trinity Health is asking the Board to adjudicate the same issue in Trinity Health 2007 DSH SSI Post 1498-R Data Match CIRP that it already adjudicated for the same chain providers, for the same year in 2017-D11 and 2017-D12. Trinity Health has stipulated that the issues in the Trinity Health 2007 SSI appeal are the same as in the Trinity Health 2007 Dual Eligible Appeals.

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 - 405.1840 (2013), a provider has a right to a hearing before the Board with respect to 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 notice of the final determination.

Further, 42 U.S.C. § 1395oo(f)(1) requires that "Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under

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[3] Joint Stipulation 3 and 4 dated May 24, 2017.
[4] Provider Rep.
[5] The provider had included seven, but the Board transferred the one provider for FY 2006 per request of Hall Render to 17-0489GC as that appeal was for 2006.

subsection (b) must be brought by such providers as a group with respect to any matter involving an issue common to such providers."

Per § 405.1837(b)(1) Mandatory use of group appeals.

> (i) Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, must bring the appeal as a group appeal.

Per PRRB Rule 19.2 Mandatory (CIRP) Groups:

> Mandatory CIRP group appeals must contain all providers eligible to join the group who intend to appeal the disputed common issue. The Board will determine that a group appeal is fully formed upon:
>
> - written notice from the group representative that the group is fully formed, or,
> - a Board order issued after the group representative has the opportunity to present evidence regarding whether any CIRP providers who have not received final determinations could potentially join the group.[6]

Based on the Providers stipulations that the group issue in 2017-D11 which contained 13-2276GC is the same issue presented in the current appeal 13-2281GC, the Board finds that five of the seven Providers in 13-2281GC have already had the Dual Eligible/SSI SSA data issue adjudicated for FY 2007. The Board dismisses those five providers from the current case #13-2281GC as duplicative (Providers #'s2, 3, 4, 5 and 7). Per Board Rule 4.5, No Duplicate Filings, A Provider may not appeal an issue from a final determination in more than one appeal. Further the preamble to the 2008 Final Rule[7] states that once the Board has determined a CIRP has been fully formed no other Providers under common ownership can appeal, unless the Board modifies the fully formed group. However the Board can't modify the fully formed group in 13-2276GC to include the two additional providers from 13-2281GC as both the Board and the Administrator Decisions have been issued.

Therefore the Board finds the remaining two providers in 13-2281GC that were not part of the Board's adjudication of the Dual Eligible SSI issue in 2017-D11, failed to meet the common issue requirements of 42 U.S.C. § 1395oo(f)(1) and 405.1837(b)(1), and dismisses those providers (Provider #1 (05-0093 St Agnes Hospital, 6/30/07) and #6 (36-0012 Mount Caramel Saint 6/30/07). As there are no Providers remaining in 13-2281GC, the appeal is closed.

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

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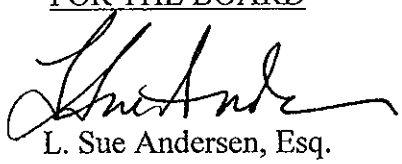
[6] Effective July 1, 2009; March 1, 2013.
[7] Federal Register Vol.73, No.101 May 23, 2008 at 30213.

Board Members Participating

L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
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

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CERTIFIED MAIL

OCT 31 2017

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

Re: Franciscan Alliance 2010 DSH SSI Fraction Dual Eligible Days CIRP, Case No. 15-1989GC
Specifically Direct Adds for: Franciscan St. Margaret Health (15-0004) & Franciscan St. Anthony (15-0015)

Dear Ms. O'Brien Griffin:

The Provider Reimbursement Review Board (the Board) has reviewed the request for reinstatement of the Franciscan Alliance 2010 DSH SSI Fraction Dual Eligible Days CIRP, Case No. 15-1989GC and the requests for Franciscan St. Margaret Health (15-0004) & Franciscan St. Anthony (15-0015) to be added to the group. The pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

The Franciscan Alliance 2010 DSH SSI Fraction Dual Eligible Days Common Issue Related Party (CIRP) group was filed on March 27, 2015 with one participant: Franciscan Health Indianapolis (15-0162) for FYE 12/31/2010.

By letter dated August 8, 2017, Hall Render, Killian, Heath & Lyman (Hall Render) advised that Franciscan Health Indianapolis was the only participant in the chain pursuing the SSI Fraction Dual Eligible Days for FYE 2010. Therefore, Hall Render requested that the Provider be transferred from the CIRP group to an optional group for the same issue, Case No. 17-1408G. The Board granted the transfer and closed the CIRP Case No. 15-1989GC on August 14, 2017.

The Medicare Contractor, Wisconsin Physicians Service (WPS), issued Revised Notices of Program Reimbursement ("RNPRs") for two Providers in the Franciscan Alliance chain for the fiscal year ending FYE 12/31/2010 as follows:

Provider	RNPR Date
Franciscan Health Hammond	3/27/2017
Franciscan St. Anthony Michigan City	4/3/2017

By letter dated September 25, 2017, Hall Render filed a request for reinstatement of Case No. 15-1989GC, as well as two Model Form E's: Request to Join an Existing Group – Direct Appeal From Final Determination (Direct Add) for the two participants filing from receipt of their RNPRs.

WPS filed an objection to Hall Render's request to reinstate the group. WPS contends that the cost reports were reopened to review Medicaid Days used in the calculation of the Medicaid fractions of the DSH percentage. Because these adjustments are not related to the SSI Fraction, which is the issue under appeal in this group, WPS argues that the reinstatement and the Direct Adds should be denied.

On October 3, 2017, Hall Render filed a Request to Transfer the original participant, Franciscan Health Indianapolis (15-0162), from the optional group to which it was transferred (Case No. 17-1408G) back to the CIRP group, Case No. 15-1989GC (provided the CIRP group is reinstated).

Board Determination:

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

The Board finds that it does not have jurisdiction over Franciscan Health Hammond and Franciscan St. Anthony Michigan City because these Providers are appealing from RNPRs which did not specifically adjust the SSI Fraction Dual Eligible Days issue.

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

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

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

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.

> (b)(2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

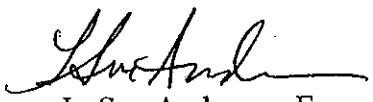
Although the SSI fraction is one component included in the disproportionate patient percentage (DPP) calculation which is used to determine the DSH payment, the SSI fraction is a distinct component from the Medicaid component which was adjusted in the RNPRs under consideration in this case (The DPP is made up of the Medicaid fraction and the Medicare/SSI fraction). The Medicaid days were removed from the Providers' Medicaid fractions because the patients were not eligible for Medicaid based on a review from the Office of the Inspector General (OIG). This is a stand-alone adjustment on W/S S-3. Based on the documentation provided, there was no impact to the SSI fraction, as it remained the same. Because appeals from RNPRs are limited to the specific matters revised in the revised determination the Board finds that it does not have jurisdiction over Franciscan Health Hammond and Franciscan St. Anthony Michigan City.

Since the Direct Adds for Franciscan Health Hammond and Franciscan St. Anthony Michigan City are denied, there is no justification for the Board to reinstate the CIRP group, Case No. 15-1989GC. Consequently, the request to transfer the sole FYE 2010 CIRP participant, Franciscan Health Indianapolis, from the optional group, Case No. 17-1408G, back to the CIRP group, Case No. 15-1989GC is also denied.

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
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 .1877

cc: Byron Lamprecht, Wisconsin Physicians Service (J-8)
Wilson C. Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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OCT 3 1 2017

Certified Mail

Christopher L. Keough
Akin Gump Strauss Hauer & Feld, LLP
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Washington, DC 20036

RE: Expedited Judicial Review Request
HCA 2009 DSH—Medicare Advantage Plan Days Group
FYE: 2009
PRRB Case No.: 13-0464GC

Dear Mr. Keough:

On October 3, 2017, the Provider Reimbursement Review Board ("PRRB" or "Board") received a request for expedited judicial review ("EJR") for the above-referenced group appeal (dated October 2, 2017). The Board has reviewed the request and hereby grants EJR for the issue in this group appeal, as explained below.

The issue in this group 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 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] The instant 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] October 2, 2017 EJR Request at 4.
[2] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[3] *Id.*
[4] *See* 42 U.S.C. § 1395ww(d)(5).
[5] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

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, then is used to determine the amount of the DSH payment due to the qualifying hospital.[7] The DPP is defined as the sum of two fractions expressed as percentages.[8] Those two fractions are the "Medicare" or "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 utilized by the Medicare contractors to compute a hospital's DSH eligibility and 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

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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.

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 years 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)

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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.*

Consequently, within the Secretary's response to the commenter, the Secretary announced that CMS would include 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 substantive regulatory change had in fact occurred but that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule.[21] As a result, the pertinent regulatory language was "technically corrected" to reflect that Part C days were required to be included in the Medicare fraction of the DPP 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, as the providers point out, the Secretary has not acquiesced or taken action to implement the decision[23] 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.[24]

In *Allina*, the Court affirmed the district court's decision "that the Secretary's final rule was not a logical outgrowth of the proposed rule."[25] 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

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[20] 72 Fed. Reg. 47,130, 47,384 (Aug. 22, 2007).
[21] *Id.*
[22] 746 F. 3d 1102 (D.C. Cir. 2014).
[23] October 2, EJR Request at 4.
[24] 69 Fed. Reg. at 49,099.
[25] *Allina* at 1109.

Medicaid fraction. To obtain relief, the providers seek a ruling on the procedural and substantive validity of the 2004 rule that the providers 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.

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.[26]

The providers included in this EJR request filed appeals of either original notices of program reimbursement ("NPRs") or revised NPRS ("RNPRs") in which the Medicare contractor settled cost reporting periods ending on or before December 31, 2009.

For appeals of original NPRs for cost reporting time periods ending on or after December 31, 2008, 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 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 cost reports under protest.[27]

For participants filing appeals from RNPRs, the Board only has jurisdiction to hear a participant's appeal of matters that the Medicare contractor specifically revised within the RNPR.[28]

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[26] 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).
[27] 42 C.F.R. § 405.1835(a)(1) (2008).
[28] 42 C.F.R. § 405.1889(b)(1)-(2) (2008).

Jurisdictional Determination for Providers

The Board finds that all providers involved with the instant EJR request have had an adjustment to the SSI%[29] on their respective NPRs/RNPRs 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 ending in 2009, thus the cost reporting periods fall squarely within the time frame covered by the Secretary's final rule being challenged in this EJR request.[30] 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 federal 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 federal court in either the D.C. Circuit *or* the federal 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*,[31] the D.C. Circuit Court agreed with the Board's decision to grant EJR for the identical issue involved in the instant 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;

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[29] The terms "SSI fraction," "SSI%," and "Medicare fraction" are synonymous and used interchangeably within this decision

[30] 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

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

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

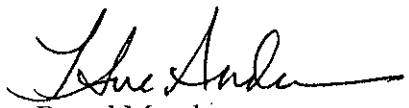
4) it is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), are valid.

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