DEPARTMENT OF HEALTH & HUMAN SERVICES

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

CERTIFIED MAIL

DEC 04 2017

FirstHealth Montgomery Memorial Hospital
Chris Fraley
Administrative Director-Revenue Cycle Management
110 Page Road
P.O. Box 3000
Pinehurst, NC 28374

RE: FirstHealth Montgomery Memorial Hospital
Provider No. 34-1303
FYE 9/30/2014
PRRB Case No. 18-0154

Dear Mr. Fraley:

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

Pertinent Facts:

The Provider submitted a request for hearing for fiscal year ended 9/30/2014, to which the Board assigned case number 18-0154. The appeal was based on a Notice of Program Reimbursement ("NPR") dated March 22, 2017 and the appeal request was received by the Board on October 27, 2017. In its cover letter to the appeal, the Provider advises that it did not timely receive a copy of the NPR because the MAC sent it to an incorrect email address. The provider requests consideration and acceptance of the appeal request because of the extenuating circumstances.

Provider's Contentions:

In its cover letter and supporting documents, the Provider made the following arguments:

- The NPR was issued to Cfarley.@firsthealth.org but the correct email address for the Provider is CMFraley@firsthealth.org. This has always been the email address for this contact person, Chris Fraley, Assistant Director of Revenue Cycle Management.
- The MAC used the correct email address for the issuance of a related Provider's NPR 6 months earlier (see attachments at tab 5 of the appeal request) so was aware of the proper address.

- The NPR email was also sent to a second contact at FirstHealth (Bryan Hawkins per tab 4) but this employee left the organization in February 2017 (the month before issuance of the NPR in question).

Board Determination:

Pursuant to 42 C.F.R. § 405.1835(a) (2016), a provider has a right to a hearing before the Board, if the provider is dissatisfied with the contractor's final determination, the amount in controversy is $10,000 or more, and the Board receives the provider's request within 180 days of the date of receipt of the final determination. Per 42 C.F.R. § 405.1801(a) and Board Rule 4.3, the date of receipt of a final determination is presumed to be 5 days after the date of issuance, unless the actual receipt was established by the preponderance of the evidence to be a later date.

Given the Provider's NPR issuance date of March 22, 2017, and allowing for the 5-day mailing presumption and the 180-day appeal period, the deadline for filing the appeal was calculated to be Saturday, September 23, 2017. If the last day of the designated time period falls on a weekend, Federal holiday, or a day in which the reviewing entity is not able to conduct business in the usual manner, then 42 C.F.R. § 405.1801(d) provides that the deadline becomes the next business day. Therefore, the filing deadline for this Provider became Monday, September 25, 2017. The Board's receipt of the appeal request on October 27, 2017 was 32 days after the required filing deadline.

The good cause extension standard is 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) ... ." In addition, Board Rule 6 requires that Model Form A - Individual Appeal Request and all supporting documentation listed on the request are required to file an individual appeal. Model Form A (page 1) indicates that if the receipt of the final determination is more than 5 days after the date of issuance, then the provider must specify the date received and provide supporting documentation of the actual date of receipt. However, there is no identification or support for the actual date of receipt within the Provider's documentation.

The Medicare Contractor's NPR email transmission includes language that indicates "... the Overpayment Demand Letter and the NPR Letter are also being sent via certified mail." The NPR itself also indicated that it was transmitted by Certified Mail. Based on the Certified Mail tracking number on the NPR, the U.S. Postal Service tracking history reflects that the hard copy package was received at the Provider's address on March 24, 2017. This date is only 2 days after the date of issuance.

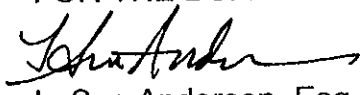
Therefore, the Board finds that while the Provider clearly documented that the email transmission was sent to the wrong address, the Provider failed to address the actual date of receipt of the NPR (either by email or hard copy) or that the actual receipt exceeded the 5-day mailing presumption. In fact, the available evidence demonstrates that the NPR package was actually received within 5 days from the issuance of the final determination. Thus, the 180-day appeal period began to run from the presumed date of receipt leading to the deadline of September 25, 2017 as calculated above.

Because the appeal request was not filed in conformance with 42 C.F.R. § 1395oo(f) and the Board Rules, the Board dismisses case number 18-0154 as it was not filed on a timely basis.

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: Palmetto GBA c/o National Government Services (J-M)
Wilson C. Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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DEC 04 2017

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RE: **Expedited Judicial Review Determination**

McLaren Health Care 2011 DSH Medicare/Medicaid Part C Days CIRP Group
PRRB Case No. 14-4213GC

Cook County Chicago 2008 DSH Medicare/Medicaid Medicare Advantage Days CIRP
PRRB Case No. 13-3897GC

Palmetto Health 2006 DSH Medicare/Medicaid Fraction Part C Days CIRP
PRRB Case No. 13-1858GC

MediSys Health Network 2010 Medicare/Medicaid Part C Days CIRP Group
PRRB Case No. 14-2549GC

Palmetto Health 2009 DSH Medicare/Medicaid Fraction Part C Days CIRP
PRRB Case No. 14-1497GC

Dear Ms. O'Brien Griffin:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' November 8, 2017 request for expedited judicial review (EJR) (received November 16, 2017).[1] The Board's determination is set forth below.

Issue

The issue for which EJR has been requested is:

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

[1] UPS attempted delivery of the EJR request on November 9, 2017 but the Board's office was closed due to flooding. UPS did not reattempt delivery again until November 15, 2017.
[2] November 8, 2017 EJR Request at 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").[3] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[4]

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[5] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[6]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[7] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[8] The DPP is defined as the sum of two fractions expressed as percentages.[9] Those two fractions are referred to as the "Medicare/SSI"[10] fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

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

The Medicare/SSI fraction is computed annually by CMS, and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[11]

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

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

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

> . . . *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*

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[15] *Id.*

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

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

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

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

> *proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[20] (emphasis added)

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

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

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius,*[22] vacated the FFY 2005 IPPS rule. However, 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 Providers assert that that the Medicare fraction of the DSH calculation is improperly understated due to the Secretary's erroneous inclusion of inpatient days attributable to Medicare Advantage patients in both the numerator and the denominator of the of the Medicare fraction. The failure to include such days in the Medicaid fraction also understated that fraction. The Providers point out that the authority upon which CMS relied to collect Medicare Advantage days information is the DSH regulation at 42 C.F.R. § 412.106, which includes Medicare Advantage days in the description of the days included in the Medicare fraction. However, the enabling statute for this regulation, 42 U.S.C. §1395ww(d)(5)(f), makes no mention of the inclusion of Medicaid Advantage days in the Medicare fraction, only traditional Part A days. The Providers contend that Medicare Advantage beneficiaries are not entitled to benefits under Part A, but instead are entitled to benefits under Part C. As a result, the Providers are challenging the validity of the regulation to the extent that 42 C.F.R. § 412.106 contradicts the enabling statute at 42 U.S.C. § 1395ww(d)(5)(F).[24]

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[20] *Id.*
[21] 72 Fed. Reg. 47,130, 47,384 (Aug. 22, 2007).
[22] 746 F. 3d 1102 (D.C. Cir. 2014).
[23] November 8, 2017 EJR Request at 8.
[24] *Id.* at 2.

In challenging the validity of the regulation, the Providers assert that the regulation was adopted in violation of the Administrative Procedures Act (APA). They contend that the Secretary violated the APA when she deprived the public the opportunity to comment on the regulation. This position was upheld in the decisions in both *Allina I* and *Allina II*.[25]

The Providers argue that any Medicare Advantage days that are also dual eligible days cannot be counted in the Medicare ratio for the same reasons as set forth above. Primarily, they believe, the regulation requiring inclusion of dual eligible days in the Medicare ratio is invalid and the days must be counted in numerator of the Medicaid fraction. This allegedly improper treatment resulted in the under payment to Providers as DSH eligible providers of services to indigent patients, and includes any other related adverse impact to DSH payments, such as capital DSH payments.[26]

With respect to EJR, the Providers believe that the Board has jurisdiction over the matter at issue and lacks the legal authority to decide the legal question presented. The Providers posit that the Board is not able to address the legal question of whether CMS correctly followed the statutory mandates for rulemaking set forth in the APA and the statute and is bound by Secretary's actions. The Providers do not believe that the Board has the authority to implement the effect of *Allina I* and *Allina II* decisions until the Secretary instructs it to do so.[27]

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.[28]

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[25] *Id.*
[26] *Id.*
[27] *Id.* at 7
[28] The regulations governing Board jurisdiction begin at 42 C.F.R. § 405.1835. 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).

In four of the groups included in this EJR request, the Providers filed appeals of their original notices of program reimbursement ("NPRs") in which the Medicare contractor settled cost reporting periods ending in 2008 through 2011. Case number 13-1858GC includes Providers appealing from revised NPRs for the settled cost reporting period ending in 2006.

For purposes of Board jurisdiction over a cost reporting period that ends on or before December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[29]

For appeals of original NPRs for cost reporting time periods ending on or after December 31, 2008, the Providers preserve their respective rights to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either including a claim for the specific item on their cost report for the period where the Provider seeks payment they believe to be in accordance with Medicare policy, or self-disallowing the specific item by following the applicable procedures for filing a cost report under protest. See 42 C.F.R. § 405.1835(a)(1) (2008).

For appeals of RNPRs for cost reporting periods ending in the 2006 calendar year, the Providers must demonstrate that the issue under review was specifically revisited on reopening.[30]

Jurisdiction

The Board finds that the Providers involved with the instant EJR request have had Part C days excluded from the Medicaid fraction, have had a specific adjustment to the SSI fraction, or have properly protested/self-disallowed the appealed issue such that the Board has jurisdiction to hear their respective appeals.[31] In addition, the Providers' documentation shows that the estimated amount in controversy for the group appeals exceed $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.

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[29] 108 S.Ct. 1255 (1988).

[30] 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.

[31] On November 14, 2017, one of the Medicare contractors, Wisconsin Physicians Service ("WPS"), filed an objection to the EJR request for PRRB Case No. 14-4213GC. 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 the Board is not bound by the Secretary's regulation that the federal district court vacated in *Allina*. The Board's explanation of its authority regarding this issue addresses the arguments set out in WPS' challenge.

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

The Providers within this EJR request filed appeals covering calendar years 2006 and 2008 through 2011, thus the cost reporting periods fall squarely within the time frame that covers the Secretary's final rule being challenged.[32] In addition, the Board recognizes that the D.C. Circuit vacated the regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). In addition, within its July 25, 2017 decision in *Allina Health Services v. Price*, the D.C. Circuit Court agreed with the Board's determination 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 this appeal are entitled to a hearing before the Board;

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

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

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject 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 in each group appeal, the Board hereby closes the cases.

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[32] 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 2011 cost reporting periods and earlier.

[33] *See* 863 Fed. 3d 937 (D.C. Cir. 2017).

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)
Schedules of Providers

Certified w/ Schedules of Providers
cc: Danene Hartley, National Government Services (J-6) (13-3897GC)
Laurie Polson, Palmetto GBA c/o NGS (J-M) (13-1858GC & 14-1497GC)
Pam VanArsdale, National Government Services, Inc. (J-K) (14-2549GC)
Byron Lamprecht, WPS (J-8)(14-4213GC)
Wilson Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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DEC 04 2017

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President
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First Coast Services Options, Inc.
Geoff Pike
Provider Audit and Reimbursement Dept.
532 Riverside Avenue
Jacksonville, FL 32202

RE: Wuesthoff Memorial Hospital
Provider No. 10-0092
FYE 9/30/2008
PRRB Case No. 13-3106

Dear Mr. Ravindran and Mr. Pike

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the documents in the above referenced appeal. The Board's jurisdictional decision is set forth below.

BACKGROUND:

The Provider was issued a revised Notice of Program Reimbursement ("NPR") on February 25, 2013 for fiscal year end ("FYE") 9/30/2008. On January 24, 2014, the Provider filed an appeal request with the Board that identified two issues:

1. Disproportionate Share Hospital (DSH) Payment/ Supplemental Security Income (SSI) Percentage (Provider Specific); and
2. Disproportionate Share Hospital (DSH)/ Supplemental Income (SSI) (Systemic Errors).[1]

On March 20, 2014, the Board received the following transfer requests from the Provider:

- QRS 2008 DSH Medicare Managed Care Part C Days Group, PRRB CN: 13-2306G
- QRS 2008 DSH Dual Eligible Days Group, PRRB CN: 13-2693G;
- QRS 2008 DSH SSI Percentage Group, PRRB CN: 13-2694G;
- QRS 2008 DSH SSI Fraction/Medicare Managed Care Part C Days Group, PRRB CN: 14-1167G;
- QRS 2008 DSH SSI Fraction/Dual Eligible Days Group, PRRB CN: 14-1171G.

The Board received the Provider's Final Position Paper on August 29, 2017, which briefed one issue: SSI Provider specific.

[1] The SSI Systemic Errors issue statement is very detailed and references sub-issues such as dual eligible days and Part C days.

BOARD'S DECISION:

Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue. The jurisdictional analysis for Issue No. 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the Systemic Errors issue and should be dismissed by the Board.[2] The DSH Payment/SSI Percentage (Provider Specific) issue concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital Calculation."[3] The Provider's legal basis for Issue No. 1 also asserts 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)."[4] The Provider argues that "its SSI percentage published by [CMS] was incorrectly computed . . . ."[5]

However, the Provider's Systemic Errors issue is "[whether] the Secretary properly calculated the Provider's Disproportionate Share Hospital/Supplemental Security Income percentage."[6] The Provider's legal basis for the Systemic Errors issue is that "the SSI percentages calculated by [CMS] and used by the Lead [Medicare Contractor] to settle their Cost Report [were] incorrectly computed . . . ."[7] Thus, the Provider's disagreement with how the Medicare Contractor calculated the SSI percentage that would be used for the DSH percentage is duplicative of the Systemic Errors issue that has been transferred to a group appeal. Because the Systemic Errors issue is no longer in the individual appeal as it was transferred to a group appeal, the Board should dismiss this aspect of Issue No. 1.

The second aspect of Issue No. 1—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—should be dismissed by the Board for lack of jurisdiction. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes.

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

Medicare Managed Care Part C Days in the Medicaid fraction and Dual Eligible Days in the Medicaid fraction

The Board finds that it does not have jurisdiction over the Medicare Managed Care Part C Days in the Medicaid fraction and the Dual Eligible Days in the Medicaid fraction issues and therefore denies the Provider's requests to transfer these issues to group appeals. The Provider appealed from a revised NPR that did not adjust these two issues.

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.
> >
> > (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.

This Provider's revised NPR was issued in order to update its SSI percentage. There is nothing in the record to establish that the Provider's Medicaid fraction was adjusted, therefore the Board finds that it does not have jurisdiction over the Medicaid fraction Part C days issue and the Medicaid fraction dual eligible days issue. The Board hereby denies the Provider's requests to transfer the Part C days issue to case no. 13-2306G and the dual eligible days issue to case no. 13-2693G.

CONCLUSION:

The Board denies jurisdiction over the SSI Provider Specific issue, the Medicaid fraction Part C days issue, and the Medicaid fraction dual eligible days issue. There are no issues that remain

pending in the appeal, therefore PRRB Case No. 13-3106 is hereby closed and removed from the Board's docket.

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

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

For the Board:

Gregory H. Ziegler for

L. Sue Andersen, Esq.
Chairperson

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DEPARTMENT OF HEALTH & HUMAN SERVICES

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DEC 04 2017

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Noridian Healthcare Solutions, LLC
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RE: Asante Three Rivers Community
Juris. Challenge DSH – SSI (Provider Specific) and Medicaid Eligible Days
PN: 38-0002
FYE: 9/30/2010
PRRB Case Number: 13-3746

Dear Mr. Kramer and Mr. Ward,

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

Asante Three Rivers Community Hospital ("Asante" or "Provider") filed a timely appeal on September 13, 2013 from its March 19, 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 – SSI(Systemic Error)
(3) DSH-Medicaid Eligible Days
(4) DSH-Managed Care Part C Days
(5) DSH-Part A Dual Eligible Days.
(6) Rural Floor Budget Neutrality ("RFBNA").

After transfers of issues only Issue # 1 and #3 remain in the case.[1]

The Medicare Contractor filed a jurisdictional challenges on October 9, 2014 regarding Issue #2 DSH-Medicaid Eligible Days. Asante filed their jurisdictional response on October 29, 2014. The Medicare Contractor filed an additional challenge on and October 2, 2017 regarding Issue #1, DSH – SSI (Provider Specific). Asante filed their jurisdictional responsive brief on October 26, 2017.

Medicare Contractor's Position

[1] *See* Medicare Contractor's Jurisdictional Challenge dated September 29, 2017 and Medicare Contractor Position Paper dated September 26, 2017.

Provider Specific SSI
The Medicare Contractor contends the SSI issue is a duplicative issue since the SSI data is the underlying issue in both Issue 1 and 2, and the Provider has transferred the duplicative issue to a group appeal.[2] The Medicare Contractor contends under Board rules the Provider is barred from appealing a duplicative SSI% issue. The Medicare Contractor requests that the Board dismiss the Provider Specific SSI issue due to duplication.[3]

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 Asante included an amount in the protested line of W/S E Part A line 30, however this relates to the SSI and rebasing of the Sole Community Hospital rates issues. The Medicare Contractor further insists it is clear that the protested amount does not relate to the additional Title XIX eligible days issue.[4]

Provider's Contentions

Provider Specific SSI
Asante contends each of the SSI issues is a separate and distinct issue and the Board should find jurisdiction over the SSI issue. Asante 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 2010. Asante further contends it has analyzed the Medicare Part A records and has been 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. Asante contends it is not seeking realignment but addressing the various errors of omission and commission that do not fit into the "systematic errors" category.[5]

Medicaid Eligible Days
Asante contends that the Board does have jurisdiction pursuant to Board Rule 7.2(B) and under the provisions of 42 U.S.C.§1395oo(a)(1)(B) since the issuance of a NPR and timely appeal properly triggers the Board's jurisdiction over this Provider. Further, Asante states that there was an audit Adjustment (ADJ#21) to Provider's DSH calculation and this adjustment is enough to warrant Board jurisdiction over DSH/Medicaid Eligible day's issue. Asante 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. Asante further questions the validity of applying the Presentment rule.[6]

Board Decision

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[2] Case # 14-3079GC.
[3] *See* Jurisdictional challenge dated September 29, 2017 (Received October 2, 2017).
[4] *See* Jurisdictional challenge dated October 7, 2014.
[5] *See* Provider's Jurisdictional Response dated October 24, 2017.
[6] Provider's Jurisdictional Response dated October 27, 2014.

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.

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."[7]

Asante filed its Final Position paper on August 23, 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 CMS it will identify patients that were not included in the SSI percentage.[8]

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.21). However, the Board finds that this issue is duplicative of the SSI Systemic Errors issue appealed in Group Case No. Case No. 14-3079GC. 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 four 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.

Medicaid Eligible Days

After reviewing Asante'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 2010 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.[9]

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

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[7] See Providers Individual Appeal Request dated September 12, 2013.
[8] *See* Provider's Final Position Paper, page 9.
[9] *See* Provider's Jurisdictional Response dated October 27, 2014 and Position Paper.

> (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 Asante 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 Asante 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. Therefore the appealed issue of Medicaid Eligible Days in this instance does not meet the jurisdictional requirements of the 42 C.F.R. § 405.1835(a)(1) and Board Rule 7.2(C).

As there are no 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
Charlotte Benson for
L. Sue Andersen, Esq.
Chairperson

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.
cc: Wilson C. Leong, Federal Specialized Services.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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DEC 0 4 2017

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RE: Asante Three Rivers Community
Juris. Challenge DSH – SSI (Provider Specific) and Medicaid Eligible Days
PN: 38-0002
FYE: 9/30/2009
PRRB Case Number: 13-3745

Dear Mr. Kramer and Mr. Ward,

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

Asante Three Rivers Community Hospital ("Asante" or "Provider") filed a timely appeal on September 13, 2013 from its March 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 – SSI(Systemic Error)
(3) DSH-Medicaid Eligible Days
(4) DSH-Managed Care Part C Days
(5) DSH-Part A Dual Eligible Days.
(6) Rural Floor Budget Neutrality ("RFBNA").

After transfers of issues only Issue # 1 and #3 remain in the case.[1]

The Medicare Contractor filed a jurisdictional challenge on September 22, 2017 regarding Issue #1, DSH – SSI (Provider Specific) and Issue #2 DSH-Medicaid Eligible Days. Asante filed their jurisdictional responsive brief on October 18, 2017.

Medicare Contractor's Position

Provider Specific SSI

[1] *See* Medicare Contractor's Jurisdictional Challenge dated September 21, 2017 and Medicare Contractor Position Paper dated September 26, 2017.

The Medicare Contractor contends the SSI issue is a duplicative issue since the SSI data is the underlying issue in both Issue 1 and 2, and the Provider has transferred the duplicative issue to a group appeal.[2] Since the Board Rule 4.5 states a Provider may not appeal an issue from a final determination in more than one appeal. The Medicare Contractor requests that the Board find that its lacks jurisdiction as the Provider is in violation of Board rule 4.5.[3]

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 Provider included an amount in the protested line of the cost report[4], however this relates to the SSI and the exclusion of Labor and Delivery Days for DSH. The Medicare Contractor further insists it is clear that the protested amount does not relate to the additional Title XIX eligible days issue.[5]

Provider's Contentions

Provider Specific SSI
Asante contends each of the SSI issues is a separate and distinct issue and the Board should find jurisdiction over the SSI issue. Asante 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. Asante further contends it has analyzed the Medicare Part A records and has been 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. Asante contends it is not seeking realignment but addressing the various errors of omission and commission that do not fit into the "systematic errors" category.[6]

Medicaid Eligible Days
Asante contends that the Board does have jurisdiction pursuant to Board Rule 7.2(B) and under the provisions of 42 U.S.C.§1395oo(a)(1)(B), since the issuance of a NPR and timely appeal properly triggers the Board's jurisdiction over this Provider. Further, Asante states that there were adjustments to Provider's DSH calculation and these adjustment are enough to warrant Board jurisdiction over DSH/Medicaid Eligible day's issue. Asante 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. Asante further questions the validity of applying the Presentment rule.[7]

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

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[2] Case # 14-3073GC.
[3] *See* Jurisdictional challenge dated September 21,2017.
[4] W/S E Part A line 30 is utilized.
See Jurisdictional challenge dated September 21, 2017.
[6] *See* Provider's Jurisdictional Response dated October 17, 2017.
[7] Provider's Jurisdictional Response dated October 17, 2017.

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."[8]

Asante filed its Final Position paper on August 23, 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 CMS it will identify patients that were not included in the SSI percentage.[9]

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)ercentage (Adj.20). However, the Board finds that this issue is duplicative of the SSI Systemic Errors issue appealed in Group Case No. Case No. 14-3073GC. 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 four 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.

Medicaid Eligible Days

After reviewing Asante'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.[10]

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

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See Providers Individual Appeal Request dated September 12, 2013.

[9] *See* Provider's Final Position Paper, page 9.

[10] *See* Provider's Jurisdictional Response dated October 17, 2017 and Position Paper.

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 Asante 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 Asante failed to claim the Medicaid eligible days or include them as a protested amount on the cost report. Therefore the appealed issue of Medicaid Eligible Days in this instance does not meet the jurisdictional requirements of the 42 C.F.R. § 405.1835(a)(1) and Board Rule 7.2(C).

As there are no 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

Charlotte Benson Jr

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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Pam VanArsdale
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RE: St. Vincent's Medical Center
Juris. Challenge DSH – SSI (Provider Specific), Medicaid Eligible Days, and DSH Medicaid Fraction-Dual Eligible Days
PN: 07-0028
FYE: 9/30/2010
PRRB Case Number: 15-0232

Dear Mr. Kramer and Ms. VanArsdale,

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

St. Vincent's Medical Center ("St. Vincent's or "Provider") filed a timely appeal on October 27, 2014 from its May 2, 2014 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 – SSI(Systemic Error)
(3) DSH SSI-Managed Care Part C Days
(4) DSH-Part A Dual Eligible Days.
(5) DSH Medicaid -Managed Care Part C Days
(6) DSH-Medicaid Fraction Dual Eligible Days
(7) DSH –Medicaid Eligible Days
(8) DSH-Medicare Managed Care Part C Days
(9) DSH-Dual Eligible Days
(10)DSH-Connecticut State Administered Days

After transfers of issues only Issue #1, #6, #7 and #9 remain in the case.[1] The Medicare Contractor filed a jurisdictional challenges on September 24, 2015 regarding Issue #1, DSH – SSI (Provider Specific) and on October 19, 2017 for Issue #6, Issue #7 and Issue #9. St. Vincent's filed their jurisdictional responsive brief on November 15, 2017.

Medicare Contractor's Position

[1] *See* Medicare Contractor's Jurisdictional Challenge dated October 19, 2017.

Provider Specific SSI (Issue #1)
The Medicare Contractor contends the SSI issue is a duplicative issue since the SSI data is the underlying issue in both Issue 1 and 2, and the Provider has transferred the duplicative issue to a group appeal.[2] The Medicare Contractor contends under Board rules the Provider is barred from appealing a duplicative SSI% issue. The Medicare Contractor requests that the Board dismiss the Provider Specific SSI issue due to duplication.[3]

DSH Medicaid Fraction-Dual Eligible Days (Issue #6 and #9)
The Medicare Contractor contends that St. Vincent's has abandoned issues #6 and #9, since the Provider did not brief the DSH Dual Eligible Days issues in either the Preliminary or the Final Position Papers. The Medicare Contractor insists that these issues be dismissed and cites the Board Rules and a Prior Jurisdictional Decision.[4]

Medicaid Eligible Days (Issue #7)
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 admits that there was an adjustment (#7) made to reduce the Medicaid days however it contends that this adjustment reduced duplicate days and an extrapolation of an error.[5]

The Medicare Contractor further contends the when the Provider submitted its cost report, it included a list of protested items, one of which was additional Medicaid eligible days that had not yet been verified by the state when the cost report was submitted, however the list did not state the dollar amount for each item.[6] There was a protested amount of $3,402,547 removed with Adjustment 24, from the protested line of the cost report, W/S E Part A Line 30, however as the Provider did not follow the procedures or (steps) for filing a cost report under appeal, the Medicare Contractor insists that the Medicaid Eligible days issue be dismissed from the current appeal.[7]

Provider's Contentions

Provider Specific SSI (Issue #1)
St Vincent's contends each of the SSI issues is a separate and distinct issue and the Board should find jurisdiction over the issue. St. Vincent's 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 2010. St. Vincent's further contends it has analyzed the Medicare Part A records and has been 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. St. Vincent's contends it is not seeking realignment

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[2] Case # 13-3068GC.
[3] *See* Jurisdictional challenge dated September 28, 2015 and October 19, 2017 (Received October 20, 2017).
[4] Board Rule 25, 23.3 and Board Jurisdictional Decision of *Rush University Medical Center* (Case # 06-0871). See Exhibit I-2, p.2 and I-3, p.1)
[6] See Jurisdictional challenge dated October 19, 2017, Exhibit I-4.
[7] *See* Jurisdictional challenge dated October 19, 2017, p.4.

but addressing the various errors of omission and commission that do not fit into the "systematic errors" category.[8]

DSH Medicaid Fraction-Dual Eligible Days (Issue #6 and #9)
The Provider contends that Issue #6(DSH-Medicaid Fraction Dual Eligible Days) is the same as Issue #9(DSH-Dual Eligible Days) and request that the Board consolidate the Issues with Issue #9.

Medicaid Eligible Days (Issue #7)
St. Vincent's contends that the Board does have jurisdiction pursuant to Board Rule 7.2(B) and under the provisions of 42 U.S.C.§1395oo(a)(1)(B). Since the issuance of a NPR and timely appeal properly triggers the Board's jurisdiction over this Provider. Further, St. Vincent's states that there was an audit Adjustment (ADJ#27) to Provider's DSH calculation and this adjustment is enough to warrant Board jurisdiction over DSH/Medicaid Eligible day's issue. St. Vincent's 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. St. Vincent's further questions the validity of applying the Presentment rule.[9]

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 - 405.1840 (2015), 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
St. Vincent's filed in its original appeal request, Issue # 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. St. Vincent 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."[10]

St. Vincent's filed its Final Position paper on August 29, 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 CMS it will identify patients that were not included in the SSI percentage.[11]

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

[8] *See* Provider's Jurisdictional Response dated November 14, 2017.
[9] Provider's Jurisdictional Response dated November 14, 2017.
[10] See Providers Individual Appeal Request dated October 22, 2014.
[11] *See* Provider's Final Position Paper, page 8-9.

issue as it relates to the "errors of omission and commission" as there was an adjustment to the SSI percentage (Adj.20). However, the Board finds that this issue is duplicative of the SSI Systemic Errors issue appealed in Group Case No. 13-3068GC. 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 three years since the NPR).

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

DSH Medicaid Fraction-Dual Eligible Days (Issue #6 and #9)
The Board grants the Provider's request to consolidate both issues into Issue #9-DSH Dual Eligible Days. However, as the Provider failed to explain the facts or make any arguments with respect to the issues in its final position paper, the Board considers the issue abandoned in accordance with Board Rule 41.2. Which states "the Board may also dismiss a case or an issue on its own motion: (1) if it has a reasonable basis to believe that the issues have been fully settled or abandoned."

Medicaid Eligible Days
The Board has reviewed the entire record, including St. Vincent's Individual Appeal Request, both parties Position Papers and the Jurisdictional challenge which included the Contractors work papers and the Providers Cost Report submission letter. The Board finds that the Provider included a protested amount for additional Medicaid eligible days, as verified by the contractor with adjustment #24, "Adjustment made to remove protest amount from the cost report per the cost report instructions. The protested amount is for various DSH issues that are currently under appeal (Eligible days, . . .).

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)".

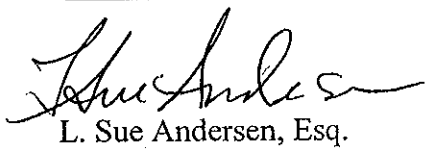
The Provider acknowledged there would be additional days paid by the state, and the Provider did included a total of $3,402,547 on the protested line for the additional Medicaid days and four other issues. The cost report cover letter lists the items being specifically protested, one of which was Eligible Days not verified by the state. The Board finds that the combination of the W/S E Part A protested claim for $3,402,547 and the description of the issues included in that protested amount calculation substantially documents the Provider's protested claim. The MAC acknowledged the protested claim for eligible days in its adjustment description to remove the protest amount. Therefore the appealed issue of Medicaid Eligible Days in this instance meets the jurisdictional requirements of the 42 C.F.R. § 405.1835(a)(1) and Board Rule 7.2(C) as the Provider followed the procedures of CMS 15-2, Section 115. The Case will remain open for the remaining item of Medicaid Eligible Days.

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 this 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.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

DEC 07 2017

Russell Kramer
Quality Reimbursement Services
150 N. Santa Anita Avenue
Suite 570A
Arcadia, CA 91006

RE: Baptist Health 2005 Medicaid Fraction Dual Eligible (Part A-Exhausted Benefits) Group, FYE 9/30/2005, PRRB Case No. 15-2050GC
Baptist Health 2005 Dual Eligible Days (No Pay Part A Days) Group FYE 9/30/2005, PRRB Case No. 15-2048GC

Dear Mr. Kramer:

The Provider Reimbursement Review Board (Board) has reviewed the November 9 and 10, 2017 requests for expedited judicial review (EJR)[1] in the above referenced cases (received November 13, 2017). Prior to rendering a determination with respect to the request for EJR, the Board needs additional information. This request for additional information affects the 30-day period for responding to the EJR requests. *See* 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii) and (e)(3)(ii).

Background

Case numbers 15-2048GC and 15-2050GC were scheduled for a live hearing before the PRRB on November 21, 2017.

On October 6, 2017, the Provider requested postponement of 15-2048GC pending the outcome of similar cases (08-2955GC, 13-0016G and 08-2598G) previously heard by the Board. The issue in those appeals dealt with Dual Eligible (Medicare/Medicaid) days where the providers did not bill Medicare for the claims, therefore the Dual Eligible days would not have been included in the MEDPAR file. On October 11th, 2017, the Board sent correspondence to the Provider asking them to 1.) Document how the facts of 15-2048GC was similar to the cases cited by the Provider in its postponement request, and 2.) If in fact the case was appropriate for own-motion EJR based on the facts presented in the appeal.

[1] The Providers submitted identical EJR requests dated November 9 and 10 in case number 15-2048GC. Both EJR requests were received on November 13, 2017. In case number 15-2050GC, they submitted a single EJR request dated November 10, 2017 which received on November 13, 2017.

On October 6, 2017, the Provider requested postponement of 15-2050GC pending the outcome of *Stringfellow Memorial Hospital v. Price* in the D.D. District Court. The provider states that the issue in this appeal deals substantially as the same issue as *Stringfellow* which is a challenge to the DSH regulation and whether the SSI% should include total or covered days. On October 19th, 2017, the Board staff sent notice to the Provider that the postponement was denied.

PRRB Case No. 15-2048GC

In their initial hearing request the Providers identified the issue under appeal as:

> [The Providers] contend[] that the Intermediary did not allow patient days associated with certain Medicare Part A and Title XIX [Medicaid] dual eligible patients to be included in the numerator of either the SSI percentage or the Medicaid Percentage of the Medicare DSH [disproportionate share hospital] calculation. These patients were eligible for Medicare Part A benefits, however, no payments were made by Medicare Part A for these patients. The Intermediary did not allow the days to be included in the Medicaid Proxy and CMS [the Centers for Medicare & Medicaid Services] did not include the days in the calculation of the SSI percentage.
>
> *******
>
> CMS has stated that the SSI fraction would only include patient days paid by Medicare Part A, intermediaries have refused to recognize these dual eligible patient days, which lack Medicare Part A payments, in the Medicaid percentage of the Medicare DSH payment calculation . . . . [the Providers] contend that the terms **paid** and **entitled** must be consistent with one another due to the usage of the two perms in 42 C.F.R. § 412.106(b) . . . .
>
> *******
>
> . . .[The Providers] contend that these days must be included in either the Medicaid percentage or the SSI [supplemental security income] factor in the Medicare DSH formula.[2]

The Providers identified the following issue as the subject of their EJR request:

> The Board [should] either require the recalculation of the SSI percentage using a denominator based solely on covered and paid for Medicare days, or alternatively, an expansion of the numerator to include paid as well as unpaid and covered as well as non-covered days. The Board should require a recalculation of the SSI

[2] Providers' March 25, 2015 Hearing Request, Tab 2.

> percentage using a denominator based solely on covered and paid for Medicare days, or alternatively, an expansion of the numerator to include paid as well as unpaid and cover as well as non-covered days.[3]

On page 3 of their EJR request, the Provider state that they are requesting:

> [A] determination of whether the Board has the authority to either set aside CMS's policy of including unpaid Part A days in the Medicare Fraction or setting aside CMS's policy of excluding unpaid SSI days from the numerator of the Medicare fraction.

In their position paper, the Providers contend that:

> [T]he Intermediary did not allow inpatient days associated with certain Medicare Part A and Title XIX dual eligible patients to be included in the numerator of either the numerator of either the SSI percentage or the Medicaid percentage of the Medicare DSH calculation. These patients were eligible for Medicare Part A benefits, however no payments were made by Medicare Part A for these patients. The Intermediary did not allow the days to be included in the Medicaid Proxy and CMS did not include the days in the SSI percentage.[4]

The Providers go on to assert that these days must be included in either the Medicaid percentage or the SSI percentage factor in the Medicare DSH formula. The days should be eligible for inclusion in one or the other of the two percentages.[5]

In the Board's October 11, 2017 letter indicating it was considering EJR on its own motion,[6] the Board noted that the days at issue have been labeled "No Pay Part A" days that were not included in either the Medicare/SSI fraction or Medicaid fraction of the DSH payment. The Providers stated that the patients were eligible for Medicare Part A benefits, however, no payments were made under Part A. The Providers were asked to indicate whether the claims were billed to Medicare, and, if they were billed, why they were not paid. In the November 9th EJR request, the Providers state that the claims had been submitted to Medicare, and the claims were not paid because the patients had exhausted their Medicare benefits.[7]

PRRB Case No. 15-2050GC

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[3] Providers' November 9, 2017 EJR Request at 1.
[4] Providers' February 1, 2017 Position Paper at 3.
[5] *Id.* at 4.
[6] *See* 42 C.F.R. § 405.1842(c).
[7] Providers November 9, 2017 EJR Request at 1.

In its hearing request, the Provider identified the issue that is the subject of the appeal as:

> Baptist Health Exhausted Care Caid Dual Eligible Group (BHECC) contends that the Intermediary did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, BHECC disagrees with the calculation of the second computation of the disproportionate patient percentage, the Medicaid days proxy, set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.
>
> BHECC contends that the Intermediary failed to include all Medi-Medi patient days for Medicare Part A patients whose Medicare Part A benefits were exhausted, but who were still eligible for Medicaid, in the Medicaid percentage of the Medicare DSH calculation. These days should have been included in the Medicaid percentage of the DSH calculation.[8]

In their position paper, the Provider reiterated the exact statement above issue description and stated that they had provided the Intermediary at audit with a detailed patient listing for all Medicaid eligible days, but subsequent reviews allowed the providers to identify additional eligibility. The Providers proposed to submit the additional list to the Intermediary for review and inclusion in the Medicaid fraction.[9]

In their November 10, 2017 EJR request, the Providers describe the issue as:

> [W]hether the MAC should have excluded from the Medicare fraction non-covered patient days, i.e. days attributable to patients who were enrolled in Medicare and entitled to SSI, but for whom Medicare did not make payment for their hospital stay, either because that patient's Medicare benefit days were exhausted, or because a third party made payment for that patient's hospital stay. The [P]rovider [sic] contends that these non-covered patient days should be excluded from the Medicare fraction. The [P]rovider [sic] further contends that these non-covered patient days should be treated consistently; that is, they should be either included in both the top and bottom of the SSI fraction, or excluded from both the top and bottom and also in the Medicaid fraction.[10]

Consolidation of Cases

[8] Providers' March 25, 2015 Hearing Request, Tab 2.
[9] Providers' February 2, 2107 Final Position Paper at 4-5.
[10] Providers' November 10, 2017 EJR Request at 1.

After reviewing the record in both of these cases, the Board has concluded that the issues in these cases are the same: whether exhausted, dual eligible days should be included in the numerator or denominator of the DSH calculation. Since both group appeals include the same two related Providers for the same cost year, and the Providers have more than one appeal of the issue pending for the same fiscal year, the Board is consolidating both appeals into 15-2050GC and closing case number 15-2048GC. Case number 15-2050GC will remain open and the Board will consider the request for EJR of the issue in case number 15-2050GC.

Schedules of Provider in Case No. 15-2050GC

Upon review of the Schedule of Providers in case 15-2050GC, the Board has found that they are unable to determine if it has jurisdiction over the two Providers as some of the required documentation needed to make that decision is not included in the jurisdictional documents.

Information Needed: Jurisdictional Documents

This Providers' timely appeals are based on the submission of an individual hearing requests. The information under Tab B for both Providers does not include the complete hearing request to enable the Board to determine if the dual eligible issue was part of the individual hearing requests. The Providers are to submit the complete individual hearing request including the Statement of the Issue. A copy of the overnight carriers' delivery of the documents to the Board is also to be included under Tab B for both the filing of the individual appeals and the group appeal.

In addition, Model Form B, the Group Appeal Request, was placed under Tab G. The complete Model Form B including the Schedule of Providers, the statement of the issue which were included in the request used to establish the group or Model Form D, Direct Add of Provider to a Group are to be placed under Tab G for each Provider. A copy of the Model Form D, Request to Transfer to a Group, should also be place under Tab G for each Provider.

Organization of Jurisdictional Documents

Each Provider's jurisdiction documents are to be grouped together. For example, for Provider # 1, Tab 1A, Tab 1B, Tab 1 D, Tab 1G and Tab 1H should be placed together. The same organizational pattern should be followed for the second Provider in the case.

Tab H Letter of Representation

Board Rule 5.4[11] requires that a letter designating the representation must be on the Provider's letterhead and be signed by an owner or officer of the Provider. The letter must reflect the Providers' fiscal year under appeal and contain the relevant contact information described in the

[11] The Board's Rules can be found on the internet at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/index.html.

rule. In this case, the Providers included the contact information on Model Form B, not the required letter. The Providers are to include a letter of representation that meets the requirements of Rule 5.4 under Tab H.

Upon receipt of the corrected jurisdictional documents the Board will review the Providers' request for EJR.

Sincerely,

L. Sue Andersen, Esq.
Chairperson

cc: Geoff Pike, First Coast Service Options
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Certified Mail DEC 07 2017

Stephanie A. Webster, Esq.
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Expedited Judicial Review Determination
RE: Adventist Health System 2006–2014 (Pre-10/01/2013) Post-Allina Medicare Part C Days Groups, PRRB Case Nos. 13-0889GC, 13-1158GC, 13-1183GC, 14-0938GC, 14-2831GC, 14-2832GC, 14-3829GC, 14-4230GC, 15-2722GC, 15-2723GC, 15-3054GC, 16-1399GC, 16-1400GC

Dear Ms. Webster:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' November 8, 2017 request for expedited judicial review (EJR) (received November 20, 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[1]] fraction, or whether, if not regarded as 'entitled to benefits under Part A,' they should instead be included in the Medicaid fraction" of the DSH[2] adjustment.[3]

Statutory and Regulatory Background: Medicare DSH Payment

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

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[6] These cases involve the hospital-specific DSH adjustment, which requires the

[1] "SSI" is the acronym for "Supplemental Security Income."
[2] "DSH" is the acronym for "disproportionate share hospital."
[3] Providers' November 17, 2017 EJR Request at 4.
[4] *See* 42 U.S.C. § 1395ww(d)(I)-(5); 42 C.F.R. Part 412.
[5] *Id.*
[6] *See* 42 U.S.C. § 1395ww(d)(5).

Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[7]

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

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

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

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

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

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

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

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

Medicare Advantage Program

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

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

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

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

With the creation of Medicare Part C in 1997,[16] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their

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

care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004. [17]

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

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

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

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

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

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

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

> associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[20] (emphasis added)

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

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

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

Providers' Request for EJR

The 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] *Id.*
[21] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[22] 746 F. 3d 1102 (D.C. Cir. 2014).
[23] November 17, 2017 EJR Request at 1.
[24] 69 Fed. Reg. at 49,099.
[25] *Allina* at 1109.

validity of the 2004 rule that they claim the Board lacks the authority to grant. The providers argue that since the Secretary has not acquiesced to the decision in *Allina*, the Board remains bound by the regulation and EJR is appropriate.

Decision of the Board

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

Jurisdictional Determination for Providers

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the providers requesting EJR. Pursuant to the pertinent regulations governing Board jurisdiction, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more for an individual appeal or $50,000 or more for a group, and the request for hearing is filed within 180 days of the date of receipt of the final determination.[26]

The majority of the participants in the subject groups appealed from original NPRs that were for cost reporting periods ending from 2006 through 2014. For purposes of Board jurisdiction over a cost reporting period that ends on or before December 30, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen*.[27]

For appeals of original NPRs for cost reporting time periods ending on or after December 31, 2008, the Providers preserve their respective rights to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either including a claim for the specific item on their cost report for the period where the Provider seeks payment they believe to be in accordance with Medicare policy, or self-disallowing the specific item by following the applicable procedures for filing a cost report under protest. See 42 C.F.R. § 405.1835(a)(1) (2008).

Case numbers 13-0889GC, 13-1158GC, 13-1183GC and 14-4230GC include participants that appealed from revised NPRs (RNPRs). Regarding appeals from revised NPRs, the applicable regulations explain that a RNPR is considered a separate and distinct determination, and,

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[26] 42 C.F.R. § 405.1835(a) (2008).
[27] 108 S.Ct. 1255 (1988).

depending on when the RNPR was issued, the issue on appeal must have been either reviewed[28] or revised[29] as a prerequisite for Board jurisdiction.

For the Providers that have appealed from both original and RNPRs in case numbers 13-0889GC and 14-4230GC, the Board will not issue a jurisdictional determination for the RNPR appeals. The Board has determined that these Providers have jurisdictionally valid appeals pending for the same fiscal year ends from the original NPRs; therefore reaching a decision on the RNPR appeals is futile as the outcome for these Providers will not be affected.

The remaining participants appealing from RNPRs in this EJR request have a specific adjustment to the SSI fraction/dual-eligible Part C days such that the Board has jurisdiction to hear their respective appeals. In addition, the Providers' documentation shows that the estimated amount in controversy for each group appeal exceeds $50,000, as required for a group appeal and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor.

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

The providers within this EJR request filed appeals covering cost reporting periods with fiscal years ending 2006 through 2014,[30] thus the cost reporting periods fall squarely within the time frame that covers the Secretary's final rule being challenged.[31] The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed,* No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

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[28] 42 C.F.R. § 405.1885, 1889; *see also HCA Health Services v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994) (holding that when a fiscal intermediary reopens its original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening).

[29] 42 C.F.R. § 405.1885, 1889 (2008), "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" (emphasis added).

[30] The participants in Case Nos. 16-1399GC and 16-1400GC have cost years that began 7/1/2013.

[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 FYs that began prior to 10/1/2013.

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:

L. Sue Andersen, Esq.
Chairperson

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

cc: Geoff Pike, First Coast Services Options (J-N) (Certified w/Schedules)
Mounir Kamal, Novitas Solutions, Inc. (J-H) (Certified w/Schedules)
Wilson Leong, Esq., CPA, FSS (w/Schedules)

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13-3249

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DEC 12 2017

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Danene Hartley, Appeals Lead
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RE: Jurisdictional Determination
All Saints Medical Center
Provider No.: 52-0096
FYE: June 30, 2009
PRRB Case No.: 13-3249

Dear Mr. Ravindran and Ms. Hartley:

This case involves All Saints Medical Center's ("All Saints'") appeal of its Medicare reimbursement for the fiscal year ending ("FYE") on June 30, 2009. In response to the Medicare contractor's jurisdictional challenge, the Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed All Saints' documentation. The Board finds that it does not have jurisdiction to hear All Saints' appeal of its Supplemental Security Income ("SSI") percentage "provider-specific" issue, as this issue is already contained within a group appeal, or its Medicaid eligible days issue, because All Saints did not claim or protest these days as required by regulation. As these two issues are the only issues remaining within the instant appeal, the Board hereby closes this case, as explained below.

Pertinent Facts

On May 8, 2013, the Medicare contractor issued All Saints' notice of program reimbursement ("NPR") for the cost reporting period ending on June 30, 2009. On August 26, 2013, the Board received All Saints' Request for Hearing ("RFH") in which All Saints seeks Board review of two issues—"provider-specific" SSI percentage calculation and Medicaid eligible days.

All Saints summarizes its "provider-specific" SSI percentage issue as follows:

> The provider contends that its SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[1]

All Saints summarizes its second issue as follows "[t]he [Medicare contractor] failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage . . ."[2]

On August 9, 2017, the Board received the Medicare contractor's jurisdictional challenge in which the contractor claims that the Board lacks jurisdiction to hear the issues in this appeal because (1) All Saints' provider-specific SSI issue is already contained within a common issue related party ("CIRP") group appeal, and (2) the Medicare contractor has not made a final determination regarding All Saints' Medicaid eligible days.

The Board received All Saints' Jurisdictional Response ("Response") on September 7, 2017. In its Response, All Saints makes the following arguments in support of Board jurisdiction:

1. SSI provider-specific

All Saints claims that its "SSI systemic" issue and its "SSI provider-specific" issue are "separate and distinct," and that the two issues represent different "components" of the SSI calculation. All Saints differentiates the SSI "systemic" issue from the SSI "provider-specific" issue by claiming that the former "covers more in-depth aspects of the MedPar data but more importantly the treatment of Medicare Advantage, Medicare Managed Care, Medicare+Choice and/or Part C days[,]" as well as CMS Ruling 1498-R.[3] All Saints states that, in contrast, its SSI "provider-specific" issue addresses "various errors of omission and commission that do not fit into the 'systemic errors' category."[4]

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[1] RFH Tab 3 at unnumbered page 1.
[2] *Id.* at unnumbered pages 1-2.
[3] Response at 2.
[4] *Id.*

2. Medicaid eligible days

With respect to the Medicaid eligible days issue, All Saints states that as the Medicare contractor specifically adjusted All Saints' disproportionate share hospital ("DSH") payment, the Board has jurisdiction to hear its Medicaid eligible days issue. All Saints also claims that it self-disallowed its Medicaid eligible days pursuant to Board Rule 7.2(B). Generally, All Saints argues 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."[5]

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

Pursuant to 42 C.F.R. §§ 405.1835-405.1840 (2012), a provider has a right to a Board hearing 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 hearing is filed within 180 days of the date of receipt of the final determination. Under 42 C.F.R. § 405.1835(a)(1) (2012), a provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either (i) including a claim for the specific item on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or (ii) self-disallowing the specific item by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be in accordance with Medicare policy. In addition, pursuant to 42 C.F.R. § 405.1837(b)(1) (2012), two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue must bring the appeal as a group appeal.

Under Board Rule 4.5 (March 1, 2013), a provider may not appeal an issue from a final determination in more than one appeal.

Issue 1—SSI provider-specific

Although All Saints filed the instant appeal of its May 8, 2013 NPR on August 26, 2013, All Saints was also an original participant of the QRS WHFC 2009 DSH SSI Percentage CIRP Group appeal (PRRB Case No. 13-3224GC) filed on August 27, 2013. In this CIRP group, All Saints filed its appeal from the identical NPR that serves as the basis for the instant case. The issue contained within 13-3224GC is described as "[w]hether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage." Specifically, the CIRP group issue statement lists a number of SSI calculation "deficiencies," such as availability of MEDPAR and SSA records; paid v. eligible days; not in agreement with provider's records; fundamental problems in the SSI percentage calculation; covered v. total days; non-covered days such as Exhausted Benefit days,

[5] *Id.* at 3.

Medicare Second Payor days, Medicare Advantage days/Medicare+Choice/Part C days; CMS Ruling 1498-R and "failure to adhere to required notice and comment rule making procedures in adopting policy on EB, MSP and MA days."[6]

In its Response, All Saints tries to distinguish its "SSI provider-specific" issue contained within the instant appeal from the "SSI systemic" issue involved in the CIRP group appeal. Although All Saints argues that its "provider-specific" issue is a challenge to "various errors of omission and commission that do not fit into the 'systemic errors' category[,]" All Saints fails to describe any such "errors" in its documentation. All Saints does not relate any specific "errors of omission and commission" being challenged in the instant appeal, but, rather, just makes the general statement that it is challenging "other" types of errors.

In addition, All Saints does not further clarify its position in its Final Position Paper, but merely reiterates that "CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (June 30)."[7] It appears that All Saints is also requesting a realignment of the fiscal year underlying its SSI percentage, but such a realignment is not accomplished through an appeal but, rather, through a written request submitted to the Medicare contractor.[8]

The Board finds, therefore, that All Saints has not shown that its SSI "provider-specific" issue challenges any different SSI components than are being challenged in the SSI "systemic errors" issue in CIRP group PRRB Case No. 13-3224GC and that these two issues are the same. Since All Saints' SSI "systemic errors" issue is already contained within a mandatory CIRP group, the Board hereby dismisses All Saints' "provider-specific" issue from the instant appeal.

Issue 2—Medicaid eligible days

In its jurisdictional challenge, the Medicare contractor argues that All Saints did not claim, on its as-filed cost report, the Medicaid eligible days at issue in the instant appeal, therefore, the Medicare contractor did not issue a final determination with respect to these days and the Board does not have jurisdiction to consider them. The Medicare contractor goes on to state that Audit Adjustment 9 on All Saints' audit report shows that the contractor *added* 702 Medicaid eligible days during settlement of the cost report.[9] The contractor asserts that All Saints is now, within its RFH, requesting additional Medicaid eligible days that it never claimed or protested on its as-filed cost report as required under the applicable regulations.

In its Response, All Saints supports its assertion that the Board has jurisdiction over its Medicaid eligible days by claiming that it "self-disallowed" these days "in accordance with Board Rule 7.2(B)." All Saints also argues for Board jurisdiction because "the [Medicare contractor] adjusted the Provider['s] DSH [and] the Provider is dissatisfied with its DSH reimbursement."[10]

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[6] PRRB Case No. 13-3224GC RFH Ex. 2.
[7] FPP at 8.
[8] *See* 42 C.F.R. § 412.106(b)(3) (2013).
[9] Jurisdictional Challenge at Ex. JC-1.
[10] Response at 3.

All Saints filed a July 21, 2014 response to the Board's Alert 10 in which it recounts the impediments it faced when attempting to obtain a complete Medicaid eligible days list prior to its cost report submission due date. However, under the jurisdictional regulations governing Board jurisdiction for All Saints' June 30, 2009 cost reporting period, All Saints was required to have either included a claim for these days on its cost report—something All Saints declares it was unable to do—*or* self-disallowed the days by following the procedures for filing a cost report under protest.[11] In the instant case, All Saints has not shown that it fulfilled either requirement, thus the Board must find that it does not have jurisdiction over All Saints' Medicaid eligible days issue.

Conclusion

The Board finds that it lacks jurisdiction to hear All Saints' appeal of the two issues involved in the instant case. The Board, therefore, dismisses these issues and hereby closes this appeal.

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

Board Members Participating:

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

For the Board:

Charlotte Benson for
L. Sue Andersen, Esq.
Board Member

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

cc: Wilson Leong, Federal Specialized Services

[11] 42 C.F.R. § 405.1835(a)(1) (2008).

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DEC 12 2017

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RE: Jurisdictional Determination
All Saints Medical Center
Provider No.: 52-0096
FYE: June 30, 2010
PRRB Case No.: 14-2505

Dear Mr. Ravindran and Ms. Hartley:

This case involves All Saints Medical Center's ("All Saints'") appeal of its Medicare reimbursement for the fiscal year ending ("FYE") on June 30, 2010. In response to the Medicare contractor's jurisdictional challenge, the Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed All Saints' documentation. The Board finds that it does not have jurisdiction to hear All Saints' appeal of its Supplemental Security Income ("SSI") percentage "provider-specific" issue, as this issue is already contained within a group appeal, or its Medicaid eligible days issue, because All Saints did not claim or protest these days as required by regulation. As these two issues are the only issues that All Saints briefed in its Final Position Paper ("FPP") for the instant appeal, the Board hereby closes this case, as explained below.

Pertinent Facts

On September 3, 2013, the Medicare contractor issued All Saints' notice of program reimbursement ("NPR") for the cost reporting period ending on June 30, 2010. On February 18, 2014, the Board received All Saints' Request for Hearing ("RFH") in which All Saints seeks Board review of three issues—"provider-specific" SSI percentage calculation, Medicaid eligible days and Medicaid eligible labor room days.

On February 23, 2015, the Board received the Medicare contractor's jurisdictional challenge in which the contractor claims that the Board lacks jurisdiction to hear All Saints' Medicaid eligible days issue because All Saints updated—and received—all the Medicaid days included on an amended as-filed cost report. Therefore, the Medicare contractor argues that it did not make a

final determination on the days added in the appeal request. The contractor also states that All Saints failed to protest these days in the amended cost report.

The Board received All Saints' Jurisdictional Response ("Response") on March 18, 2015. In its response, All Saints argues that the Board has jurisdiction over its Medicaid eligible days issue because (1) the Medicare contractor specifically adjusted All Saints' disproportionate share hospital ("DSH") payment, (2) All Saints "self-disallowed" its Medicaid eligible days pursuant to Board Rule 7.2(B), and (3) All Saints claims that the documentation necessary to support DSH is often not available in time to include all Medicaid eligible days on the cost report."[1]

The Board received All Saints' FPP on August 23, 2017. Within its FPP, All Saints briefs only two issues—"(1) whether the correct SSI percentage was used in the DSH calculation, and (2) whether the numerator of the 'Medicaid fraction' properly includes all 'eligible' Medicaid days, regardless of whether such days were paid days."[2]

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

Pursuant to 42 C.F.R. §§ 405.1835-405.1840 (2013), a provider has a right to a Board hearing 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 hearing is filed within 180 days of the date of receipt of the final determination. Under 42 C.F.R. § 405.1835(a)(1) (2013), a provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either (i) including a claim for the specific item on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or (ii) self-disallowing the specific item by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be in accordance with Medicare policy. In addition, pursuant to 42 C.F.R. § 405.1837(b)(1) (2013), two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue must bring the appeal as a group appeal.

Under Board Rule 4.5 (March 1, 2013), a provider may not appeal an issue from a final determination in more than one appeal.

Issue 1—SSI "provider-specific"

When All Saints filed the instant appeal of its FYE June 30, 2010 cost reporting period, it included the following regarding its "provider-specific" issue:

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[1] Response at 7.
[2] FPP at 3.

> The provider contends that its[] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation . . . The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[3]

With respect to the very last sentence, if All Saints is requesting a realignment of the fiscal year underlying its SSI percentage, such a realignment is not accomplished through an appeal but through a written request submitted to the Medicare contractor.[4]

With respect to the remaining part of the issue description, the issue statement for the common issue related party ("CIRP") group appeal PRRB Case No. 13-3267GC describes the following issue: "The Providers . . . contend that the SSI percentages calculated by [CMS] [do] not address all the deficiencies as described in *Baystate* . . ." The providers' issue statement goes on to describe the following reasons underlying the challenge—availability of MEDPAR and SSA records, paid v. eligible days, not in agreement with provider's records, fundamental problems in the SSI percentage calculation, covered v. total days and failure to adhere to required notice and comment rulemaking procedures. The Board notes that All Saints directly added an appeal of its June 30, 2010 NPR to this CIRP group in addition to filing the instant individual appeal based on the same final determination.

Following review of both issue statements, the Board finds that All Saints' SSI provider specific issue in the instant appeal does not challenge any different SSI components than are being challenged in the SSI issue in CIRP group PRRB Case No. 13-3267GC and that these two issues are the same. Since All Saints' SSI "systemic errors" issue is already contained within a mandatory CIRP group, the Board hereby dismisses All Saints' "provider-specific" issue from the instant appeal.

Issue 2—Medicaid eligible days

In its jurisdictional challenge, the Medicare contractor argues that All Saints did not claim, on its as-filed cost report, the Medicaid eligible days at issue in the instant appeal, therefore, the Medicare contractor did not issue a final determination with respect to these days and the Board does not have jurisdiction to consider them. The contractor states that All Saints updated—and received—all the Medicaid days included on All Saints' amended as-filed cost report, therefore, the Medicare contractor did not make a final determination regarding the days added in the appeal request. The contractor also points out that All Saints failed to protest these days in the amended cost report.

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[3] RFH TAB 3 at unnumbered page 1.
[4] *See* 42 C.F.R. § 412.106(b)(3) (2012).

In its Response, All Saints supports its assertion that the Board has jurisdiction over its Medicaid eligible days because it "self-disallowed" these days "in accordance with Board Rule 7.2(B); because "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 because the Medicare contractor adjusted All Saints' DSH and All Saints is dissatisfied with its DSH reimbursement.[5]

Under the jurisdictional regulations governing Board jurisdiction for All Saints' June 30, 2010 cost reporting period, in order to preserve its right to claim dissatisfaction with the amount of Medicare payment for the specific item at issue, All Saints was required to have either included a claim for these days on its cost report or self-disallowed the days by following the procedures for filing a cost report under protest.[6] In the instant case, All Saints has not shown that it fulfilled either requirement, thus the Board must find that it does not have jurisdiction over All Saints' Medicaid eligible days issue.

Conclusion

The Board finds that it lacks jurisdiction to hear All Saints' appeal of the two issues remaining in the instant case. The Board, therefore, dismisses these issues and hereby closes this appeal.

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

Board Members Participating:

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Gregory Ziegler, CPA, CPC-A

For the Board:

Charlotte Benson for

L. Sue Andersen, Esq.
Board Member

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

cc: Wilson Leong, Federal Specialized Services

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[5] Response at 7.
[6] 42 C.F.R. § 405.1835(a)(1) (2008).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: Jurisdictional Determination
All Saints Medical Center
Provider No.: 52-0096
FYE: June 30, 2011
PRRB Case No.: 15-0902

Dear Mr. Ravindran and Ms. Hartley:

This case involves All Saints Medical Center's ("All Saints'") appeal of its Medicare reimbursement for the fiscal year ending ("FYE") on June 30, 2011. In response to the Medicare contractor's jurisdictional challenge, the Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed All Saints' documentation. The Board finds that it does not have jurisdiction to hear All Saints' appeal of its Supplemental Security Income ("SSI") percentage "provider-specific" issue, as this issue is already contained within a group appeal, or its Medicaid eligible days issue, because All Saints did not claim or protest these days as required by regulation. As these two issues are the only issues remaining within the instant appeal, the Board hereby closes this case, as explained below.

Pertinent Facts

On June 12, 2014, the Medicare contractor issued All Saints' notice of program reimbursement ("NPR") for the cost reporting period ending on June 30, 2011. On December 8, 2014, the Board received All Saints' Request for Hearing ("RFH") in which All Saints requested Board review of eight issues. Shortly after filing its RFH, All Saints transferred six of its issues to various group appeals. All Saints' remaining two issues are its "provider-specific" SSI percentage calculation and Medicaid eligible days.

Within its RFH, All Saints summarizes its "provider-specific" SSI percentage issue as follows:

> The Provider contends that its SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation. . . The Provider is seeking SSI data from CMS in order to reconcile

> its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[1]

All Saints summarizes its second issue as follows: "[t]he [Medicare contractor] failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage . . ."[2]

On September 22, 2017, the Board received the Medicare contractor's jurisdictional challenge in which the contractor claims that the Board lacks jurisdiction to hear the issues remaining in this appeal because (1) All Saints' provider-specific SSI issue is already contained within a common issue related party ("CIRP") group appeal, and (2) the Medicare contractor has not made a final determination regarding All Saints' Medicaid eligible days.

The Board received All Saints' Jurisdictional Response ("Response") on October 19, 2017. In its Response, All Saints makes the following arguments in support of Board jurisdiction:

1. SSI provider-specific

All Saints claims that its "SSI systemic" issue and its "SSI provider-specific" issue are "separate and distinct," and that the two issues represent different "components" of the SSI calculation. All Saints differentiates the SSI "systemic" issue from the SSI "provider-specific" issue by claiming that the former "covers more in-depth aspects of the MedPar data but more importantly the treatment of Medicare Advantage, Medicare Managed Care, Medicare+Choice and/or Part C days[,]" as well as CMS Ruling 1498-R.[3] All Saints states that, in contrast, its SSI "provider-specific" issue addresses "various errors of omission and commission that do not fit into the 'systemic errors' category."[4]

2. Medicaid eligible days

With respect to the Medicaid eligible days issue, All Saints states that as the Medicare contractor specifically adjusted All Saints' disproportionate share hospital ("DSH") payment, the Board has jurisdiction to hear its Medicaid eligible days issue. All Saints also claims that it self-disallowed its Medicaid eligible days pursuant to Board Rule 7.2(B). Generally, All Saints argues 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."[5]

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[1] RFH Tab 3 at unnumbered page 1.
[2] *Id.* at unnumbered pages 1-2.
[3] Response at 2.
[4] *Id.*
[5] *Id.* at 3.

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

Pursuant to 42 C.F.R. §§ 405.1835-405.1840 (2010), a provider has a right to a Board hearing 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 hearing is filed within 180 days of the date of receipt of the final determination. Under 42 C.F.R. § 405.1835(a)(1) (2010), a provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item at issue by either (i) including a claim for the specific item on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or (ii) self-disallowing the specific item by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be in accordance with Medicare policy. In addition, pursuant to 42 C.F.R. § 405.1837(b)(1) (2014), two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue must bring the appeal as a group appeal.

Under Board Rule 4.5 (March 1, 2013), a provider may not appeal an issue from a final determination in more than one appeal.

Issue 1—SSI provider-specific

When All Saints filed the instant appeal of its June 12, 2014 NPR, it initially included eight issues. All Saints describes "Issue 1" as Disproportionate Share Hospital Payment ("DSH")/SSI Provider Specific and "Issue 2" as DSH/SSI Systemic Errors. With respect to "Issue 2," All Saints states that it is challenging its SSI percentage calculation based upon the following reasons: availability of MEDPAR and SSA records; paid v. eligible days; not in agreement with provider's records; fundamental problems in the SSI percentage calculation; covered v. total days; non-covered days such as Exhausted Benefit days, Medicare Second Payor days, Medicare Advantage days/Medicare+Choice/Part C days; CMS Ruling 1498-R and "failure to adhere to required notice and comment rule making procedures in adopting policy on EB, MSP and MA days."[6] All Saints transferred its "Issue 2" to CIRP group PRRB Case No. 14-4102GC on August 12, 2015.

In its jurisdictional challenge, the Medicare contractor claims that All Saints' SSI Provider Specific issue is duplicative of its SSI Systemic Errors issue. In its Response, All Saints tries to distinguish the two issues by arguing that its "provider-specific" issue is a challenge to "various errors of omission and commission that do not fit into the 'systemic errors' category." However, All Saints fails to describe any additional "errors" in its documentation for Issue 1 nor does it relate any specific "errors of omission and commission" being challenged in the instant appeal, but, rather, just makes the general statement that it is challenging "other" types of errors.

[6] RFH TAB 3 at unnumbered page 2.

In addition, All Saints does not further clarify its position in its Final Position Paper ("FPP"), but merely reiterates that "CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (June 30)."[7] It appears that All Saints is also requesting a realignment of the fiscal year underlying its SSI percentage, but such a realignment is not accomplished through an appeal but, rather, through a written request submitted to the Medicare contractor.[8]

The Board finds, therefore, that All Saints has not shown that its SSI "provider-specific" issue challenges any different SSI components than are being challenged in the SSI "systemic errors" issue in CIRP group PRRB Case No. 14-4102GC and that these two issues are the same. Since All Saints' SSI "systemic errors" issue is already contained within a mandatory CIRP group, the Board hereby dismisses All Saints' "provider-specific" issue from the instant appeal.[9]

Issue 2—Medicaid eligible days

In its jurisdictional challenge, the Medicare contractor argues that All Saints did not claim, on its as-filed cost report, the Medicaid eligible days at issue in the instant appeal, therefore, the Medicare contractor did not issue a final determination with respect to these days and the Board does not have jurisdiction to consider them. The Medicare contractor specifically states that it added Medicaid eligible days in the NPR and that All Saints' "original cost report submission was filed with no Protested Amounts."[10] The contractor asserts that All Saints is now, within its RFH, requesting additional Medicaid eligible days that it never claimed or protested on its as-filed cost report as required under the applicable regulations.

In its Response, All Saints supports its assertion that the Board has jurisdiction over its Medicaid eligible days by claiming that it "self-disallowed" these days "in accordance with Board Rule 7.2(B)." All Saints also argues for Board jurisdiction because "the [Medicare contractor] adjusted the Provider['s] DSH [and] the Provider is dissatisfied with its DSH reimbursement."[11]

Under the jurisdictional regulations governing Board jurisdiction for All Saints' June 30, 2011 cost reporting period, in order to preserve its right to claim dissatisfaction with the amount of Medicare payment for the specific item at issue, All Saints was required to have either included a claim for these days on its cost report or self-disallowed the days by following the procedures for filing a cost report under protest.[12] In the instant case, All Saints has not shown that it fulfilled either requirement, thus the Board must find that it does not have jurisdiction over All Saints' Medicaid eligible days issue.

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[7] FPP at 8.
[8] *See* 42 C.F.R. § 412.106(b)(3) (2013).
[9] *See* Board Rule 4.5 (March 1, 2013).
[10] Jurisdictional Challenge at 2.
[11] Response at 3.
[12] 42 C.F.R. § 405.1835(a)(1) (2008).

Conclusion

The Board finds that it lacks jurisdiction to hear All Saints' appeal of the two issues involved in the instant case. The Board, therefore, dismisses these issues and hereby closes this appeal.

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

Board Members Participating:

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

For the Board:

Charlotte Benson for

L. Sue Andersen, Esq.
Board Member

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

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Refer to: 13-3106 & 14-4143

DEC 13 2017

CERTIFIED MAIL

Community Health Systems, Inc.
Nathan Summar
Vice President Revenue Management
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RE: Requests for Expedited Judicial Review
Wuesthoff Memorial Hospital – Rockledge
Provider No.: 10-0092
FYE: 9/30/2008 & 9/30/2010
PRRB Case Nos. 13-3106 & 14-4143

Dear Mr. Summar,

The Provider Reimbursement Review Board ("Board") has received the Requests for Expedited Judicial Review ("EJR") dated December 4, 2017 for case numbers 13-3106 and 14-4143. The Board hereby denies the requests for EJR as the above-referenced appeals were closed by the Board on December 4, 2017 and November 15, 2017, respectively.

The Board also received the Requests for Postponements dated December 5, 2017 for the December 12, 2017 hearing date in case numbers 13-3106 and 14-4143. The postponement requests are hereby denied because the appeals have already closed and been removed from the Board's calendar.

Finally, the Board notes that Quality Reimbursement Services, Inc. is the representative of record in case number 13-3106. Unless the Provider submits a letter to the Board indicating otherwise, the Board will continue to correspond with Quality Reimbursement Services, Inc. for case number 13-3106.

FOR THE BOARD

L. Sue Andersen, Esq.
Chairperson

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DEC 15 2017

Certified Mail

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RE: **Expedited Judicial Review Determination**
Valley Health 2007 DSH Medicare/Medicaid Medicare Advantage Days CIRP Group
PRRB Case No. 13-1292GC

Dear Ms. O'Brien Griffin:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' December 6, 2017 request for expedited judicial review (EJR) (received December 7, 2017). The Board's determination is set forth below.

Issue

The issue for which EJR has been requested is:

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

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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[1] December 6, 2017 EJR Request at 1.
[2] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[3] *Id.*
[4] *See* 42 U.S.C. § 1395ww(d)(5).
[5] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[6] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[7] The DPP is defined as the sum of two fractions expressed as percentages.[8] Those two fractions are referred to as the "Medicare/SSI"[9] fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

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

The Medicare/SSI fraction is computed annually by CMS, and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[10]

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

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

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

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[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(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 Medicare fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction* . . . (emphasis added)[17]

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

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

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

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[16] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).
[17] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).
[18] 69 Fed. Reg. at 49,099.
[19] *Id.*

Although the change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 final rule was issued.[20] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule. As a result, Part C days were required to be included in the Medicare fraction as of October 1, 2004.

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

Providers' Request for EJR

The Providers assert that that the Medicare fraction of the DSH calculation is improperly understated due to the Secretary's erroneous inclusion of inpatient days attributable to Medicare Advantage patients in both the numerator and the denominator of the of the Medicare fraction. The failure to include such days in the Medicaid fraction also understated that fraction. The Providers point out that the authority upon which CMS relied to collect Medicare Advantage days information is the DSH regulation at 42 C.F.R. § 412.106, which includes Medicare Advantage days in the description of the days included in the Medicare fraction. However, the enabling statute for this regulation, 42 U.S.C. §1395ww(d)(5)(f), makes no mention of the inclusion of Medicaid Advantage days in the Medicare fraction, only traditional Part A days. The Providers contend that Medicare Advantage beneficiaries are not entitled to benefits under Part A, but instead are entitled to benefits under Part C. As a result, the Providers are challenging the validity of the regulation to the extent that 42 C.F.R. § 412.106 contradicts the enabling statute at 42 U.S.C. § 1395ww(d)(5)(F).[23]

In challenging the validity of the regulation, the Providers assert that the regulation was adopted in violation of the Administrative Procedures Act (APA). They contend that the Secretary violated the APA when she deprived the public the opportunity to comment on the regulation. This position was upheld in the decisions in both *Allina I* and *Allina II.*[24]

The Providers argue that any Medicare Advantage days that are also dual eligible days cannot be counted in the Medicare ratio for the same reasons as set forth above. Primarily, they believe, the regulation requiring inclusion of dual eligible days in the Medicare ratio is invalid and the days must be counted in numerator of the Medicaid fraction. This allegedly improper treatment resulted in the under payment to Providers as DSH eligible providers of services to indigent

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[20] 72 Fed. Reg. 47,130, 47,384 (Aug. 22, 2007).
[21] 746 F. 3d 1102 (D.C. Cir. 2014).
[22] December 6, 2017 EJR Request at 8.
[23] *Id.* at 2.
[24] *Id.*

patients, and includes any other related adverse impact to DSH payments, such as capital DSH payments.[25]

With respect to EJR, the Providers believe that the Board has jurisdiction over the matter at issue and lacks the legal authority to decide the legal question presented. The Providers posit that the Board is not able to address the legal question of whether CMS correctly followed the statutory mandates for rulemaking set forth in the APA and the statute and is bound by Secretary's actions. The Providers do not believe that the Board has the authority to implement the effect of *Allina I* and *Allina II* decisions until the Secretary instructs it to do so.[26]

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.[27]

The Providers in the group case covered by this EJR request filed appeals of their original notices of program reimbursement ("NPRs") in which the Medicare contractor settled the cost reporting periods ending in 2007.

For purposes of Board jurisdiction over a cost reporting period that ends on or before December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen*.[28]

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[25] *Id.*
[26] *Id.* at 7
[27] The regulations governing Board jurisdiction begin at 42 C.F.R. § 405.1835. 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).
[28] 108 S.Ct. 1255 (1988).

Jurisdiction

The Board finds that the Providers involved with the instant EJR request have had Part C days excluded from the Medicaid fraction, have had a specific adjustment to the SSI fraction, or have properly protested/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 the group appeal exceeds $50,000 and the appeal was timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in this case.

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

The Providers within this EJR request filed appeals covering calendar year 2007, thus the cost reporting period falls squarely within the time frame that covers the Secretary's final rule being challenged.[29] In addition, the Board recognizes that the D.C. Circuit vacated the regulation in *Allina* for the time period at issue in this request. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). In addition, within its July 25, 2017 decision in *Allina Health Services v. Price*, the D.C. Circuit Court agreed with the Board's determination to grant EJR for the identical issue involved in the instant EJR request.[30]

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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[29] As stated in the FY 2014 IPPS Final Rule, the Secretary "proposed to readopt the policy of counting the days of patients enrolled in MA plans in the Medicare fraction of the DPP[,]" thus "sought public comments from interested parties . . ." following publication of the FY 2014 IPPS Proposed Rule, 78 Fed. Reg. 27578 (May 10, 2013). Ultimately, the Secretary finalized this DSH policy for FFY 2014 and subsequent years on August 19, 2013, in the FY 2014 IPPS Final Rule. *See* 78 Fed. Reg. 50496, 50615 (Aug. 19, 2013). The Provider appeals in the instant EJR request are all based upon FY 2011 cost reporting periods and earlier.

[30] *See* 863 Fed. 3d 937 (D.C. Cir. 2017).

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 in the group appeal, the Board hereby closes the case.

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)
Schedule of Providers

cc: Laurie Polson, Palmetto GBA c/o NGS (J-M) (Certified w/enclosures)
Wilson Leong, Esq., CPA, Federal Specialized Services (w/enclosures)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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DEC 15 2017

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Expedited Judicial Review Determination
RE: HCA 2010 DSH Medicare Advantage Plan Days Group
PRRB Case No. 13-1368GC

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' December 6, 2017 request for expedited judicial review (EJR) (received December 7, 2017). The Board's determination is set forth below.

The issue in these appeals is:

> Whether "Medicare Part C patients are 'entitled to benefits' under Part A, such that they should be counted in the Medicare Part A/SSI[1] fraction and excluded from the Medicaid fraction numerator . . ." of the DSH[2] adjustment.[3]

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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[1] "SSI" is the acronym for "Supplemental Security Income."
[2] "DSH" is the acronym for "disproportionate share hospital."
[3] Providers' December 6, 2017 EJR Request at 4.
[4] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[5] *Id.*
[6] *See* 42 U.S.C. § 1395ww(d)(5).
[7] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

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

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

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

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

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

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

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

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

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

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

With the creation of Medicare Part C in 1997,[16] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C

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

days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.[17]

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

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

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

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

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

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[17] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).
[18] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).
[19] 69 Fed. Reg. at 49,099.
[20] *Id.*

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

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

Providers' Request for EJR

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

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[21] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[22] 746 F. 3d 1102 (D.C. Cir. 2014).
[23] December 6, 2017 EJR Request at 1.
[24] 69 Fed. Reg. at 49,099.
[25] *Allina* at 1109.

Decision of the Board

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

Jurisdictional Determination for Providers

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the providers requesting EJR. Pursuant to the pertinent regulations governing Board jurisdiction, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more for an individual appeal or $50,000 or more for a group, and the request for hearing is filed within 180 days of the date of receipt of the final determination.[26]

All of the participants in the subject group appealed from original NPRs that were for the cost reporting periods ending 2010. For appeals of original NPRs for cost reporting time periods ending on or after December 31, 2008, the Providers preserve their respective rights to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either including a claim for the specific item on their cost report for the period where the Provider seeks payment they believe to be in accordance with Medicare policy, or self-disallowing the specific item by following the applicable procedures for filing a cost report under protest. See 42 C.F.R. § 405.1835(a)(1) (2008).

In addition, the Providers' documentation shows that the estimated amount in controversy for the group appeal exceeds $50,000, as required for a group appeal and the appeal was timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor.

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

The providers within this EJR request filed appeals covering the cost reporting period with fiscal year ending 2010, thus the cost reporting period falls squarely within the time frame that covers the Secretary's final rule being challenged.[27] 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

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[26] 42 C.F.R. § 405.1835(a) (2008).

[27] 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 FYs that began prior to 10/1/2013.

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

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

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

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)
Schedule of Providers

cc: Byron Lamprecht, Wisconsin Physicians Service (J-5) (Certified w/Schedules)
Wilson Leong, Esq., CPA, FSS (w/Schedules)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

DEC 15 2017

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

First Coast Services Options, Inc.
Geoff Pike
Provider Audit and Reimbursement Dept.
532 Riverside Avenue
Jacksonville, FL 32202

RE: Wuesthoff Memorial Hospital
Provider No. 10-0092
FYE 9/30/2007
PRRB Case No. 13-3053

Dear Mr. Ravindran and Mr. Pike,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the documents in the above referenced appeal. The Board's jurisdictional decision is set forth below.

BACKGROUND:

The Provider was issued an original Notice of Program Reimbursement ("NPR") on February 28, 2013 for fiscal year end ("FYE") 9/30/2007. On August 29, 2013, the Provider filed an appeal request with the Board that identified eight issues. The Provider later requested to transfer various issues to group appeals.

On September 26, 2014, the Medicare Contractor filed a Jurisdictional Challenge over several issues pending in this appeal.[1] In its response to the Jurisdictional Challenge, the Provider requested to withdraw the Medicaid eligible observation bed days issue from the appeal.

On December 5, 2017, Community Health Systems ("CHS") submitted a Request for Expedited Judicial Review ("EJR") of the SSI Provider Specific Issue. On the next day, CHS submitted a request to withdraw several issues from the appeal. CHS was never entered as the representative in this appeal.

On December 8, 2017, the representative of record, Quality Reimbursement Services, Inc. ("QRS") re-submitted the Request for EJR and the issue withdrawals.

The only issue that remains pending in this appeal is the SSI Provider Specific issue.

[1] The Provider has since withdrawn all of the issues over which the Medicare Contractor challenged jurisdiction, therefore the Board need not address the Medicare Contractor's contentions.

BOARD'S DECISION:

Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue. The jurisdictional analysis for Issue No. 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the Systemic Errors issue.[2] The DSH Payment/SSI Percentage (Provider Specific) issue concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital Calculation."[3] The Provider's legal basis for Issue No. 1 also asserts 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)."[4] The Provider argues that "its SSI percentage published by [CMS] was incorrectly computed . . . ."[5]

However, the Provider's Systemic Errors issue is "[whether] the Secretary properly calculated the Provider's Disproportionate Share Hospital/Supplemental Security Income percentage."[6] The Provider's legal basis for the Systemic Errors issue is that "the SSI percentages calculated by [CMS] and used by the Lead [Medicare Contractor] to settle their Cost Report [were] incorrectly computed . . . ."[7] Thus, the Provider's disagreement with how the Medicare Contractor calculated the SSI percentage that would be used for the DSH percentage is duplicative of the Systemic Errors issue that has been transferred to a group appeal, case no. 13-2679G. Because the Systemic Errors issue is no longer in the individual appeal as it was transferred to a group appeal, the Board hereby dismisses this aspect of Issue No. 1.

The second aspect of Issue No. 1—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed for lack of jurisdiction. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can

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

be dissatisfied with for appealing purposes, therefore the Board finds that it does not have jurisdiction over this portion of the SSI Provider Specific issue.

EJR Request

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

The Board hereby denies the Provider's request for EJR because it does not have jurisdiction over the SSI Provider Specific Issue as part of this individual appeal (see discussion, above), therefore the first requirement of 42 C.F.R. § 405.1842(f)(1) is not satisfied.

Additionally, the Board notes that the issue the Provider has requested the Board EJR is labeled as Provider Specific, but upon review the Board has determined that the issue is actually the SSI Systemic Errors issue statement. The Provider has transferred the SSI Systemic Errors issue to case no. 13-2679G.

The Provider states in its request for EJR that it requested in its issue statement that the Board either:

> Require a recalculation of the SSI percentage using a denominator based solely on covered and paid for Medicare days, or alternatively, an expansion of the numerator to include paid as well as unpaid and covered as well as non-covered days. The Board should require a recalculation of the SSI percentage using a denominator based solely on covered and paid for Medicare days, or alternatively, an expansion of the numerator to include paid as well an unpaid and covered as well as non-covered days.

The Provider then identifies the issue as "whether the Centers for Medicare and Medicaid Services' ("CMS's") unlawfully interprets the term "entitled" in applying differential treatment to the counting of days to compute the Medicare disproportionate share hospital ("DSH") payment.

The Provider's initial appeal request for the Provider Specific issue reads:

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S. C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' [*sic*] SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to benefits in their

calculation. The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.

The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include.

A large focus of the Provider's EJR request relates to the term "entitled." Although this issue statement does briefly mention Part A "entitled," the Provider goes into much more detail about this concept in its SSI Systemic Errors issue statement; and again, this issue has been transferred to a group appeal.

Conclusion

The only issue that remains pending in this appeal is the SSI Provider Specific issue, over which the Provider has requested the Board grant EJR. The Board finds that it does not have jurisdiction over the issue (because part of the issue is duplicative of the SSI Systemic Errors issue which has been transferred to case no. 13-2679G and because there is no final determination with respect to realignment). Therefore, the Board denies the Provider's request for EJR over the issue, as jurisdiction is a prerequisite to granting EJR per 42 C.F.R. § 405.1842(f)(1).

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 Ziegler, CPA, CPC-A

For the Board:

L. Sue Andersen, Esq.
Chairperson

cc: Federal Specialized Services
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DEPARTMENT OF HEALTH & HUMAN SERVICES

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DEC 15 2017

RE: **Expedited Judicial Review Determination**

Trinity Health 2007 DSH Medicare/Medicaid Medicare Advantage Days CIRP Group
PRRB Case No. 16-2375GC

Community Healthcare System 2014 DSH Medicare/Medicaid Medicare Advantage Days CIRP Group, PRRB Case No. 16-2388GC

Dear Ms. O'Brien Griffin:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' December 4, 2017 request for expedited judicial review (EJR) (received December 6, 2017). The Board's determination is set forth below.

Issue

The issue for which EJR has been requested is:

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

Statutory and Regulatory Background: Medicare DSH Payment

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

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

[1] December 4, 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).

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[6] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[7] The DPP is defined as the sum of two fractions expressed as percentages.[8] Those two fractions are referred to as the "Medicare/SSI"[9] fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

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

The Medicare/SSI fraction is computed annually by CMS, and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[10]

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

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

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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[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)(I).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] "SSI" stands for "Supplemental Security Income."
[10] 42 C.F.R. § 412.106(b)(2)-(3).
[11] 42 C.F.R. § 412.106(b)(4).

Medicare Advantage Program

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

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

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

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

With the creation of Medicare Part C in 1997,[15] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C

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

days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.[16]

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicare fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction* . . . (emphasis added)[17]

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

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

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

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[16] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).
[17] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).
[18] 69 Fed. Reg. at 49,099.
[19] *Id.*

Although the change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 final rule was issued.[20] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule. As a result, Part C days were required to be included in the Medicare fraction as of October 1, 2004.

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

Providers' Request for EJR

The Providers assert that that the Medicare fraction of the DSH calculation is improperly understated due to the Secretary's erroneous inclusion of inpatient days attributable to Medicare Advantage patients in both the numerator and the denominator of the of the Medicare fraction. The failure to include such days in the Medicaid fraction also understated that fraction. The Providers point out that the authority upon which CMS relied to collect Medicare Advantage days information is the DSH regulation at 42 C.F.R. § 412.106, which includes Medicare Advantage days in the description of the days included in the Medicare fraction. However, the enabling statute for this regulation, 42 U.S.C. §1395ww(d)(5)(f), makes no mention of the inclusion of Medicaid Advantage days in the Medicare fraction, only traditional Part A days. The Providers contend that Medicare Advantage beneficiaries are not entitled to benefits under Part A, but instead are entitled to benefits under Part C. As a result, the Providers are challenging the validity of the regulation to the extent that 42 C.F.R. § 412.106 contradicts the enabling statute at 42 U.S.C. § 1395ww(d)(5)(F).[23]

In challenging the validity of the regulation, the Providers assert that the regulation was adopted in violation of the Administrative Procedures Act (APA). They contend that the Secretary violated the APA when she deprived the public the opportunity to comment on the regulation. This position was upheld in the decisions in both *Allina I* and *Allina II.*[24]

The Providers argue that any Medicare Advantage days that are also dual eligible days cannot be counted in the Medicare ratio for the same reasons as set forth above. Primarily, they believe, the regulation requiring inclusion of dual eligible days in the Medicare ratio is invalid and the days must be counted in numerator of the Medicaid fraction. This allegedly improper treatment resulted in the under payment to Providers as DSH eligible providers of services to indigent patients, and includes any other related adverse impact to DSH payments, such as capital DSH payments.[25]

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[20] 72 Fed. Reg. 47,130, 47,384 (Aug. 22, 2007).
[21] 746 F. 3d 1102 (D.C. Cir. 2014).
[22] December 4, 2017 EJR Request at 8.
[23] *Id.* at 2.
[24] *Id.*
[25] *Id.*

With respect to EJR, the Providers believe that the Board has jurisdiction over the matter at issue and lacks the legal authority to decide the legal question presented. The Providers posit that the Board is not able to address the legal question of whether CMS correctly followed the statutory mandates for rulemaking set forth in the APA and the statute and is bound by Secretary's actions. The Providers do not believe that the Board has the authority to implement the effect of *Allina I* and *Allina II* decisions until the Secretary instructs it to do so.[26]

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.[27]

All of the participants in Case No. 16-2388GC filed appeals of their original notices of program reimbursement ("NPRs") in which the Medicare contractor settled the cost reporting period ending 6/30/2014. Case No. 16-2375GC includes 3 participants appealing from original NPRs and 4 participants appealing from revised NPRs ("RNPRs") in which the Medicare contractor settled the cost reporting period ending 6/30/2007.

For purposes of Board jurisdiction over a cost reporting period that ends on or before December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen*.[28]

For appeals of original NPRs for cost reporting time periods ending on or after December 31, 2008, the Providers preserve their respective rights to claim dissatisfaction with the amount of

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[26] *Id.* at 7

[27] The regulations governing Board jurisdiction begin at 42 C.F.R. § 405.1835. 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).

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

Medicare payment for a specific item at issue by either including a claim for the specific item on their cost report for the period where the Provider seeks payment they believe to be in accordance with Medicare policy, or self-disallowing the specific item by following the applicable procedures for filing a cost report under protest. See 42 C.F.R. § 405.1835(a)(1) (2008).

For appeals of RNPRs for cost reporting periods ending in the 2007 calendar year, the Providers must demonstrate that the issue under review was specifically revisited on reopening.[29]

Jurisdiction

The Providers involved with the instant EJR request have had Part C days excluded from the Medicaid fraction, have had specific adjustments to the SSI fraction, or have properly protested/self-disallowed the appealed issue such that the Board has jurisdiction to hear their respective appeals.[30] In addition, the Providers' documentation shows that the estimated amount in controversy for each group appeal exceeds $50,000, as required for a group appeal and the appeals were timely filed.

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

The Providers in the groups within this EJR request filed appeals covering cost reporting years 6/30/2007 and 6/30/2014, thus the cost reporting periods fall squarely within the time frame that covers the Secretary's final rule being challenged.[31] In addition, the Board recognizes that the D.C. Circuit vacated the regulation in *Allina* for the time period at issue in this request. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). In addition, within its July 25, 2017 decision in *Allina Health Services v. Price*, the D.C. Circuit Court agreed with the Board's determination to grant EJR for the identical issue involved in the instant EJR request.[32]

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[29] For any provider that files an appeal from a revised NPR ("RNPR") issued after August 21, 2008, the Board only has jurisdiction to hear that provider's appeal of matters that the Medicare contractor specifically revised within the RNPR. *See* 42 C.F.R. § 405.1889(b)(1) (2008).

[30] On December 5, 2017, one of the Medicare contractors, Wisconsin Physicians Service ("WPS"), filed an objection to the EJR request for PRRB Case No. 16-2388GC. 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 the Board 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.

[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 FYs that began prior to 10/1/2013 and earlier.

[32] *See* 863 Fed. 3d 937 (D.C. Cir. 2017).

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 in each group appeal, the Board hereby closes the cases.

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)
Schedules of Providers

cc: Danene Hartley, National Government Services (J-6) (Certified w/enclosures)
Byron Lamprecht, Wisconsin Physicians Service (J-8) (Certified w/enclosures)
Wilson Leong, Esq., CPA, Federal Specialized Services (w/enclosures)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

DEC 15 2017

Certified Mail

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

RE: Expedited Judicial Review Request
Hall Render DSH Medicare/Medicaid Fraction Part C Days Groups
FYE: 2007, 2009-2011
PRRB Case Nos.: 13-1879GC, 14-2566GC, 15-0399GC, 15-1615GC, 15-2008GC and 15-2881GC

Dear Ms. Elias:

On November 21, 2017, the Provider Reimbursement Review Board ("PRRB" or "Board") received a request for expedited judicial review ("EJR") (dated November 20, 2017) for the above-referenced group appeals. The Board has reviewed the request and hereby grants EJR for the issue in these group appeals for all Providers, as explained below.

The issue in these group 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] November 20, 2017 EJR Request at 2.
[2] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[3] *Id.*
[4] *See* 42 U.S.C. § 1395ww(d)(5).

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 the Centers for Medicare & Medicaid Services ("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." The terms "SSI fraction," "SSI%," "SSI ratio" and "Medicare fraction" are synonymous and used interchangeably within this decision.
[10] 42 C.F.R. § 412.106(b)(2)-(3).

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

Medicare Advantage Program

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

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

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

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

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

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

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 . . .*[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]

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) (emphasis added).

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

[19] *Id* (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).

In this case, the Providers contend that all Part C days should be excluded from the Part A/SSI fraction and the Medicaid-eligible Part C days should be included in the numerator of the Medicaid fraction. To obtain relief, the Providers seek a ruling on the procedural and substantive validity of the 2004 rule that the Providers claim the Board lacks the authority to grant. The Providers argue

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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] November 20, 2017 EJR Request at 8.
[24] 69 Fed. Reg. at 49,099.
[25] *Allina* at 1109.

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 September 30, 2007, and December 31, 2011.

For Providers with appeals filed from 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]

For Providers with appeals filed from original NPRs for cost reporting time periods ending on or after December 31, 2008, a Provider preserves its right to claim dissatisfaction with the amount of Medicare payment for the Part C days issue by either (1) including a claim for the specific item on its cost report for the time period in situations where the Provider seeks payment that it believes

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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] 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."

to be in accordance with Medicare policy, or (2) self-disallowing the specific item by following the applicable procedures for filing cost reports under protest in situations where the Provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy.[28]

For Providers with appeals filed from RNPRs issued after August 21, 2008, the Board has jurisdiction to hear a Provider's appeal of matters that the Medicare contractor specifically revised within the Provider's RNPR.[29]

Jurisdictional Determination for the Providers

The Board finds that all the Providers involved with the instant EJR request have had an adjustment to the SSI ratio on their respective NPRs/RNPRs or have properly self-disallowed the appealed issue such that the Board has jurisdiction to hear their 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 2007 and 2009-2011, thus the cost reporting periods fall squarely within the time frame covered by the Secretary's final rule being challenged in this EJR request.[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).[31] 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*,[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. Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.[33]

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[28] *See* 42 C.F.R. § 405.1835(a)(1) (2008).
[29] *See* 42 C.F.R. § 405.1889(b)(1) (2008).
[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 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).
[32] 863 F.3d 937 (D.C. Cir. July 25, 2017).
[33] One of the Medicare contractors, Wisconsin Physicians Service ("WPS"), filed an objection to the EJR requests for PRRB Case Nos. 15-0399GC, 15-1615GC, and 15-2008GC. In its filings, WPS argues that the Board should deny the Providers' EJR request because the Board is not bound by the Secretary's regulation that the federal district

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

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

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)
Schedules of Providers

cc: Mounir Kamal, Novitas Solutions, Inc. (Certified Mail w/Schedules of Providers ("SOP"))
Laurie Polson, Palmetto GBA c/o National Government Services (Certified Mail w/SOP)
Judith E. Cummings, CGS Administrators (Certified Mail w/SOP)
Byron Lamprecht, Wisconsin Physicians Service (Certified Mail w/SOP)
Wilson Leong, Federal Specialized Services (w/SOP)

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court vacated in *Allina* and, therefore, the Board has the authority to decide the issue under appeal. The Board's explanation of its authority regarding this issue addresses the arguments set out in WPS' challenges.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

DEC 21 2017

CERTIFIED MAIL

Community Health Systems, Inc.
Nathan Summar
Vice President Revenue Management
4000 Meridian Boulevard
Franklin, TN 37067

Wisconsin Physicians Service
Byron Lamprecht
Cost Report Appeals
2525 N 117th Avenue, Suite 200
Omaha, NE 68164

RE: Navarro Regional Hospital, 45-0447, 12/31/2005, CN 16-2323
Longview Regional Medical Center, 45-0702, 12/31/2005, CN 16-2324
Springs Memorial Hospital, 42-0036, 11/30/2005, CN, 16-2325
South Baldwin Regional Medical Center, 01-0083, 09/30/2005, CN 16-2503
Chestnut Hill Hospital, 39-0026, 06/30/2005, CN 17-0351
Hillcrest Hospital South, 37-0202, 12/31/2005, CN 17-0352
Lake Wales Medical Center, 10-0099, 12/31/2005, CN 17-0410

Dear Mr. Summar and Mr. Lamprecht,

Each of the Providers listed above appealed from a Revised Notice of Program Reimbursement (RNPR) for a 2005 cost reporting period. Each RNPR was issued to include the most recent SSI percentage that was recalculated by the Centers for Medicare and Medicaid Services ("CMS") (post-2011 Final Rule with new data matching). Each of the RNPRs were issued between March 4, 2016 and May 11, 2016.

Each Provider filed an individual appeal with one issue: the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)*. All of the Providers also appealed the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Systemic Errors)* issue directly into 16-1489GC, Community Health Systems ("CHS") 2005 Post 1498R SSI Data Match Group.

Board's Decision

Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)

Although the Medicare Contractor did not challenge jurisdiction over this issue, the Board finds that it does not have jurisdiction over the SSI Provider Specific issue for any of the above-referenced Providers. The jurisdictional analysis for the SSI Provider Specific issue has two

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

The first aspect of the issue – the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage – is duplicative of the Systemic Errors issue that was directly added to case no. 16-1489GC and is hereby dismissed by the Board.[1] The DSH Payment/SSI Percentage (Provider Specific) issue concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital Calculation."[2] The Providers' legal basis for the SSI Provider Specific issue also asserts 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)."[3] The Providers argue that the "SSI percentage published by [CMS] was incorrectly computed . . . ." and ". . . specifically disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[4]

The Providers' Systemic Errors issue as stated in the group appeal request for case no. 16-1489GC is:

> 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 . . .
>
> ***
>
> CMS's improper treatment and policy changes resulted in an underpayment to the Providers . . .

Thus, the Providers' disagreement with how the Medicare Contractor calculated the SSI percentage that would be used for the DSH percentage as stated in the Provider specific issue statement is duplicative of the Systemic Errors issue that has been filed directly into a group appeal.

CMS' regulation interpretation is clearly not specific to only this provider, it applies to ALL SSI calculations, and as this provider is part of a chain, the Provider would be required by the CIRP regulations to pursue that challenge with related providers in a CIRP group appeal. The Provider

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[1] *See* Providers' Individual Appeal Requests at Tab 3 and Appeal Request in 16-1489GC.
[2] *Id.* at Tab 3.
[3] *Id.*
[4] *Id.*

is misplaced in trying to state that the regulatory challenge is related to any "provider specific" SSI issue that could possibly remain in an individual appeal. Because all of the above-referenced Providers directly added the Systemic Errors issue to a CIRP group appeal, the Board hereby dismisses the first portion of the SSI Provider Specific issue because it is duplicative of the Systemic Errors issue.

The second aspect of the Provider Specific issue – the Providers preserving their right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period – is hereby dismissed by the Board for lack of jurisdiction. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied for appealing purposes. Furthermore, one of the Providers, South Baldwin, has a 09/30/2005 cost reporting period, therefore its SSI percentage has already been calculated based on the Federal fiscal year end. Therefore, there is not dispute for South Baldwin as it cannot request realignment. Based on this reasoning, the Board finds that it does not have jurisdiction over the realignment portion of the Providers' issue statements.

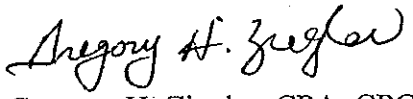
Conclusion

The only issue filed in these appeals is the SSI Provider Specific issue and the Board finds that it does not have jurisdiction over this issue for the seven above-referenced Providers. The Board finds that the Providers' challenges to the DSH SSI regulation and statute are properly pending in a CIRP Group. With respect to the potential requests for realignment, the Board finds that it does not have jurisdiction over this portion of the issue and hereby dismisses it from the above-referenced appeals. PRRB Case Nos. 16-2323; 16-2324; 16-2325; 16-2503; 17-0351; 17-0352; and 17-0410 are 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



Gregory H. Ziegler, CPA, CPC-A
Board Member

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

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Community Health Systems, Inc.
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Vice President Revenue Management
4000 Meridian Boulevard
Franklin, TN 37067

Wisconsin Physicians Service
Byron Lamprecht
Cost Report Appeals
2525 N 117th Avenue, Suite 200
Omaha, NE 68164

RE: Bayfront Health Brooksville, 10-0071, 09/30/2006, CN 16-1655
East Georgia Regional Medical Center, 11-0075, 09/30/2006, CN 16-1805
Merit Health Biloxi, 25-0007, 09/30/2006, CN 16-1695
Chester Regional Medical Center, 42-0019, 09/30/2006 CN 16-2284

Dear Mr. Summar and Mr. Lamprecht,

All of the Providers listed above appealed a Revised Notice of Program Reimbursement (RNPR) for a 2006 cost reporting period. Each of the RNPRs was issued to include the most recent SSI percentage that was recalculated by CMS (post-2011 Final Rule with new data matching). Each of the RNPRs was issued between November 18, 2015 and February 24, 2016.

Each of the Providers filed individual appeals with two issues: 1) *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* issue and 2) *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage).* All of the Providers transferred the second issue to PRRB Case No. 13-3026GC, HMA 2006 DSH SSI Percentage Group.

Board's Decision

Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)

Although the Medicare Contractor did not challenge jurisdiction over this issue, the Board finds that it does not have jurisdiction over the SSI Provider Specific issue for any of the above-referenced Providers. The jurisdictional analysis for Issue No. 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the Systemic Errors issue that was transferred to 13-3026GC and should be dismissed by the Board.[1] The DSH Payment/SSI Percentage (Provider Specific) issue concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital Calculation."[2] The Provider's legal basis for Issue No. 1 also asserts 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)."[3] The Provider argues that "its SSI percentage published by [CMS] was incorrectly computed . . . ." and it ". . . specifically disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[4]

The Providers' Systemic Errors issue is "[whether] the Secretary properly calculated the Provider's Disproportionate Share Hospital/Supplemental Security Income percentage."[5] The Provider's legal basis for the Systemic Errors issue is that "the SSI percentages calculated by [CMS] and used by the Lead [Medicare Contractor] to settle their Cost Report [were] incorrectly computed . . . ."[6] Thus, the Providers' disagreement with how the Medicare Contractor calculated the SSI percentage that would be used for the DSH percentage is duplicative of the Systemic Errors issue that has been transferred to a group appeal.

CMS regulation interpretation is clearly not specific to only one provider, it applies to ALL SSI calculations, and as this provider is part of a chain, the Provider would be required by the CIRP regulations to pursue that challenge with related providers in a CIRP group appeal. The Providers are misplaced in arguing that the regulatory challenge is related to any "provider specific" SSI issue that could possibly remain in an individual appeal.

Because the Systemic Errors issue was transferred to a CIRP group appeal, the Board should dismiss this aspect of Issue No. 1.

The second aspect of Issue No. 1—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is hereby dismissed by the Board for lack of jurisdiction. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting period instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. Here, each of the four Providers has a 09/30/2006 cost reporting period, which is the same as the Federal fiscal year, so there is nothing for the Providers to dispute or realign. Therefore, the Board finds that it does not

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[1] *See* Provider's Individual Appeal Request at Tab 3, Issue 1 & 2 and Appeal Request in 13-3026GC.
[2] *Id.* at Tab 3, Issue 1.
[3] *Id.*
[4] *Id.*
[5] *Id.* at Tab 3, Issue 2.
[6] *Id.*

have jurisdiction over the realignment portion of the SSI Provider Specific issue because there is no final determination with which the Providers could be dissatisfied.

Conclusion

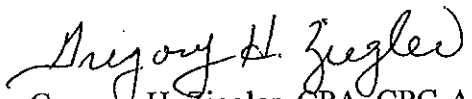
The only issue pending in these appeals is the SSI Provider Specific issue. The Board finds that the Providers' challenge to the DSH SSI regulation and statute is properly pending in a CIRP Group, and therefore dismisses that portion of the SSI Provider specific issue for all four Providers. The Board also dismisses the realignment portion of the SSI Provider Specific issue because the Providers' cost reporting year is the same as the Federal fiscal year, therefore there is nothing to dispute or realign and there is no final determination from which the Providers could be dissatisfied.

The Board denies jurisdiction over the SSI Provider Specific issue for the four above-referenced Providers. PRRB Case Nos. 16-1655; 16-1805; 16-1695; and 16-2284 are 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



Gregory H. Ziegler, CPA, CPC-A
Board Member

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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DEC 2 2 2017

CERTIFIED MAIL

Quality Reimbursement Services, Inc.
Russell Kramer
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

National Government Services, Inc.
Pam VanArsdale
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206-6744

RE: St. Vincent's Medical Center
Medicare Advantage Days in Medicare Fraction
PN: 07-0028
FYE: 9/30/2009
PRRB Case Number: 11-0794

Dear Mr. Kramer and Ms. VanArsdale,

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

Background

St. Vincent's Medical Center ("St. Vincent's" or "Provider") filed an appeal on August 25, 2011, from the untimely issuance of its Notice of Program Reimbursement ("NPR"). In the appeal request, the Provider identified the date the cost report was sent to the Medicare Contractor as March 3, 2010 and included a copy of its March 3, 2010 cost report submission at Tab 1. The sole issue initially raised in the appeal was the Medicare Advantage Days in the Medicare fraction of the DSH payment adjustment.[1] The Medicare Contractor initially filed a jurisdictional challenge on February 2, 2012 regarding the validity of the appeal as CMS had not issued the 2009 SSI ratios that are the subject of the appeal. On September 28, 2017, the Medicare Contractor filed an additional challenge stating the Provider did not file its appeal from its perfected amended cost report. The Provider responded to the Medicare Contractor's challenge on October 26, 2017.

Medicare Contractor's Position

The Medicare Contractor contends in its 2012 challenge that the appeal was invalid as the cost report under appeal had not yet been finalized and the calculation of the SSI% the Provider is challenging had not yet been released or implemented in the cost report. In the second challenge, filed in 2017, the Medicare Contractor alleges that St. Vincent's submitted an amended cost report on June 1, 2010, which was accepted by the Medicare Contractor and replaced the original filed cost report. When the Provider filed its appeal request, it was clear that it filed from the non-timely issuance of an NPR of the original March 3, 2010 cost report submission. The March 3, 2010 cost report was the only report identified on Model Form A and the only cost report pages submitted were from the March 3, 2010 filing. The

[1] *See* Model Form A-Individual Appeal Request dated August 24, 2011.

Medicare Contractor concludes that, clearly, the Provider did not file its appeal from its "perfected" or amended cost report submitted on June 1, 2010.

The Medicare Contractor states that the Provider's submission and its acceptance of an amended cost report that was received on June 1, 2010 created a new twelve month period to issue an NPR that commenced from the date of receipt of the amended cost report. This new twelve month period would run through June 1, 2011. Once the amended cost report was accepted and amended, the Medicare Contractor could not settle the initial cost report, as the amended replaced the initial.

The Medicare Contractor contends that as the Provider appealed from the untimely issuance of the NPR from the original filed cost report, it was premature as the accepted amended replaced the original filed.[2] The Medicare Contractor summarizes the sequence of events as:

Event	Date	Exhibit(JC)
Cost Report Received by MAC (Original #1)	3/3/2010	I-3, p. 1
Cost Report Received by MAC (Amended #2)	6/1/2010	I-3, p. 2
12 month deadline to issue NPR by MAC of Amended cost report	6/1/2011	I-3, p. 2 (12 months after cost report receipt date)
Deadline to appeal untimely determination (180 days from NPR deadline)	11/28/2011	
Appeal Request	8/24/2011	I-1
Deadline to timely add an issue (60 days from 11/28/2011)	1/27/2012	
Date of Provider's Preliminary Positon Paper	4/2/2012	
Date of Provider's Final Positon Paper	8/29/2017	
NPR	5/9/2013	I-4, p. 6

The Medicare Contractor further contends in its 2017 jurisdictional challenge that St. Vincent's also attempted to untimely add the Medicare Advantage days--Medicaid fraction issue to the current appeal via the Provider's preliminary and final positon papers. Even though the Provider's appeal request addresses only the Medicare fraction of the DSH calculations. Additionally, the Medicare Contractor contends St. Vincent's is also a participant member of CN 13-2566GC,Ascension Health 2009 DSH Medicaid Fraction Part C Days, and CN 13-2615GC, Ascension Health 2009 DSH Medicare Fraction Part C Days, therefore the Provider cannot also have this issue in an individual open case for the same fiscal year. The Medicare Contractor is requesting that the Board dismiss the current appeal, due to a lack of jurisdiction.[3]

[2] Medicare Contractor Jurisdictional Challenge dated September 27, 2017, Exhibit I-3 p.2.
[3] *Id.* at 4 of 5.

Provider's Position

St. Vincent's emphasizes that it filed its cost report on March 3, 2010, and then amended its cost report on June 1, 2010 with the Medicare Contractor. The twelve month deadline for the Medicare Contractor to issue the NPR was June 1, 2011. The deadline to file an appeal from a failure to issue a timely determination was November 28, 2011. St. Vincent's contends it filed its appeal on August 24, 2011 and is therefore timely. St. Vincent's further contends it inadvertently left out the documentation for the amended cost report, and will submit it under a separate cover. St. Vincent's states since its appeal was based on the filing of the June 1, 2010 amended cost report, the Board should find jurisdiction over the current appeal.

St. Vincent's agrees that it appealed the same issue in multiple appeals and contends that while the issue is identical in both appeals, the determination rights differ from a non-issuance of an NPR appeal and an appeal from an NPR. Therefore, the issues are not duplicative, as the rights under each appeal vary, and therefore each appeal is separate and distinct. St. Vincent's contends that the Board should find jurisdiction over the Part C issue in the current case.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 - 405.1840 (2011), a provider has a right to a hearing before the Board with respect to 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.

The Board finds that 42 U.S.C. § 1395oo(a)(1)(B) grants providers the opportunity to file an appeal from not timely receiving a timely NPR, therefore there is no merit to the Medicare Contractor's argument set forth in the February 2, 2012 jurisdictional challenge that the appeal was not valid due to the 2009 SSI percentages not yet being released. [4]

However, the Board finds that it does not have jurisdiction over the current appeal as the Provider filed the appeal from the submission of the as-filed cost report, as identified on the model form used to establish an individual case. Although St. Vincent argued that the appeal would be timely filed from its submission of its amended cost report, the Provider failed to appeal from that final determination. In fact, there was no mention of an amended cost report submitted at all by the Provider in the appeal request. In the appeal request, the Provider clearly states that it is filing the current appeal from the

[4] The United States District Court for the District of Columbia issued an order in *Charleston Area Med. Ctr. v. Sebelius*, No. 13-643 (RMC) (D.D.C. filed May 3, 2013) that the Board *et al.* are enjoined from applying 42 C.F.R. § 405.1835(a)(1)'s dissatisfaction requirement for Board jurisdiction to any pending or future Board appeal that, pursuant to 42 U.S.C. § 1395oo(a)(1)(B), is based on the Medicare contractor's failure to issue a timely NPR. In the Secretary's responses to the Court's May 27, 2014 and June 10, 2014 Orders to Show Cause, the Secretary made a binding concession that 42 C.F.R. § 405.1835(a)(1)'s requirement that a Medicare provider must establish its "dissatisfaction" by claiming reimbursement for the item in question in its Medicare cost report or by listing the items as a "protested amount" in its cost report, should not apply to Board appeals that are based on the provisions of the Medicare statute, 42 U.S.C § 1395oo(a)(1)(B), that provide for appeal to the Board where a Medicare contractor does not issue a timely NPR.

March 3, 2010 cost report submission. The Provider also attached the cost report certification page which also referenced March 3, 2010 (submission #1) as the date received by the "Intermediary."[5]

The Board finds that the amended cost report replaces and supersedes the originally filed cost report. To this end, the Medicare Contractor will only issue a final determination on the most recently filed and accepted cost report. So where a provider files an amended cost report that is accepted, the Medicare Contractor will not issue a final determination for any previously filed cost report.[6]

The Board's finding is supported by the regulation 42 C.F.R. § 405.1803(a) which requires that "[u]pon receipt of a provider's cost report, or amended cost report where permitted or required, the contractor must within a reasonable period of time (as described in [§ 405.1835(c)(1)]), furnish the provider . . . a written notice reflecting the contractor's determination of the total amount of reimbursement . . . ." Section 405.1835(c)(1) provides for a right to appeal 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 (as specified in § 413.24(f) of this chapter)."[7] If a provider files (and the Medicare Contractor accepts) an amended cost report, then the provider is clearly at "fault" for the Medicare Contractor's inability to issue a final determination on the relevant cost reporting period.

Based on this rationale, the Board finds that it does not have jurisdiction over the current Provider appeal since the appeal was filed based on as-filed cost reports, but the Provider subsequently submitted an amended cost report that was accepted. The Provider could have timely filed an appeal from not receiving a timely issued NPR from the amended cost report filing, but failed to do so. Each final determination is a distinct determination, and each must be appealed separately.[8] As there are no remaining issues in this current appeal the case is hereby closed and removed from the Board's docket.

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

Board Members Participating

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

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[5] Model Form A Individual Appeal Request dated August 24, 2011.
[6] Note that filing an amended cost report occurs before a final determination is issued. If a final determination has been issued and a provider seeks a change to its reimbursement, it must file a request to reopen under the provisions of 42 C.F.R. § 405.1885 and the Medicare Contractor must agree to reopen the provider's cost report. This is a separate process from filing an amended cost report.
[7] Emphasis added.
[8] The Provider also filed an appeal of the Medicare Advantage Days in the numerator and the denominator of the SSI fraction from the NPR issued on May 5, 2013. The Provider's appeal is pending in 13-2556GC and 13-2615GC. No jurisdictional review had been completed for the provider as part of those group appeals at this time.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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DEC 2 2 2017

CERTIFIED MAIL

Community Health Systems, Inc.
Nathan Summar
Vice President Revenue Management
4000 Meridian Boulevard
Franklin, TN 37067

Wisconsin Physicians Service
Byron Lamprecht
Cost Report Appeals
2525 N 117th Avenue, Suite 200
Omaha, NE 68164

RE: North Okaloosa Medical Center, 10-0122, 03/31/2006, CN 16-2573
Greenbriar Valley Medical Center, 51-0002, 04/30/2006, CN 17-0120
Eastern New Mexico Medical Center, 32-0006, 05/31/2006, CN 17-0056
Lakeway Regional Hospital, 44-0067, 05/31/2006, CN 17-0122
Lutheran Hospital of Indiana, 15-0017, 06/30/2006, CN 17-0118
Chestnut Hill Hospital, 39-0026, 06/30/2006, CN 17-0131
Brandywine Hospital, 39-0076, 06/30/2006, CN 17-0132
Jennersville Regional Hospital, 39-0220, 06/30/2006, CN 17-0123
St. Mary's Regional Medical Center, 04-0041, 08/31/2006, CN 17-0164
National Park Medical Center, 04-0078, 08/31/2006, CN 17-0344
Abilene Regional Medical Center, 45-0558, 08/31/2006, CN 16-2286
South Baldwin Regional Medical Center, 01-0083, 09/30/2006, CN 16-2209
Northwest Medical Center, 04-0022, 10/31/2006, CN 16-2252
Hillcrest Hospital Claremore, 37-0039, 10/31/2006, CN 16-2235
Hillcrest Hospital South, 37-0202, 12/31/2006, CN 16-2287
Williamette Valley Medical Center, 38-0071, 12/31/2006, CN 16-2288
Navarro Regional Hospital, 45-0447, 12/31/2006, CN 16-2424

Dear Mr. Summar and Mr. Lamprecht,

Each of the Providers listed above appealed a Revised Notice of Program Reimbursement (RNPR) for a 2006 cost reporting period. Each of the RNPRs was issued to include the most recent SSI percentage recalculated by CMS (post-2011 Final Rule with new data matching).

Each of the Providers filed individual appeals with one issue: 1) *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* issue. Each of the Providers also appealed the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage* Issue directly into PRRB Case No. 13-0605GC Community Health Systems (CHS) 2006 Post 1498R SSI Data Match Group.

Board's Decision

Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)

Although the Medicare Contractor did not challenge jurisdiction over this issue, the Board finds that it does not have jurisdiction over the SSI Provider Specific issue for any of the above-referenced Providers. The jurisdictional analysis for the SSI Provider Specific issue has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the Systemic Errors issue that was directly added to 13-0605GC and is dismissed by the Board.[1] The DSH Payment/SSI Percentage (Provider Specific) issue concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital Calculation."[2] The Providers' legal basis for Issue No. 1 also asserts 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)."[3] The Providers argue that "its SSI percentage published by [CMS] was incorrectly computed . . . ." and it ". . . specifically disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[4]

The Providers' Systemic Errors group issue is, "The failure of the [Medicare Contractor] 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. . . ."[5] Thus, the Provider's disagreement with how the Medicare Contractor calculated the SSI percentage that would be used for the DSH percentage is duplicative of the Systemic Errors issue that has filed directly into a group appeal.

The issue of how CMS interpreted its regulation is not an issue that applies "specifically" to one Provider; the issue applies to ALL SSI calculations. Because the Providers at issue here are Common Issue Related Party ("CIRP") Providers, they are required by regulation to pursue the common issue in a group appeal.[6] Because each of the above-referenced Providers directly added the Systemic Errors issue to a CIRP group appeal, the Board hereby dismisses the first

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[1] *See* Provider's Individual Appeal Request at Tab 3 and Appeal Request in 13-0605GC.
[2] *Id.* at Tab 3.
[3] *Id.*
[4] *Id.*
[5] Issue Statement in PRRB Case No. 13-0605GC.
[6] 42 C.F.R. § 405.1837(b)(1)(i).

portion of the SSI Provider Specific issue because it is duplicative of the SSI Systemic Errors issue.

The second aspect of the Provider Specific issue – the Providers preserving their right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period – is hereby dismissed by the Board for lack of jurisdiction. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied for appeal purposes. Furthermore, one of the Providers, South Baldwin, has a 09/30/2006 cost reporting period, therefore its SSI percentage has already been calculated based on the Federal fiscal year end. Therefore, there is not dispute for South Baldwin as it cannot request realignment. Based on this reasoning, the Board finds that it does not have jurisdiction over the realignment portion of the Providers' issue statements.

Conclusion

The only issue filed in these appeals is the SSI Provider Specific issue and the Board finds that it does not have jurisdiction over this issue for the seventeen above-referenced Providers. The Board finds that the Providers' challenges to the DSH SSI regulation and statute are properly pending in a CIRP Group and therefore dismisses that portion of the issue for these individual appeals. With respect to the potential requests for realignment, the Board finds that it does not have jurisdiction over this portion of the issue and hereby dismisses it from the above-referenced appeals. PRRB Case Nos. 16-2573; 17-0120; 17-0056; 17-0122; 17-0118; 17-0131; 17-0132; 17-0123; 17-0164; 17-0344; 16-2286; 16-2209; 16-2252; 16-2235; 16-2287; 16-2288; and 16-2424 are 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

Charlotte Benson for

Gregory H. Ziegler, CPA, CPC-A
Board Member

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
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410-786-2671

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RE: DeTar Hospital Navarro, 45-0147, 09/30/2005, CN 17-0481
Laredo Medical Center, 45-0029, 09/30/20005, CN 17-0482
Valley Hospital & Medical Center, 50-0119, 12/31/2005, CN 17-0510
Memorial Hospital of Salem County, 31-0091, 12/31/2005, CN 17-0409
Mineral Area Regional Medical Center, 26-0116, 12/31/2005, CN 17-0486
Lea Regional Medical Center, 32-0065, 12/31/2005, CN 16-2026
College Station Medical Center, 45-0299, 10/31/2005, CN 17-0445

Dear Mr. Summar and Mr. Lamprecht,

Each of the Providers listed above appealed a Revised Notice of Program Reimbursement (RNPR) for a 2005 cost reporting period. Each of the RNPRs was issued to include the most recent SSI percentage recalculated by CMS (post-2011 Final Rule with new data matching).

Each of the Providers filed individual appeals with two issues: 1) *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* and 2) Medicaid Eligible Days.

All of the Providers also appealed the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage* Issue directly into PRRB Case No. 16-1489GC Community Health Systems (CHS) 2005 Post 1498R SSI Data Match Group.

Board's Decision

Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)

Although the Medicare Contractor did not challenge jurisdiction over this issue, the Board finds that it does not have jurisdiction over the SSI Provider Specific issue for any of the above-referenced Providers. The jurisdictional analysis for the SSI Provider Specific issue has two

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

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the Systemic Errors issue that was directly added to 16-1489GC and is dismissed by the Board.[1] The DSH Payment/SSI Percentage (Provider Specific) issue concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital Calculation."[2] The Providers' legal basis for Issue No. 1 also asserts 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)."[3] The Providers argue that "its SSI percentage published by [CMS] was incorrectly computed . . . ." and it ". . . specifically disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[4]

The Providers' Systemic Errors group issue is, "The failure of the [Medicare Contractor] 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. . . ."[5] Thus, the Providers' disagreement with how the Medicare Contractor calculated the SSI percentage that would be used for the DSH percentage is duplicative of the Systemic Errors issue that has filed directly into a group appeal.

The issue of how CMS interpreted its regulation is not an issue that applies "specifically" to one Provider; the issue applies to ALL SSI calculations. Because the Providers at issue here are Common Issue Related Party ("CIRP") Providers, they are required by regulation to pursue the common issue in a group appeal.[6] Because each of the above-referenced Providers directly added the Systemic Errors issue to a CIRP group appeal, the Board hereby dismisses the first portion of the SSI Provider Specific issue because it is duplicative of the SSI Systemic Errors issue.

The second aspect of the Provider Specific issue – the Providers preserving their right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period – is hereby dismissed by the Board for lack of jurisdiction. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a

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[1] *See* Provider's Individual Appeal Request at Tab 3 and Appeal Request in 16-1489GC.
[2] *Id.* at Tab 3.
[3] *Id.*
[4] *Id.*
[5] Issue Statement in PRRB Case No. 16-1489GC.
[6] 42 C.F.R. § 405.1837(b)(1)(i).

written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied for appeal purposes. Furthermore, two of the Providers, DeTar Hospital Navarro and Laredo Medical Center, have a 09/30/2005 cost reporting period, therefore their SSI percentages will be calculated on the Federal fiscal year even if they requested a realignment (because their cost reporting year is the Federal fiscal year). Therefore, there is no dispute for DeTar Hospital Navarro and Laredo Medical Center. Based on this reasoning, the Board finds that it does not have jurisdiction over the realignment portion of the Providers' issue statements.

Disproportionate Share Hospital (DSH) Payment – Medicaid Eligible Days

The Board finds that it does not have jurisdiction over the Medicaid Eligible Days issue for any of the above-referenced Providers because they all appealed from RNPRs that did not specifically adjust Medicaid eligible days.

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.
> >
> > (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 RNPR. Here, the Providers' RNPRs each only adjusted the SSI percentage. As Medicaid eligible days were not specifically adjusted, the Board finds that it does not have jurisdiction over the Medicaid Days issue in any of the appeals.

Conclusion

The Board finds that it does not have jurisdiction over the SSI Provider Specific or Medicaid eligible days issues in any of the above-referenced appeals. The Board finds that the Providers' challenges to the DSH SSI regulation and statute are properly pending in a CIRP Group and therefore dismisses that portion of the issue for these individual appeals. With respect to the potential requests for realignment, the Board finds that it does not have jurisdiction over this portion of the issue and hereby dismisses it from the above-referenced appeals. Finally, the Board finds that it does not have jurisdiction over the Medicaid eligible days issue because all of the Providers appealed from RNPRs that did not adjust eligible days.

PRRB Case Nos. 17-0481, 17-0482, 17-0510, 17-0409, 17-0486, 16-2026, and 17-0445 are 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

Charlotte Benson for

L. Sue Andersen, Esq.
Chairperson

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

cc: Wilson Leong, FSS

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RE: Northwest Medical Center—Bentonville
Provider No. 04-0022
FYE 10/31/2010
PRRB Case No. 16-1754

Dear Mr. Summar and Mr. Lamprecht,

Northwest Medical Center – Bentonville, the Provider, appealed a Revised Notice of Program Reimbursement (RNPR) for the 10/31/2010 cost reporting period. The RNPR, issued on November 30, 2015, was issued to revise NPR payments and to record overpayments that were submitted with the as-filed cost reports.

The Provider filed the appeal with two issues: 1) *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* and 2) *Disproportionate Share Hospital (DSH) Payment – Medicaid Eligible Days.*

Board's Decision

The Board finds that it does not have jurisdiction over either the SSI Provider Specific or the Medicaid Eligible Days issues because the Provider appealed from a RNPR that did not specifically adjust the SSI percentage or Medicaid eligible days.

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.
>
> (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 RNPR. Here, the Provider's RNPR only adjusted NPR payments and overpayments that had not been previously recorded properly. The Provider indicated that both issues were "self-disallowed" and did not cite to an audit adjustment in its appeal request. Because neither issue under appeal was specifically adjusted in the RNPR, the Board finds that it does not have jurisdiction over the SSI Provider Specific or the Medicaid Eligible Days issues.

Conclusion

The only issues that remain pending in this appeal are the SSI Provider Specific and Medicaid eligible days issues. The Board finds that it does not have jurisdiction over either issue as neither were adjusted in the RNPR, therefore the Board does not have jurisdiction pursuant to 42 C.F.R. § 405.1889. PRRB Case Nos. 16-1754 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

Charlotte Benson for

L. Sue Andersen, Esq.
Chairperson

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
cc: Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: Heart of Florida Regional Medical Center
Provider No. 10-0137
FYE 6/30/2010
PRRB Case No. 17-2122

Dear Mr. Summar and Mr. Lamprecht,

Heart of Florida Regional Medical Center, the Provider, appealed a Revised Notice of Program Reimbursement (RNPR) for the 6/30/2010 cost reporting period. The RNPR, issued on March 3, 2017, was issued to include allowable Medicaid eligible days and to remove non-allowable Medicaid eligible days from the cost report.

The Provider filed the appeal with two issues: 1) *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* and 2) *Disproportionate Share Hospital (DSH) Payment – SSI%.*

Board's Decision

The Board finds that it does not have jurisdiction over either issue in this appeal because the Provider appealed from a RNPR that did not specifically adjust the SSI percentage.

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.
>
> (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 RNPR. Here, the Provider's RNPR only adjusted Medicaid eligible days, and did not adjust the SSI percentage. The Provider referenced the eligible day adjustments as the adjustments under appeal in its appeal request. Because the SSI percentage was not specifically adjusted in the RNPR, the Board finds that it does not have jurisdiction over either issue under appeal.

Conclusion

The only issues pending in this appeal are the SSI Provider Specific and SSI Systemic Errors issues. The Board finds that it does not have jurisdiction over either issue as the SSI percentage was not adjusted in the RNPR. PRRB Case No. 17-2122 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

Charlotte Benson for

L. Sue Andersen, Esq.
Chairperson

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
cc: Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: Hartselle Medical Center, 01-0009, 1/31/2006, CN 16-2197
Kosciusko Community Hospital, 15-0133, 02/28/2006, CN 17-0681
Southside Regional Medical Center, 49-0067, 02/28/2006, CN 17-0432
Dupont Hospital LLC, 15-0150, 03/31/2006, CN 17-0444
Mountain View Regional Medical Center, 32-0085, 03/31/2006, CN 17-0130
Western Arizona Regional Medical Center, 03-0101, 08/31/2006, CN 17-0431
San Angelo Community Medical Center, 45-0340, 08/31/2006, CN 16-2055
DeTar Hospital Navarro, 45-0147, 09/30/2006, CN 16-2285

Dear Mr. Summar and Mr. Lamprecht,

Each of the Providers listed above appealed a Revised Notice of Program Reimbursement (RNPR) for a 2006 cost reporting period. Each of the RNPRs was issued to include the most recent SSI percentage recalculated by CMS (post-2011 Final Rule with new data matching).

Each of the Providers filed individual appeals with two issues: 1) *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* and 2) Medicaid Eligible Days.

All of the Providers also appealed the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage* Issue directly into PRRB Case No. 13-0605GC Community Health Systems (CHS) 2006 Post 1498R SSI Data Match Group.

Board's Decision

Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)

Although the Medicare Contractor did not challenge jurisdiction over this issue, the Board finds that it does not have jurisdiction over the SSI Provider Specific issue for any of the above-

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

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the Systemic Errors issue that was directly added to 13-0605GC and is dismissed by the Board.[1] The DSH Payment/SSI Percentage (Provider Specific) issue concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital Calculation."[2] The Providers' legal basis for Issue No. 1 also asserts 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)."[3] The Providers argue that "its SSI percentage published by [CMS] was incorrectly computed . . . ." and it ". . . specifically disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[4]

The Providers' Systemic Errors group issue is, "The failure of the [Medicare Contractor] 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. . . ."[5] Thus, the Providers' disagreement with how the Medicare Contractor calculated the SSI percentage that would be used for the DSH percentage is duplicative of the Systemic Errors issue that has filed directly into a group appeal.

The issue of how CMS interpreted its regulation is not an issue that applies "specifically" to one Provider; the issue applies to ALL SSI calculations. Because the Providers at issue here are Common Issue Related Party ("CIRP") Providers, they are required by regulation to pursue the common issue in a group appeal.[6] Because each of the above-referenced Providers directly added the Systemic Errors issue to a CIRP group appeal, the Board hereby dismisses the first portion of the SSI Provider Specific issue because it is duplicative of the SSI Systemic Errors issue.

The second aspect of the Provider Specific issue – the Providers preserving their right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period – is hereby dismissed by the Board for lack of jurisdiction. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting

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[1] *See* Provider's Individual Appeal Request at Tab 3 and Appeal Request in 13-0605GC.
[2] *Id.* at Tab 3.
[3] *Id.*
[4] *Id.*
[5] Issue Statement in PRRB Case No. 13-0605GC.
[6] 42 C.F.R. § 405.1837(b)(1)(i).

data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied for appeal purposes. Furthermore, one of the Providers, DeTar Hospital Navarro, has a 09/30/2006 cost reporting period, therefore its SSI percentage will be calculated on the Federal fiscal year even if it requested a realignment (because its cost reporting year is the Federal fiscal year). Therefore, there is no dispute for DeTar Hospital Navarro. Based on this reasoning, the Board finds that it does not have jurisdiction over the realignment portion of the Providers' issue statements.

Disproportionate Share Hospital (DSH) Payment – Medicaid Eligible Days

The Board finds that it does not have jurisdiction over the Medicaid Eligible Days issue for any of the above-referenced Providers because they all appealed from RNPRs that did not specifically adjust Medicaid eligible days.

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.
> >
> > (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 RNPR. Here, the Providers' RNPRs each only adjusted the SSI percentage. As Medicaid eligible days were not specifically adjusted, the Board finds that it does not have jurisdiction over the Medicaid Days issue in any of the appeals.

Conclusion

The Board finds that it does not have jurisdiction over the SSI Provider Specific or Medicaid eligible days issues in any of the above-referenced appeals. The Board finds that the Providers' challenges to the DSH SSI regulation and statute are properly pending in a CIRP Group and therefore dismisses that portion of the issue for these individual appeals. With respect to the potential requests for realignment, the Board finds that it does not have jurisdiction over this portion of the issue and hereby dismisses it from the above-referenced appeals. Finally, the Board finds that it does not have jurisdiction over the Medicaid eligible days issue because all of the Providers appealed from RNPRs that did not adjust eligible days.

PRRB Case Nos. 16-2197; 17-0681; 17-0432; 17-0444; 17-0130; 17-0431; 16-2055; and 16-2285 are 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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DEC 28 2017

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Wisconsin Physicians Service
Byron Lamprecht
Cost Report Appeals
2525 N 117th Avenue, Suite 200
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RE: Tennova Healthcare Lebanon (University)
Provider No. 44-0193
FYE 10/31/2006
PRRB Case No. 16-2181

Dear Mr. Summar and Mr. Lamprecht,

Tennova Healthcare Lebanon, the Provider, appealed a Revised Notice of Program Reimbursement (RNPR) for the 10/31/2006 cost reporting period. The RNPR was issued to include the most recent SSI percentage recalculated by CMS (post-2011 Final Rule with new data matching). The RNPR was issued on February 16, 2016.

The Provider filed the appeal with 9 issues. All of the issues, except for issues #1 and #7, were transferred to group appeals. The issues that remain pending in this appeal are: 1.) *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* and 7.) *Disproportionate Share Hospital (DSH) Payment – Medicaid Eligible Days.*

Board's Decision

Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)

Although the Medicare Contractor did not challenge jurisdiction over this issue, the Board finds that it does not have jurisdiction over the SSI Provider Specific issue for the Provider. The jurisdictional analysis for the SSI Provider Specific issue has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the Systemic Errors issue that was directly added to 13-3026GC and is dismissed by the Board.[1] The DSH Payment/SSI Percentage (Provider Specific) issue concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital Calculation."[2] The Providers' legal basis for Issue No. 1 also asserts 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)."[3] The Providers argue that "its SSI percentage published by [CMS] was incorrectly computed . . . ." and it ". . . specifically disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[4]

The Systemic Errors group issue is, "The failure of the [Medicare Contractor] 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. . . ."[5] Thus, the Providers' disagreement with how the Medicare Contractor calculated the SSI percentage that would be used for the DSH percentage is duplicative of the Systemic Errors issue that has filed directly into a group appeal.

The issue of how CMS interpreted its regulation is not an issue that applies "specifically" to one Provider; the issue applies to ALL SSI calculations. Because the Provider at issue here is a Common Issue Related Party ("CIRP") Provider, it is required by regulation to pursue the common issue in a group appeal.[6] Because the Provider transferred the Systemic Errors issue to a CIRP group appeal, the Board hereby dismisses the first portion of the SSI Provider Specific issue because it is duplicative of the SSI Systemic Errors issue.

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

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[1] *See* Provider's Individual Appeal Request at Tab 3, Issue 1 & 2 and Appeal Request in 13-3026GC.
[2] *Id.* at Tab 3.
[3] *Id.*
[4] *Id.*
[5] Issue Statement in PRRB Case No. 13-0605GC.
[6] 42 C.F.R. § 405.1837(b)(1)(i).

Disproportionate Share Hospital (DSH) Payment – Medicaid Eligible Days

The Board finds that it does not have jurisdiction over the Medicaid Eligible Days issue for the Provider because it appealed from a RNPR that did not specifically adjust Medicaid eligible days.

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.
>
> (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 RNPR. Here, the Provider's RNPR only adjusted the SSI percentage. As Medicaid eligible days were not specifically adjusted, the Board finds that it does not have jurisdiction over the Medicaid Days issue.

Conclusion

The only issues that remain pending in this appeal are the SSI Provider Specific and Medicaid eligible days issues. The Board finds that it does not have jurisdiction over the SSI Provider Specific or Medicaid eligible days issues. The Board finds that the Provider's challenge to the DSH SSI regulation and statute is properly pending in a CIRP Group and therefore dismisses that portion of the issue. With respect to the potential request for realignment, the Board finds that it does not have jurisdiction over this portion of the issue and hereby dismisses it from the appeal.

Finally, the Board finds that it does not have jurisdiction over the Medicaid eligible days issue because the Provider appealed from a RNPR that did not adjust eligible days.

PRRB Case Nos. 16-2181 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

Charlotte Benson for

L. Sue Andersen, Esq.
Chairperson

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

cc: Wilson Leong, FSS

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DEC 29 2017

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

RE: Gadsden Regional Medical Center
Provider No. 01-0040
FYE 12/31/2005
PRRB Case No. 17-0779

Dear Mr. Summar and Ms. Hinkle,

Gadsden Regional Medical Center, the Provider, appealed a Revised Notice of Program Reimbursement (RNPR) for the 12/31/2005 cost reporting period. The RNPR, issued on July 13, 2016, was issued to include the most recent SSI percentage recalculated by CMS (post-2011 Final Rule with new data matching).

The Provider filed the appeal with two issues: 1) *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* and 2) *Disproportionate Share Hospital (DSH) Payment – SSI%.*

The Provider also appealed the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Systemic Errors)* issue directly into PRRB Case No. 16-1489GC, Community Health Systems (CHS) 2005 Post-1498R SSI Data Match Group.

Board's Decision

Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)

Although the Medicare Contractor did not challenge jurisdiction over this issue, the Board finds that it does not have jurisdiction over the SSI Provider Specific issue in this appeal. The jurisdictional analysis for the SSI Provider Specific issue has two relevant aspects to consider: 1)

the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the Systemic Errors issue that was directly added to case no. 16-1489GC and is dismissed by the Board.[1] The DSH Payment/SSI Percentage (Provider Specific) issue concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital Calculation."[2] The Providers' legal basis for Issue No. 1 also asserts 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)."[3] The Providers argue that "its SSI percentage published by [CMS] was incorrectly computed . . . ." and it ". . . specifically disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[4]

The Providers' Systemic Errors group issue is, "The failure of the [Medicare Contractor] 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. . . ."[5] Thus, the Provider's disagreement with how the Medicare Contractor calculated the SSI percentage that would be used for the DSH percentage is duplicative of the Systemic Errors issue that has filed directly into a group appeal.

The issue of how CMS interpreted its regulation is not an issue that applies "specifically" to one Provider; the issue applies to ALL SSI calculations. Because the Providers at issue here are Common Issue Related Party ("CIRP") Providers, they are required by regulation to pursue the common issue in a group appeal.[6] Because each of the above-referenced Providers directly added the Systemic Errors issue to a CIRP group appeal, the Board hereby dismisses the first portion of the SSI Provider Specific issue because it is duplicative of the SSI Systemic Errors issue.

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

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[1] *See* Provider's Individual Appeal Request at Tab 3 and Appeal Request in 16-1489GC.
[2] *Id.* at Tab 3.
[3] *Id.*
[4] *Id.*
[5] Issue Statement in PRRB Case No. 16-1489GC.
[6] 42 C.F.R. § 405.1837(b)(1)(i).

determination from which the Provider can be dissatisfied for appeal purposes. Based on this reasoning, the Board finds that it does not have jurisdiction over the realignment portion of the Provider's issue statement.

Disproportionate Share Hospital Payment/Supplemental Security Income (SSI) Percentage

The Provider included the challenge to the SSI data as the second issue in its appeal request and also appealed the same issue directly into PRRB Case No. 16-1489GC. The Board hereby dismisses this issue from the Provider's individual appeal because the issue is properly pending in the CIRP group and the issue cannot be pending in more than one appeal pursuant to PRRB Rule 4.5.

Conclusion

The only issues pending in this appeal are the SSI Provider Specific and SSI Systemic Errors issues and the Board finds that it does not have jurisdiction over either issue. The Board finds that the Provider's challenge to the DSH SSI regulation and statute is properly pending in a CIRP Group and therefore dismisses that portion of the SSI Provider Specific issue. With respect to the potential requests for realignment, the Board finds that it does not have jurisdiction over this portion of the issue and hereby dismisses it from the above-referenced appeals. Finally, the Board dismisses the second issue in the appeal because it is properly pending in a CIRP group.

PRRB Case No. 17-0779 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

Charlotte Benson for

L. Sue Andersen, Esq.
Chairperson

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

cc: Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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DEC 29 2017

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RE: Woodland Heights Medical Center
Provider No. 45-0484
FYE 12/31/2005
PRRB Case No. 16-2348

Dear Mr. Summar and Mr. Lamprecht,

Woodland Heights Medical Center, the Provider, appealed a Revised Notice of Program Reimbursement (RNPR) for the 12/31/2005 cost reporting period. The RNPR, issued on March 4, 2016, was issued to include the most recent SSI percentage recalculated by CMS (post-2011 Final Rule with new data matching). The Provider filed an appeal with 1 issue: 1.) *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific).*

The Provider received a second RNPR on February 8, 2017. This RNPR was issued to "include allowable remanded Medicaid L&D days and to recalculate the DSH payment due to those additional days." The Provider filed an appeal of that RNPR with two issues: 1.) *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* and 2.) *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage*. The appeal from the second RNPR was incorporated into PRRB Case No. 16-2348.

The Provider also appealed the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Systemic Errors)* issue directly into PRRB Case No. 16-1489GC, Community Health Systems (CHS) 2005 Post-1498R SSI Data Match Group.

Board's Decision

Appeal from March 4, 2016 RNPR
Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)

Although the Medicare Contractor did not challenge jurisdiction over this issue, the Board finds that it does not have jurisdiction over the SSI Provider Specific issue in this appeal. The jurisdictional analysis for the SSI Provider Specific issue has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the Systemic Errors issue that was directly added to case no. 16-1489GC and is dismissed by the Board.[1] The DSH Payment/SSI Percentage (Provider Specific) issue concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital Calculation."[2] The Providers' legal basis for Issue No. 1 also asserts 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)."[3] The Providers argue that "its SSI percentage published by [CMS] was incorrectly computed . . . ." and it ". . . specifically disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[4]

The Providers' Systemic Errors group issue is, "The failure of the [Medicare Contractor] 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. . . ."[5] Thus, the Provider's disagreement with how the Medicare Contractor calculated the SSI percentage that would be used for the DSH percentage is duplicative of the Systemic Errors issue that has filed directly into a group appeal.

The issue of how CMS interpreted its regulation is not an issue that applies "specifically" to one Provider; the issue applies to ALL SSI calculations. Because the Providers at issue here are Common Issue Related Party ("CIRP") Providers, they are required by regulation to pursue the common issue in a group appeal.[6] Because each of the above-referenced Providers directly added the Systemic Errors issue to a CIRP group appeal, the Board hereby dismisses the first

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[1] *See* Provider's Individual Appeal Request at Tab 3 and Appeal Request in 16-1489GC.
[2] *Id.* at Tab 3.
[3] *Id.*
[4] *Id.*
[5] Issue Statement in PRRB Case No. 13-0605GC.
[6] 42 C.F.R. § 405.1837(b)(1)(i).

portion of the SSI Provider Specific issue because it is duplicative of the SSI Systemic Errors issue.

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

February 8, 2017 RNPR

The Board finds that it does not have jurisdiction over either issue appealed from the second RNPR because the RNPR did not specifically adjust the SSI percentage.

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.
> >
> > (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 RNPR. Here, the Provider's RNPR only adjusted labor and Delivery Days and did not

revise the SSI percentage. As the RNPR is a distinct determination, and only matters specifically adjusted can be appealed from a RNPR, the Board finds that it does not have jurisdiction over the two SSI percentage issues appealed from the February 8, 2017 RNPR.

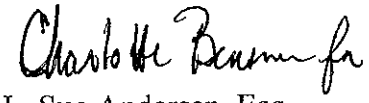
Conclusion

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue appealed from the March 4, 2016 RNPR and dismisses the issue from this appeal. The Board also finds that it does not have jurisdiction over the SSI Provider Specific and SSI Systemic Errors issues appealed from the February 8, 2017 RNPR and dismisses the issues from this appeal. PRRB Case No. 16-2348 is hereby closed and removed from the Board's docket as no issues remain pending in the appeal.

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

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

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RE: Tennova Healthcare Regional Jackson
Provider No. 44-0189
FYE 12/31/2005
PRRB Case No. 16-2279

Dear Mr. Summar and Mr. Lamprecht,

Tennova Healthcare Regional Jackson, the Provider, appealed a Revised Notice of Program Reimbursement (RNPR) for the 12/31/2005 cost reporting period. The RNPR, issued on February 19, 2016, was issued to include the most recent SSI percentage recalculated by CMS (post-2011 Final Rule with new data matching).

The Provider filed the appeal with two issues: 1) *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* and 2) *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage.*

The Provider also appealed the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Systemic Errors)* issue directly into PRRB Case No. 16-1489GC, Community Health Systems (CHS) 2005 Post-1498R SSI Data Match Group.

Board's Decision

Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)

Although the Medicare Contractor did not challenge jurisdiction over this issue, the Board finds that it does not have jurisdiction over the SSI Provider Specific issue in this appeal. The jurisdictional analysis for the SSI Provider Specific issue has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that

would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the Systemic Errors issue that was directly added to case no. 16-1489GC and is dismissed by the Board.[1] The DSH Payment/SSI Percentage (Provider Specific) issue concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital Calculation."[2] The Providers' legal basis for Issue No. 1 also asserts 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)."[3] The Providers argue that "its SSI percentage published by [CMS] was incorrectly computed . . . ." and it ". . . specifically disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[4]

The Providers' Systemic Errors group issue is, "The failure of the [Medicare Contractor] 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. . . ."[5] Thus, the Provider's disagreement with how the Medicare Contractor calculated the SSI percentage that would be used for the DSH percentage is duplicative of the Systemic Errors issue that has filed directly into a group appeal.

The issue of how CMS interpreted its regulation is not an issue that applies "specifically" to one Provider; the issue applies to ALL SSI calculations. Because the Providers at issue here are Common Issue Related Party ("CIRP") Providers, they are required by regulation to pursue the common issue in a group appeal.[6] Because each of the above-referenced Providers directly added the Systemic Errors issue to a CIRP group appeal, the Board hereby dismisses the first portion of the SSI Provider Specific issue because it is duplicative of the SSI Systemic Errors issue.

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

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[1] *See* Provider's Individual Appeal Request at Tab 3 and Appeal Request in 16-1489GC.
[2] *Id.* at Tab 3.
[3] *Id.*
[4] *Id.*
[5] Issue Statement in PRRB Case No. 13-0605GC.
[6] 42 C.F.R. § 405.1837(b)(1)(i).

reasoning, the Board finds that it does not have jurisdiction over the realignment portion of the Provider's issue statement.

Disproportionate Share Hospital Payment/Supplemental Security Income (SSI) Percentage

The Provider included the challenge to the SSI data as the second issue in its appeal request and also appealed the same issue directly into PRRB Case No. 16-1489GC. The Board hereby dismisses this issue from the Provider's individual appeal because the issue is properly pending in the CIRP group and the issue cannot be pending in more than one appeal pursuant to PRRB Rule 4.5.

Conclusion

The only issues pending in this appeal are the SSI Provider Specific and SSI Systemic Errors issues and the Board finds that it does not have jurisdiction over either issue. The Board finds that the Provider's challenge to the DSH SSI regulation and statute is properly pending in a CIRP Group and therefore dismisses that portion of the SSI Provider Specific issue. With respect to the potential requests for realignment, the Board finds that it does not have jurisdiction over this portion of the issue and hereby dismisses it from the above-referenced appeals. Finally, the Board dismisses the second issue in the appeal because it is properly pending in a CIRP group.

PRRB Case No. 16-2279 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

Charlotte Benson for

L. Sue Andersen, Esq.
Chairperson

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

cc: Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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DEC 29 2017

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Arcadia, CA 91006

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

RE: Jurisdictional Determination
Valdese General Hospital
Provider No.: 11-0034
FYE: 06/30/2010 and 6/30/2012
PRRB Case Nos.: 15-1427 and 16-1785

Dear Mr. Ravindran and Ms. Polson:

On February 12, 2015 and May 25, 2016, the Board received Valdese General Hospital's ("Valdese") timely filed Requests for Hearing based upon the original notices of program reimbursement ("NPRs") for the cost reporting periods ending on 06/30/2010 and 06/30/2012. The Provider appealed numerous issues, but prior to the Preliminary Position Papers, transferred all issues but two to group appeals, briefing only: (1) Disproportionate Share Hospital ("DSH") Payment—Medicaid Eligible Days, and (2) DSH Payment—SSI percentage (provider-specific). By letters dated August 23, 2017 Valdese withdrew the Medicaid Eligible Days issue from the instant appeals, leaving only the Provider-Specific SSI Percentage issue as the sole remaining issue within the appeals.

Valdese previously appealed in their individual appeals, and transferred to group appeals, the SSI Systemic errors issue. The "SSI Percentage - Systemic" issue transferred to 14-2601GC (2010) and 16-1141G (2012) were described as follows:

> The Providers contend that the [Medicare contractor]'s determination[s] of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute . . . The Providers further contend that the SSI percentages calculated by [CMS] [do] not address all the deficiencies as described in *Baystate Medical Center v. Leavitt*[1] . . . and incorporate[ ] a new methodology inconsistent with the Medicare statute.

[1] 545 F. Supp. 2d 20 (D.D.C 2008), *as amended*, 587 F. Supp. 2d 37 (D.D.C. 2008).

The Providers challenge their SSI percentages based on the following reasons:

1. Availability of MEDPAR and SSA records,
2. Paid days vs. Eligible days,
3. Not in agreement with provider's records,
4. Fundamental problems in the SSI percentage calculation[,]
5. Covered days vs. Total days,
6. Non-covered days, i.e., Exhausted Benefit ("EB"), Medicare Secondary Payor ("MSP") Days [a]nd Medicare Advantage, Medicare Managed Care, Medicare+Choice and/or Part C Days (Collectively "MA") Days,
7. CMS Ruling 1498-R and
8. Failure to adhere to required notice and comment rulemaking procedures in adopting policy on EB, MSP and MA days.

In the instant appeals, Valdese describes its Provider-Specific SSI percentage issue in the following manner:

> The Provider contends that the [Medicare contractor] did not determine Medicare DSH reimbursement in accordance with the Statutory instructions . . . Specifically, the Provider disagrees with the [Medicare contractor]'s calculation of the computation of the DSH percentage . . .
>
> The Provider contends that its[ ] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the [Medicare contractor] are both flawed. The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).

Board's Decision

The SSI systematic issue transferred to 14-2601GC (2010) and 15-3319GC (2012) recites a fairly comprehensive list of patient scenarios (paid v. eligible, covered v. total, non-covered) in which particular inpatient days may not have been included in the participants' SSI percentage calculations. In addition, this issue statement also lists a number of arguments (availability of records, records not in agreement) as to why its participants may not have a complete list of SSI-eligible patients. As such, in comparing the two SSI issue statements for SSI provider specific and

the SSI systemic, the issue statements describe the same SSI underlying data accuracy issue and CMS' failure to include all "entitled" patients. As Valdese is currently a participant in a group appeal and seeks to also challenge the accuracy of the data, its completeness and its failure to include all "entitled" patients, Valdese has appealed the same issue twice from the same original NPR for the same cost reporting period. The Board hereby dismisses the first portion of the SSI Provider Specific issue because it is duplicative of the SSI Systemic Errors issue residing in the group appeals.

As far as Valdese's additional wording in the Provider Specific issue statement, namely that it is reserving its right to request a recalculation of its SSI percentage based upon its cost reporting year, the Board finds that a provider's request to realign its SSI ratio with a particular cost reporting period is an election that a provider may or may not chose to employ but it is not an appealable issue before the Board. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied for appeal purposes. Based on this reasoning, the Board finds that it does not have jurisdiction over the realignment portion of the Provider's issue statement.

Conclusion

The Board finds that it lacks jurisdiction to hear Valdese's appeals of the SSI Provider Specific Issue. The Board, therefore, dismisses the issue from both appeals, and as it was the last issue, hereby closes the appeals.

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 F. Benson, CPA
Gregory Ziegler, CPA, CPC-A

For the Board:

Charlotte Benson for
L. Sue Andersen, Esq.
Board Member

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

cc: Wilson Leong, Federal Specialized Services

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Barb Hinkl.e
Cahaba GBA
C/O National Government Services
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Indianapolis, IN 46206-6474

RE: Jurisdictional Determination
Lee Regional Medical Center
Provider No.: 49-0012
FYE: 06/30/2013
PRRB Case No.: 16-1004

Dear Mr. Ravindran and Ms. Hinkle:

The Board is in receipt of Lee Regional Medical Center's ("Lee") timely filed Request for Hearing based upon the original notice of program reimbursement ("NPR") for the 06/30/2013. The Provider appealed numerous issues, but prior to the Preliminary Position Papers, transferred all issues but two to group appeals. In the cover letter for each appeal, the Provider withdrew the Medicaid eligible days issue, briefing only: (1) DSH Payment—SSI percentage (provider-specific).

Lee previously appealed in the individual appeals, and transferred to a group appeal, the SSI Systemic errors issue. The "SSI Percentage - Systemic" issue transferred to 17-0330GC (2013) were described as follows:

> The Providers contend that the [Medicare contractor]'s determination[s] of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute . . . The Providers further contend that the SSI percentages calculated by [CMS] [do] not address all the deficiencies as described in *Baystate Medical Center v. Leavitt*[1] . . . and incorporate[ ] a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:

[1] 545 F. Supp. 2d 20 (D.D.C 2008), *as amended*, 587 F. Supp. 2d 37 (D.D.C. 2008).

1. Availability of MEDPAR and SSA records,
2. Paid days vs. Eligible days,
3. Not in agreement with provider's records,
4. Fundamental problems in the SSI percentage calculation[,]
5. Covered days vs. Total days,
6. Non-covered days, i.e., Exhausted Benefit ("EB"), Medicare Secondary Payor ("MSP") Days [a]nd Medicare Advantage, Medicare Managed Care, Medicare+Choice and/or Part C Days (Collectively "MA") Days,
7. CMS Ruling 1498-R and
8. Failure to adhere to required notice and comment rulemaking procedures in adopting policy on EB, MSP and MA days.

In the instant appeals, Lee describes its Provider-Specific SSI percentage issue in the following manner:

> The Provider contends that the [Medicare contractor] did not determine Medicare DSH reimbursement in accordance with the Statutory instructions . . . Specifically, the Provider disagrees with the [Medicare contractor]'s calculation of the computation of the DSH percentage . . .
>
> The Provider contends that its[ ] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the [Medicare contractor] are both flawed. The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).

Board's Decision

The SSI systematic issue transferred to 17-0030GC (2013) recites a fairly comprehensive list of patient scenarios (paid v. eligible, covered v. total, non-covered) in which particular inpatient days may not have been included in the participants' SSI percentage calculations. In addition, this issue statement also lists a number of arguments (availability of records, records not in agreement) as to why its participants may not have a complete list of SSI-eligible patients. As such, in comparing the two SSI issue statements for SSI provider specific and the SSI systemic, the issue statements describe the same SSI underlying data accuracy issue and CMS' failure to include all "entitled" patients. As Lee is currently a participant in a group appeal and seeks to also challenge the accuracy of the data, its completeness and its failure to include all "entitled" patients, Lee has

appealed the same issue twice from the same original NPR for the same cost reporting period. The Board hereby dismisses the first portion of the SSI Provider Specific issue because it is duplicative of the SSI Systemic Errors issue residing in the group appeals.

As far as Lee's additional wording in the Provider Specific issue statement, namely that it is reserving its right to request a recalculation of its SSI percentage based upon its cost reporting year, the Board finds that a provider's request to realign its SSI ratio with a particular cost reporting period is an election that a provider may or may not chose to employ but it is not an appealable issue before the Board. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied for appeal purposes. Based on this reasoning, the Board finds that it does not have jurisdiction over the realignment portion of the Provider's issue statement.

Conclusion

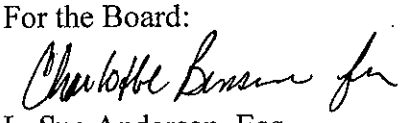
The Board finds that it lacks jurisdiction to hear Lee's appeals of the SSI Provider Specific Issue. The Board, therefore, dismisses the issue from both appeals, and as it was the last issue, hereby closes the appeals.

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 F. Benson, CPA
Gregory Ziegler, CPA, CPC-A

For the Board:



L. Sue Andersen, Esq.
Board Member

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

cc: Wilson Leong, Federal Specialized Services

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Barb Hinkle, Appeals Lead
Cahaba GBA
C/O National Government Services
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P.O. Box 6474
Indianapolis, IN 46206

RE: Jurisdictional Determination
MCG Medical Center
Provider No.: 11-0034
FYE: June 30, 2012 and June 30, 2013
PRRB Case Nos.: 16-1752 and 16-1757

Dear Mr. Ravindran and Ms. Hinkle:

On May 27, 2016, the Board received MCG's timely filed Requests for Hearing (dated May 26, 2013) based upon the original notices of program reimbursement ("NPRs") for the cost reporting periods ending on 06/30/2012 and 06/30/2013. The Provider appealed numerous issues, but prior to the Preliminary Position Papers, transferred all issues but two to a group appeal, briefing only: (1) Disproportionate Share Hospital ("DSH") Payment—Medicaid Eligible Days, and (2) DSH Payment—SSI percentage (provider-specific). By letters dated July 27, 2017 MCG withdrew the Medicaid Eligible Days issue from the instant appeals, leaving only the Provider-Specific SSI Percentage issue as the sole remaining issue within the appeals.

MCG appealed in their individual appeals, and subsequently transferred to group appeals, the SSI Systemic errors issue. The "SSI Percentage - Systemic" issue transferred to 16-1746G (2012) and 16-1141G (2013) was described as follows:

> The Providers contend that the [Medicare contractor]'s determination[s] of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute . . . The Providers further contend that the SSI percentages calculated by [CMS] [do] not address all the deficiencies as described in *Baystate Medical Center v. Leavitt*[1] . . . and incorporate[ ] a new methodology inconsistent with the Medicare statute.

[1] 545 F. Supp. 2d 20 (D.D.C 2008), *as amended*, 587 F. Supp. 2d 37 (D.D.C. 2008).

The Providers challenge their SSI percentages based on the following reasons:

1. Availability of MEDPAR and SSA records,
2. Paid days vs. Eligible days,
3. Not in agreement with provider's records,
4. Fundamental problems in the SSI percentage calculation[,]
5. Covered days vs. Total days,
6. Non-covered days, i.e., Exhausted Benefit ("EB"), Medicare Secondary Payor ("MSP") Days [a]nd Medicare Advantage, Medicare Managed Care, Medicare+Choice and/or Part C Days (Collectively "MA") Days,
7. CMS Ruling 1498-R and
8. Failure to adhere to required notice and comment rulemaking procedures in adopting policy on EB, MSP and MA days.

In the instant appeals, MCG describes its Provider-Specific SSI percentage issue in the following manner:

> The Provider contends that the [Medicare contractor] did not determine Medicare DSH reimbursement in accordance with the Statutory instructions . . . Specifically, the Provider disagrees with the [Medicare contractor]'s calculation of the computation of the DSH percentage . . .
>
> The Provider contends that its[ ] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the [Medicare contractor] are both flawed. The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).

Board's Decision

The SSI systematic issue transferred to Case Nos. 16-1746G (2012) and 16-1141G (2013) recites a fairly comprehensive list of patient scenarios (paid v. eligible, covered v. total, non-covered) in which particular inpatient days may not have been included in the participants' SSI percentage calculations. In addition, this issue statement also lists a number of arguments (availability of records, records not in agreement) as to why its participants may not have a complete list of SSI-eligible patients. As such, in comparing the two SSI issue statements for SSI provider specific and the SSI systemic, the issue statements describe the same SSI underlying data accuracy issue

and CMS' failure to include all "entitled" patients. As MCG is currently a participant in a group appeal and seeks to also challenge the accuracy of the data, its completeness and its failure to include all "entitled" patients, MCG has appealed the same issue twice from the same original NPR for the same cost reporting period. The Board hereby dismisses the first portion of the SSI Provider Specific issue because it is duplicative of the SSI Systemic Errors issue.

As far as MCG's additional wording in the Provider Specific issue statement, namely that it is reserving its right to request a recalculation of its SSI percentage based upon its cost reporting year, the Board finds that a provider's request to realign its SSI ratio with a particular cost reporting period is an election that a provider may or may not chose to employ but it is not an appealable issue before the Board. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied for appeal purposes. Based on this reasoning, the Board finds that it does not have jurisdiction over the realignment portion of the Provider's issue statement.

Conclusion

The Board finds that it lacks jurisdiction to hear MCG's appeals of the SSI Provider Specific Issue. The Board, therefore, dismisses the issue from both appeals, and as it was the last issue, hereby closes the appeals.

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 F. Benson, CPA
Gregory Ziegler, CPA, CPC-A

For the Board:

Charlotte Benson for

L. Sue Andersen, Esq.
Board Member

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

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Laurie Polson
Palmetto GBA
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P.O. Box 6474
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RE: Jurisdictional Determination
Johnston Memorial Hospital
Provider No.: 49-0053
FYE: 06/30/2011, 06/30/2012 and 06/30/2013
PRRB Case Nos.: 16-0168, 16-0234 and 16-0336

Dear Mr. Ravindran and Ms. Polson:

The Board is in receipt of Johnston Memorial Hospital's ("Johnston") timely filed Requests for Hearing based upon the original notices of program reimbursement ("NPRs") for the cost reporting periods ending on 06/30/2011, 06/30/2012 and 06/30/2013. The Provider appealed numerous issues, but prior to the Preliminary Position Papers, transferred all issues but two to group appeals. In the cover letter for each appeal, the Provider withdrew the Medicaid eligible days issue, briefing only: (1) DSH Payment—SSI percentage (provider-specific).

Johnston previously appealed in their individual appeals, and transferred to group appeals, the SSI Systemic errors issue. The "SSI Percentage - Systemic" issue transferred to 14-4296GC (2011), 16-0290GC (2012) and 16-2031GC (2013) were described as follows:

> The Providers contend that the [Medicare contractor]'s determination[s] of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute . . . The Providers further contend that the SSI percentages calculated by [CMS] [do] not address all the deficiencies as described in *Baystate Medical Center v. Leavitt*[1] . . . and incorporate[ ] a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:

[1] 545 F. Supp. 2d 20 (D.D.C 2008), *as amended*, 587 F. Supp. 2d 37 (D.D.C. 2008).

1. Availability of MEDPAR and SSA records,
2. Paid days vs. Eligible days,
3. Not in agreement with provider's records,
4. Fundamental problems in the SSI percentage calculation[,]
5. Covered days vs. Total days,
6. Non-covered days, i.e., Exhausted Benefit ("EB"), Medicare Secondary Payor ("MSP") Days [a]nd Medicare Advantage, Medicare Managed Care, Medicare+Choice and/or Part C Days (Collectively "MA") Days,
7. CMS Ruling 1498-R and
8. Failure to adhere to required notice and comment rulemaking procedures in adopting policy on EB, MSP and MA days.

In the instant appeals, Johnston describes its Provider-Specific SSI percentage issue in the following manner:

> The Provider contends that the [Medicare contractor] did not determine Medicare DSH reimbursement in accordance with the Statutory instructions . . . Specifically, the Provider disagrees with the [Medicare contractor]'s calculation of the computation of the DSH percentage . . .
>
> The Provider contends that its[ ] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the [Medicare contractor] are both flawed. The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).

Board's Decision

The SSI systematic issue transferred to 14-4296GC (2011), 16-0290GC (2012) and 16-2031GC (2013) recites a fairly comprehensive list of patient scenarios (paid v. eligible, covered v. total, non-covered) in which particular inpatient days may not have been included in the participants' SSI percentage calculations. In addition, this issue statement also lists a number of arguments (availability of records, records not in agreement) as to why its participants may not have a complete list of SSI-eligible patients. As such, in comparing the two SSI issue statements for SSI provider specific and the SSI systemic, the issue statements describe the same SSI underlying data accuracy issue and CMS' failure to include all "entitled" patients. As Johnston is currently a participant in a group appeal and seeks to also challenge the accuracy of the data, its completeness

and its failure to include all "entitled" patients, Johnston has appealed the same issue twice from the same original NPR for the same cost reporting period. The Board hereby dismisses the first portion of the SSI Provider Specific issue because it is duplicative of the SSI Systemic Errors issue residing in the group appeals.

As far as Johnston's additional wording in the Provider Specific issue statement, namely that it is reserving its right to request a recalculation of its SSI percentage based upon its cost reporting year, the Board finds that a provider's request to realign its SSI ratio with a particular cost reporting period is an election that a provider may or may not chose to employ but it is not an appealable issue before the Board. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied for appeal purposes. Based on this reasoning, the Board finds that it does not have jurisdiction over the realignment portion of the Provider's issue statement.

Conclusion

The Board finds that it lacks jurisdiction to hear Johnston's appeals of the SSI Provider Specific Issue. The Board, therefore, dismisses the issue from both appeals, and as it was the last issue, hereby closes the appeals.

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 F. Benson, CPA
Gregory Ziegler, CPA, CPC-A

For the Board:

Charlotte Benson for

L. Sue Andersen, Esq.
Board Member

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

cc: Wilson Leong, Federal Specialized Services

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RE: Mountclair Hospital, La Palma Intercomm. Hospital and Garden Grove Hospital
Provider Nos.:05-0758, 05-0580, 05-0230
FYE 12/31/2011
PRRB Case Nos. 15-2498, 15-2496, 15-2507

Dear Mr. Summar and Ms. Hinkle,

The above referenced Providers each filed an appeal of their original Notice of Program Reimbursement (NPR) for the 12/31/2011 cost reporting period. The Providers filed each appeal with two issues: 1) *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* and 2) *Disproportionate Share Hospital (DSH) Payment – Medicaid Eligible Days*. Each Provider withdrew the Medicaid eligible days issue in the preliminary position paper cover letter, briefing only: (1) DSH Payment-SSI percentage (provider-specific).

Each of the above Provider's is commonly owned or controlled by Prime Healthcare Solutions. Each of the Providers filed directly into "HRS Prime Healthcare 2011 DSH/SSI Percentage CIRP group", PRRB case number 15-0001GC. The "SSI Percentage - Systemic" issue described in the Common Issue Related Party (CIRP) group is as follows:

> The Providers contend that the [Medicare contractor]'s determination[s] of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute . . . The Providers further contend that the SSI percentages calculated by [CMS] [do] not address all the deficiencies as described in *Baystate Medical Center v. Leavitt*[1] . . . and incorporate[ ] a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:

[1] 545 F. Supp. 2d 20 (D.D.C 2008), *as amended*, 587 F. Supp. 2d 37 (D.D.C. 2008).

1. Availability of MEDPAR and SSA records,
2. Paid days vs. Eligible days,
3. Not in agreement with provider's records,
4. Fundamental problems in the SSI percentage calculation[,]
5. Covered days vs. Total days,
6. Non-covered days, i.e., Exhausted Benefit ("EB"), Medicare Secondary Payor ("MSP") Days [a]nd Medicare Advantage, Medicare Managed Care, Medicare+Choice and/or Part C Days (Collectively "MA") Days,
7. CMS Ruling 1498-R and
8. Failure to adhere to required notice and comment rulemaking procedures in adopting policy on EB, MSP and MA days.

In the instant individual appeals, the Provider's describes their Provider-Specific SSI percentage issue in the following manner:

> The Provider contends that the [Medicare contractor] did not determine Medicare DSH reimbursement in accordance with the Statutory instructions . . . Specifically, the Provider disagrees with the [Medicare contractor]'s calculation of the computation of the DSH percentage . . .
>
> The Provider contends that its[ ] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the [Medicare contractor] are both flawed. The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).

Board's Decision

The SSI systematic issue filed directly into 15-0001GC recites a fairly comprehensive list of patient scenarios (paid v. eligible, covered v. total, non-covered) in which particular inpatient days may not have been included in the participants' SSI percentage calculations. In addition, this issue statement also lists a number of arguments (availability of records, records not in agreement) as to why its participants may not have a complete list of SSI-eligible patients. As such, in comparing the two SSI issue statements for SSI provider specific and the SSI systemic, the issue statements describe the same SSI underlying data accuracy issue and CMS' failure to include all "entitled" patients. As these providers are currently a participant in a CIRP group appeal and seek to also challenge the accuracy of the data, its completeness and its failure to include all "entitled" patients, these Providers have appealed the same issue twice from the same

original NPRs for the same cost reporting period. The Board hereby dismisses the first portion of the SSI Provider Specific issue because it is duplicative of the SSI Systemic Errors issue residing in the CIRP group 15-0001GC.

As far as the Provider's additional wording in the Provider Specific issue statement, namely that it is reserving its right to request a recalculation of its SSI percentage based upon its cost reporting year, the Board finds that a provider's request to realign its SSI ratio with a particular cost reporting period is an election that a provider may or may not chose to employ but it is not an appealable issue before the Board. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied for appeal purposes. Based on this reasoning, the Board finds that it does not have jurisdiction over the realignment portion of the Provider's issue statement.

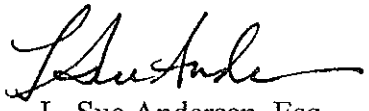
Conclusion

The Board finds that it lacks jurisdiction to hear Montclaire's, La Palma's and Garden City's appeals of the SSI Provider Specific Issue. The Board, therefore, dismisses the issue from all three appeals, and as it was the last issue, hereby closes 15-2498, 15-2496 and 15-2507.

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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DEC 29 2017

CERTIFIED MAIL

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RE: Jurisdictional Determination
Wellmont Lonesome Pine Hospital
Provider No.: 49-0114
FYE: 06/30/2012
PRRB Case Nos.: 16-0220

Dear Mr. Ravindran and Ms. Polson:

The Board is in receipt of Wellmont Lonesome Pine Hospital's ("Wellmont's") timely filed Requests for Hearing based upon the original notice of program reimbursement ("NPR") for the cost reporting periods ending 06/30/2012. The Provider appealed numerous issues, but prior to the Preliminary Position Paper, transferred all issues but one to group appeals. In the cover letter for the appeal, the Provider briefed only: (1) DSH Payment—SSI percentage (provider-specific).

Wellmont previously appealed in the individual appeals, and transferred to a group appeal, the SSI Systemic errors issue. The "SSI Percentage - Systemic" issue transferred to 16-0247GC were described as follows:

> The Providers contend that the [Medicare contractor]'s determination[s] of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute . . . The Providers further contend that the SSI percentages calculated by [CMS] [do] not address all the deficiencies as described in *Baystate Medical Center v. Leavitt*[1] . . . and incorporate[ ] a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,

[1] 545 F. Supp. 2d 20 (D.D.C 2008), *as amended*, 587 F. Supp. 2d 37 (D.D.C. 2008).

2. Paid days vs. Eligible days,
3. Not in agreement with provider's records,
4. Fundamental problems in the SSI percentage calculation[,]
5. Covered days vs. Total days,
6. Non-covered days, i.e., Exhausted Benefit ("EB"), Medicare Secondary Payor ("MSP") Days [a]nd Medicare Advantage, Medicare Managed Care, Medicare+Choice and/or Part C Days (Collectively "MA") Days,
7. CMS Ruling 1498-R and
8. Failure to adhere to required notice and comment rulemaking procedures in adopting policy on EB, MSP and MA days.

In the instant appeals, Wellmont describes its Provider-Specific SSI percentage issue in the following manner:

> The Provider contends that the [Medicare contractor] did not determine Medicare DSH reimbursement in accordance with the Statutory instructions . . . Specifically, the Provider disagrees with the [Medicare contractor]'s calculation of the computation of the DSH percentage . . .
>
> The Provider contends that its[ ] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the [Medicare contractor] are both flawed. The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).

Board's Decision

The SSI systematic issue transferred to 16-0247GC, QRS Wellmont HS 2012 DSH SSI Percentage Group, recites a fairly comprehensive list of patient scenarios (paid v. eligible, covered v. total, non-covered) in which particular inpatient days may not have been included in the participants' SSI percentage calculations. In addition, this issue statement also lists a number of arguments (availability of records, records not in agreement) as to why its participants may not have a complete list of SSI-eligible patients. As such, in comparing the two SSI issue statements for SSI provider specific and the SSI systemic, the issue statements describe the same SSI underlying data accuracy issue and CMS' failure to include all "entitled" patients. As Wellmont is currently a participant in a Common Issue Related Party (CIRP) group appeal and seeks to also challenge the accuracy of the data, its completeness and its failure to include all "entitled" patients, Wellmont has appealed the same issue twice from the same original NPR for the same cost reporting period.

The Board hereby dismisses the first portion of the SSI Provider Specific issue because it is duplicative of the SSI Systemic Errors issue residing in the CIRP group 16-0247GC.

As far as Wellmonts's additional wording in the Provider Specific issue statement, namely that it is reserving its right to request a recalculation of its SSI percentage based upon its cost reporting year, the Board finds that a provider's request to realign its SSI ratio with a particular cost reporting period is an election that a provider may or may not chose to employ but it is not an appealable issue before the Board. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied for appeal purposes. Based on this reasoning, the Board finds that it does not have jurisdiction over the realignment portion of the Provider's issue statement.

Conclusion

The Board finds that it lacks jurisdiction to hear Wellmonts's appeal of the SSI Provider Specific Issue. The Board, therefore, dismisses the issue, and as it was the last issue, hereby closes the case.

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 F. Benson, CPA
Gregory Ziegler, CPA, CPC-A

For the Board:

L. Sue Andersen, Esq.
Board Member

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

cc: Wilson Leong, Federal Specialized Services