DEPARTMENT OF HEALTH & HUMAN SERVICES

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

JAN 12 2018

CERTIFIED MAIL

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

Bruce Snyder
JL Provider Audit Manager
Novitas Solutions, Inc.
Union Trust Bldg.
501 Grant Street, Suite 600
Pittsburgh, PA 15219

RE: Jurisdictional Decision
Baylor University Medical Center
Case Number: 15-1690
FYE: 06/30/2006

Dear Mr. Ravindran and Mr. Snyder:

Baylor University Medical Center, or the Provider, is appealing the amount of Medicare Reimbursement as determined by the Medicare contractor. The Medicare Contractor has challenged jurisdiction over the sole issue in the appeal, and the Board's jurisdictional decision is as follows.

Background

The Provider filed an individual appeal with the Provider Reimbursement Review Board ("Board") on March 3, 2015, which appealed a Revised Notice of Program Reimbursement ("RNPR") dated September 4, 2014 (for the cost reporting period ending June 30, 2006) The sole issue stated in the appeal request was whether the Medicare Contractor properly excluded Medicaid Eligible days from the Disproportionate Share Hospital ("DSH") calculation?

The Provider filed a second individual appeal request with the Board on August 24, 2016, which appealed a RNPR dated February 23, 2016 (for the same cost reporting period of June 30, 2006). This request appealed two issues: 1) DSH Supplemental Security Income ("SSI") Percentage (Provider Specific), and 2) DSH SSI Percentage. The Board notified the Provider that this second appeal request was being incorporated into Case No. 15-1690, and that a supplemental preliminary position paper

would be due by January 1, 2017. The Provider did not file a supplemental preliminary position paper, and the Board dismissed the DSH SSI Percentage (Provider Specific) and DSH SSI Percentage issues from the case on February 17, 2017.

The Medicare Contractor, Novitas Solutions, Inc, has challenged the Board's jurisdiction over the sole issue in Case No. 15-1690 – DSH Medicaid Eligible days.

Medicare Contractor's Position

The Medicare Contractor challenges the Board's jurisdiction over the Medicaid Eligible Days issue, stating that it has not made a final determination regarding the additional 412 Medicaid Eligible days the Provider now seeks. The Medicare Contractor explains there were six adjustments for the RNPR dated September 4, 2014, and the Provider cites to Audit Adjustment Nos. 4 and 5 as the source of its dissatisfaction. The Medicare Contractor states that Audit Adjustment No. 4 increased Medicaid days on the cost report, and Audit Adjustment No. 5 increased the allowable DSH percentage by 2.59 (Audit Adjustment No. 5 stems from No. 4).

The Medicare Contractor's position is that although Audit Adjustment No. 4 adjusted Medicaid Eligible days, the Provider has failed to show that the 412 disputed days it now seeks were specifically reviewed and adjusted on this RNPR. The Medicare Contractor claims the 412 disputed days represent a completely new subset of days which were not previously presented to the Medicare Contractor.

The Medicare Contractor contends it did not render a final determination with respect to the additional Medicaid days now sought, and therefore the Board does not have jurisdiction pursuant to 42 C.F.R. §§ 405.1887(d) and 405.1889.

Provider's Position

The Provider filed a Jurisdictional Response to the Medicare Contractor's jurisdictional challenge on November 20, 2017. The Provider claims that the RNPR included corrections to the Provider's DSH calculation with Audit Adjustment No. 5, and therefore the Board has jurisdiction over the DSH Medicaid Eligible days issue. The Provider's position is that any adjustment to the overall DSH calculation or those related to Medicaid Eligible days provide the Board with jurisdiction.

The Provider also contends that the Board has jurisdiction over the Medicaid Eligible days issue pursuant to the *Bethesda Hospital Association v. Bowen*[1] decision, and because the Provider is dissatisfied with the amount of its total reimbursement. The Provider explains that the days at issue are often not available in time for inclusion on the cost report, and as the Board has noted in other DSH jurisdictional decisions, there are practical difficulties in getting information regarding Medicaid Eligible days. The Provider states it is dissatisfied with the Medicare Contractor's determination of reimbursement despite not having made a claim on the cost report.

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2014), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A revised NPR is considered a separate and distinct determination from which the provider may appeal. A Provider's appeal of a revised NPR is limited to the specific issues revised on reopening and does not extend further to all determinations underlying the original NPR. The effect of a revised NPR on a provider's right to a Board hearing is addressed in 42 C.F.R. § 405.1889(a)(b)(1) (2013). The regulation at § 405.1889(b)(1) provides "[o]nly 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."

The Board finds the Provider's appeal rights from this RNPR are limited to the specific issue revised on reopening – those 7,705 additional Medicaid eligible days **added** with Audit Adjustment No. 4 and the corresponding **increase** in the DSH percentage as a result of Audit Adjustment No. 5. There is no evidence in the record that the additional 412 Medicaid Eligible days the Provider now seeks were reviewed or revised by the Medicare Contractor with the RNPR under appeal. This RNPR appeal is now closed as the Board does not have jurisdiction over the Medicaid Eligible days issue.

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

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[1] *Bethesda,* 485 U.S. 399 (1988).

FOR THE BOARD

L. Sue Andersen, Esq.
Chairperson

cc: Wilson Leong, Esq., FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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JAN 12 2018

Stephanie A. Webster
J. Harold Richards
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RE: Expedited Judicial Review Request
Akin Gump 2005-2013 DSH Part C Days Appeals
FYE: 2005-2006, 2008-2011 and 2013
PRRB Case Nos.: 09-0280GC, 11-0136GC, 14-0582GC, 14-0587GC, 15-0816GC, 15-1945GC, 16-0309GC, 16-0668GC, 18-0099G, 18-0233, 18-0301 and 18-0320

Dear Ms. Webster and Mr. Richards:

On December 18, 2017, the Provider Reimbursement Review Board ("PRRB" or "Board") received a request for expedited judicial review ("EJR"), dated December 15, 2017, for the above-referenced appeals. The Board has reviewed the request and hereby grants EJR, for all Providers, of the Medicare Part C day issue in the appeals, as explained below.

The issue in these appeals is:

> [W]hether "enrollees in Part C are 'entitled to benefits' under Part A, such that they should be counted in the Medicare [Part A/SSI[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]

Background

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]

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[1] "SSI" stands for "Supplemental Security Income." The terms "SSI fraction," "SSI%," "SSI ratio" and "Medicare fraction" are synonymous and used interchangeably within this decision.
[2] The abbreviation "DSH" stands for "disproportionate share hospital."
[3] EJR Request at 4.
[4] *See* 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.
[5] *Id.*

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[8] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, then is used to determine the amount of the DSH payment due to the 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" or "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 utilized by the Medicare contractors to compute a hospital's DSH eligibility and 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

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

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the 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 . . .*[18]

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

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

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

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

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

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

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

Consequently, within her response, 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.[21] In that publication, the Secretary noted that no regulatory change had in fact occurred but that 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, 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, the Providers claim that the Secretary has not acquiesced or taken action to implement the 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).

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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] EJR Request at 1-2.
[24] 69 Fed. Reg. at 49,099.
[25] *Allina* at 1109.

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

Decision of the Board

Board's Authority and Analysis

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 and Determination

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 Board jurisdictional regulations, 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 the notice of the intermediary's determination was mailed to the provider (prior to August 21, 2008) or within 180 days of the date of receipt of the final determination (on or after August 21, 2008).[26]

The Providers included in this EJR request filed appeals based upon original NPRs, revised NPRS ("RNPRs") or the Medicare Contractor's failure to timely issue an NPR. The cost reporting periods involved in this EJR request end between December 31, 2005, and December 31, 2013.

For appeals of original NPRs for cost reporting periods ending before December 31, 2008, the providers may demonstrate dissatisfaction with the amount of Medicare reimbursement of the Part C days issue by claiming the issue as a "self-disallowed cost" pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[27]

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[26] 42 C.F.R. §§ 405.1835-405.1841 (2005); 42 C.F.R. §§ 405.1835-405.1840 (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

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

For appeals of original NPRs for cost reporting time periods ending on or after December 31, 2008, providers preserve their respective rights to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either including a claim for the specific item on their cost reports for the period where the providers seek payment they believe to be in accordance with Medicare policy, or self-disallowing the specific item by following the applicable procedures for filing cost reports under protest.[29]

For appeals of RNPRs issued after August 21, 2008, the Board only has jurisdiction to hear a provider's appeal of matters that the Medicare contractor specifically revised within the RNPR.[30]

For provider appeals filed based upon the Medicare Contractor's failure to timely issue an NPR, the providers are not required to demonstrate dissatisfaction in order to preserve their individual rights to a Board hearing.[31]

A jurisdictional review of the appeals in this EJR request shows that all of the Providers have an adjustment to the SSI% on their respective NPRs/RNPRs, have properly protested the appealed issue or have filed appeals based upon the Medicare contractor's failure to timely issue an NPR. In addition, the Providers' documentation shows that the appeals were timely filed and that the estimated amount in controversy for each group appeal exceeds $50,000 and for each individual

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submitted to [the Medicare Contractor]." The Court went on to state that "the submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations."

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

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

[30] *See* 42 C.F.R. § 405.1889(b)(1) (2008).

[31] The United States District Court for the District of Columbia issued an order in *Charleston Area Med. Ctr. v. Sebelius*, No. 16-643 (RMC) (D.D.C. filed May 3, 2013) that states 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. Subsequently, under 42 C.F.R. § 405.1835(c), CMS codified this change in Board jurisdictional requirements and set an effective date that encompasses Board appeals that were initiated or pending on or after August 21, 2008. *See* 79 Fed. Reg. 49854, 50201 (Aug. 22, 2014). All the Providers' appeals involved in the instant EJR request that were filed based upon the Medicare contractor's failure to issue a timely NPR were initiated or pending on or after August 21, 2008.

appeal exceeds $10,000. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Authority to Consider the Appealed Issue

The second part of the Board's EJR analysis concerns whether the Board lacks the authority to decide the specific legal question relevant to the 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 appeals involved in this EJR request span fiscal years 2005-2013, thus the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed,* No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in 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.

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.

[32] 863 F.3d 937 (D.C. Cir. July 25, 2017).

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the providers' request for EJR for the issue and the subject 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. [33]

Board Members Participating:

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

FOR THE BOARD:

Charlotte Benson for

L. Sue Andersen, Esq.
Chairperson

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

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

[33] The provider in PRRB Case No. 18-0320 is requesting EJR of only its Medicare Part C days issue. As there are other issues pending before the Board in PRRB Case No. 18-0320, the case will remain open following issuance of this determination.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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JAN 12 2018

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National Government Services, Inc.
Pam VanArsdale
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MP: INA 101-AF42
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RE: Middlesex Hospital
Provider No. 07-0020
FYE 9/30/2012
PRRB Case No. 15-2561

Dear Mr. Ravindran and Ms. VanArsdale,

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 November 25, 2014 for fiscal year end ("FYE") 9/30/2012. On May 7, 2015, the Provider filed an appeal request with the Board that identified ten issues. The Provider requested to transfer various issues to group appeals, including transferring the SSI Systemic Errors issue to case no. 15-1416G (QRS 2012 DSH SSI Percentage Group) and the dual eligible days issue to two groups: 15-0018G (QRS 2012 DSH Medicaid Fraction/Dual Eligible Days Group) and 15-1419G (QRS 2012 SSI Fraction Dual Eligible Days Group). The only issue that remains pending in the appeal is the SSI Provider specific issue, over which the Provider representative has requested Expedited Judicial Review ("EJR").

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.[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 . . . ."[4]

However, the Provider's 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 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. 15-1416G. 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 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. Additionally, the Provider is appealing from a 9/30/2012 cost reporting period, so its SSI percentage is already calculated on the federal fiscal year; there would be nothing to realign even if the Provider had requested realignment.

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),

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

therefore the first requirement of 42 C.F.R. § 405.1842(f)(1) is not satisfied.

Additionally, it is important to note that the issue statement in the EJR request, although labeled as "SSI Provider Specific," is really the dual eligible days issue.

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 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 dual eligible days issue, which has been transferred to group appeals.

The Provider separately appealed the Medicaid and SSI fraction dual eligible days issues, but included this explanation in both issue statements in its appeal request:

> While 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. Since CMS has stated that only "paid" days will be used in the SSI percentage, the Provider contends that the terms **paid** and **entitled** must be consistent with one another due to the usage of the two terms in 42 C.F.R. § 412.106(b) and CMS testimony. The numerator of the SSI percentage requires SSI payments to have been made, thus the denominator should also require Part A payment.

This same paragraph is also included in the group appeal request for case no. 15-1419G, QRS 2012 DSH SSI Fraction Dual Eligible Days Group and case no. 15-0018G, QRS 2012 DSH Medicaid Fraction/Dual Eligible Days Group. Therefore, the issue over which the Provider has requested EJR is actually the dual eligible days issue, which the Provider has transferred to group appeals.

Conclusion

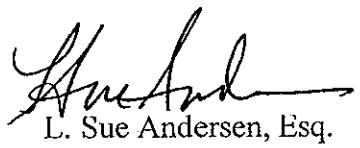
The only issue that remains pending in this appeal is the SSI Provider Specific issue, over which the Provider has requested the Board grant EJR. The Board finds that it does not have jurisdiction over the issue (a portion is duplicative of the SSI Systemic issues which was transferred to 15-1416G and there is no final determination related to the realignment request) and thus denies the Provider's request for EJR, as jurisdiction is a prerequisite to granting EJR per 42 C.F.R. § 405.1842(f)(1). Furthermore, the issue statement over which the Provider has requested EJR is really the dual eligible days issue (when comparing the actual issue statements, not how the issues are labeled), which the Provider has already requested to transfer to group appeals.

The Board finds that it does not have jurisdiction over the SSI Provider Specific Issue and denies the request for EJR. The SSI Provider Specific issue was the last issue in the appeal, therefore PRRB Case No. 15-2561 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:



L. Sue Andersen, Esq.
Chairperson

cc: Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
1508 Woodlawn Drive, Suite 100
Baltimore, MD 21207
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JAN 12 2018

Quality Reimbursement Services, Inc.
James C. Ravindran
President
150 N. Santa Anita Avenue, Suite 570A
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National Government Services, Inc.
Pam VanArsdale
Appeals Lead
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

RE: Middlesex Hospital
Provider No. 07-0020
FYE 9/30/2011
PRRB Case No. 15-1812

Dear Mr. Ravindran and Ms. VanArsdale,

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 September 23, 2014 for fiscal year end ("FYE") 9/30/2011. On March 11, 2015, the Provider filed an appeal request with the Board that identified ten issues. The Provider requested to transfer various issues to group appeals, including transferring the SSI Systemic Errors issue to case no. 15-3037G (QRS 2011 DSH SSI Percentage Group (2)) and the dual eligible days issue to two groups: 15-3031G (QRS 2011 DSH Medicaid Fraction/Dual Eligible Days Group (2)) and 15-3039G (QRS 2011 SSI Fraction Dual Eligible Days Group (2)). The only issue that remains pending in the appeal is the SSI Provider specific issue, over which the Provider representative has requested Expedited Judicial Review ("EJR").

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.[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 . . . ..."[4]

However, the Provider's 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 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. 15-3037G. 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 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. Additionally, the Provider is appealing from a 9/30/2011 cost reporting period, so its SSI percentage is already calculated on the federal fiscal year; there would be nothing to realign even if the Provider had requested realignment.

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),

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

therefore the first requirement of 42 C.F.R. § 405.1842(f)(1) is not satisfied.

Additionally, it is important to note that the issue statement in the EJR request, although labeled as "SSI Provider Specific," is really the dual eligible days issue.

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 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 dual eligible days issue, which has been transferred to group appeals.

The Provider separately appealed the Medicaid and SSI fraction dual eligible days issues, but included this explanation in both issue statements in its appeal request:

> While 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. Since CMS has stated that only "paid" days will be used in the SSI percentage, the Provider contends that the terms **paid** and **entitled** must be consistent with one another due to the usage of the two terms in 42 C.F.R. § 412.106(b) and CMS testimony. The numerator of the SSI percentage requires SSI payments to have been made, thus the denominator should also require Part A payment.

This same paragraph is also included in the group appeal request for case no. 15-3031G, QRS 2011 DSH SSI Fraction Dual Eligible Days Group (2) and case no. 15-3039G, QRS 2011 DSH Medicaid Fraction/Dual Eligible Days Group (2). Therefore, the issue over which the Provider has requested EJR is actually the dual eligible days issue, which the Provider has transferred to group appeals.

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 (a portion is duplicative of the SSI Systemic issues which was transferred to 15-1416G and there is no final determination related to the realignment request) and thus denies the Provider's request for EJR, as jurisdiction is a prerequisite to granting EJR per 42 C.F.R. § 405.1842(f)(1). Furthermore, the issue statement over which the Provider has requested EJR is really the dual eligible days issue (when comparing the actual issue statements, not how the issues are labeled), which the Provider has already requested to transfer to group appeals.

The Board finds that it does not have jurisdiction over the SSI Provider Specific Issue and denies the request for EJR. The SSI Provider Specific issue was the last issue in the appeal, therefore PRRB Case No. 15-1812 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:

L. Sue Andersen, Esq.
Chairperson

cc: Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Certified Mail

JAN 17 2018

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

RE: Expedited Judicial Review Request
Baptist Health South Florida 2006-2012 Part C Days Groups
FYE: 2006-2012
PRRB Case Nos.: 13-1470GC, 13-1471GC, 14-0776GC, 14-0780GC, 14-2210GC, 14-2219GC, 14-4246GC, 14-4247GC, 15-0514GC, 15-0515GC, 15-1699GC and 15-1700GC

Dear Mr. Keough and Mr. Talley:

On December 21, 2017, the Provider Reimbursement Review Board ("PRRB" or "Board") received a request for expedited judicial review ("EJR"), dated December 20, 2017, for the above-referenced appeals. The Board has reviewed the request and hereby grants EJR of the Medicare Part C day issue in the appeals, as explained below.

The issue in these appeals is:

> [W]hether Medicare Part C patients are 'entitled to benefits' under Part A, such that they should be counted in the Medicare Part A/SSI[1] fraction and excluded from the Medicaid fraction numerator or vice-versa.[2]

Background

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system ("PPS").[3] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[4]

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[1] "SSI" stands for "Supplemental Security Income." The terms "SSI fraction," "SSI%," "SSI ratio" and "Medicare fraction" are synonymous and used interchangeably within this decision.
[2] EJR Request at 4.
[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[5] These cases involve the disproportionate share hospital ("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, then is used to determine the amount of the DSH payment due to the 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" or "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 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

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

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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

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

Consequently, within her response, 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 regulatory change had in fact occurred but that 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, the pertinent regulatory language was "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,*[21] vacated the FFY 2005 IPPS rule. However, the Providers claim that the Secretary has not acquiesced or taken action to implement the decision.[22]

Providers' Request for EJR

The underlying issue in this EJR request involves the question of whether Medicare Part C patients are "entitled to benefits" under Part A, thereby requiring them to be counted in the Medicare Part A/SSI fraction and excluded from the Medicaid fraction numerator or vice versa.

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

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

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

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

Decision of the Board

Board's Authority and Analysis

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 and Determination

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 Board jurisdictional regulations, 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 the notice of the intermediary's determination was mailed to the provider (prior to August 21, 2008) or within 180 days of the date of receipt of the final determination (on or after August 21, 2008).[25]

The Providers included in this EJR request filed appeals based upon original notices of program reimbursement ("NPRs") or revised NPRS ("RNPRs"). The cost reporting periods involved in this EJR request end between September 30, 2006, and September 30, 2012.

For appeals of original NPRs for cost reporting periods ending before December 31, 2008, the providers may demonstrate dissatisfaction with the amount of Medicare reimbursement of the Part C days issue by claiming the issue as a "self-disallowed cost" pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[26]

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[25] 42 C.F.R. §§ 405.1835-405.1841 (2005); 42 C.F.R. §§ 405.1835-405.1840 (2008).

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

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

For appeals of original NPRs for cost reporting time periods ending on or after December 31, 2008, providers preserve their respective rights to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either including a claim for the specific item on their cost reports for the period where the providers seek payment they believe to be in accordance with Medicare policy, or self-disallowing the specific item by following the applicable procedures for filing cost reports under protest.[28]

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

A jurisdictional review of the appeals in this EJR request shows that all of the Providers have an adjustment to the SSI% on their respective NPRs/RNPRs and/or have properly protested the appealed issue. In addition, the Providers' documentation shows that the appeals were timely filed and that the estimated amount in controversy for each group appeal exceeds $50,000. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Authority to Consider the Appealed Issue

The second part of the Board's EJR analysis concerns whether the Board lacks the authority to decide the specific legal question relevant to the 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 appeals involved in this EJR request span fiscal years 2006-2012, thus the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed,* No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in federal court in

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compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations."

[27] 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.

[28] *See* 42 C.F.R. § 405.1835(a)(1) (2008).

[29] *See* 42 C.F.R. § 405.1889(b)(1) (2008).

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*,[30] 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.

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:

Gregory H. Ziegler for

L. Sue Andersen, Esq.
Chairperson

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

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

[30] 863 F.3d 937 (D.C. Cir. July 25, 2017).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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JAN 19 2018

CERTIFIED MAIL

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RE: Jurisdictional Decision
Baylor University Medical Center
Case Number: 14-1152
FYE: 06/30/2009

Dear Mr. Ravindran and Mr. Kamal:

Baylor University Medical Center, or the Provider, is appealing the amount of Medicare Reimbursement as determined by the Medicare Contractor. The Medicare Contractor has challenged jurisdiction over three issues in the appeal, and the Board's jurisdictional decision is set forth below.

Background

The following issues are stated in the Model Form A – Individual Appeal Request (Dec. 2, 2013), Tab 3:

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

2) Issue No. 2 is entitled "Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific), (hereinafter "Second DSH/SSI Percentage (Provider Specific)";

3) Issue No. 3 is entitled "Disproportionate Share Hospital ('DSH')/Supplemental Security Income ('SSI') (Systemic Errors)" (hereinafter "DSH/SSI Systemic Errors");

4) Issue No. 4 is entitled "Disproportionate Share Hospital Payment – Medicaid Eligible Days";

5) Issue No. 5 is entitled "Disproportionate Share Hospital Payment – Managed Care Part C Days";

6) Issue No. 6 is entitled "Disproportionate Share Hospital Payment – Medicaid Eligible Labor Room Days";

7) Issue 7 is entitled "Disproportionate Share Hospital Payment – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)"; and

8) Issue 8 is entitled "Rural Floor Budget Neutrality Adjustment."

The Provider has requested transfers of Issue Nos. 3, 5, and 7 to group appeals. The Provider has withdrawn Issue No. 6. The Provider did not include or brief Issue No. 8 in its Final Position Paper, and pursuant to PRRB Rule 27 this issue has been abandoned. The Medicare Contractor has filed jurisdictional challenges regarding the three remaining issues in the appeal - Issue Nos. 1, 2 and 4.

Descriptions of Issue Nos. 1, 2, and 4

Issue No. 1 is entitled "Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific)" (hereinafter "DSH/SSI Percentage Provider Specific Realigment issue"), and alleges the Provider's DSH SSI Percentage is flawed and fails to include all patients that were entitled to SSI benefits. The Provider further explains it is seeking SSI date from CMS in order to identify records that were not included in the determination of the SSI percentage, and the Provider "hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period."[1]

Issue No. 2, also entitled the "Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific)" (hereinafter "DSH/SSI Percentage Provider Specific issue"), and alleges the Provider's DSH SSI Percentage is flawed and fails to include all patients that were entitled to SSI benefits. Similar to Issue No. 1, the Provider explains it 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 calculation of the SSI percentage.[2]

[1] Provider's Model Form A – Individual Appeal Request (Dec. 2, 2013), Tab 3 at 1.
[2] Provider's Model Form A – Individual Appeal Request (Dec. 2, 2013), Tab 3 at 1-2.

Issue No. 4 is entitled "Disproportionate Share Hospital Payment – Medicaid Eligible Days" (hereinafter "DSH Medicaid Eligible Days issue"), and the Provider contends that the Medicare Contractor failed to include all Medicaid eligible days in the Medicaid Percentage of the DSH calculation.[3]

Description of Transferred Issue No. 3

Issue No. 3 is entitled "Disproportionate Share Hospital ('DSH')/Supplemental Security Income ('SSI')(Systemic Errors)" (hereinafter "DSH/SSI Systemic Errors issue"), and the Provider describes this issue as whether the DSH/SSI percentage was properly calculated. More specifically and relevant to this jurisdictional decision, the Provider describes problems with the underlying SSI data that is used to calculate the DSH SSI percentage, referring to the U.S. District Court decision *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[4] The Provider filed a Model Form D – Request to Transfer an Issue to a Group Appeal regarding Issue No. 3 (DSH/SSI Systemic Errors issue) to Case No. 14-2895G on July 31, 2014.

Medicare Contractor's Position

The Medicare Contractor is challenging jurisdiction over Issue No. 1 (DSH/SSI Percentage Provider Specific Realignment), Issue No. 2 (DSH/SSI Percentage Provider Specific) and Issue No. 4 (Medicaid Eligible Days). These are the only three remaining issues in the appeal. Regarding Issues No. 1 and 2, the Medicare Contractor states that these issues are duplicative of themselves, as well as Issue No. 3 (DSH/SSI Systemic Errors issue) which no longer resides in this appeal. The Medicare Contractor points out that all three issues contend the SSI Percentage used in processing the DSH payment was incorrect, and that PRRB Rule 4.5 prohibits the appeal of an issue from a final determination in more than one appeal.

The Medicare Contractor adds that the aspect of Issue No. 1 regarding the right to request realignment to the Provider's fiscal year end (in the DSH calculation) is not an appealable issue. The Medicare Contractor argues the Provider has never mad e a request for realignment, and the Medicare Contractor has not made a final determination with regards to this issue. Therefore, the Board does not have jurisdiction over this aspect of Issue No. 1.

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[3] Provider's Model Form A – Individual Appeal Request (Dec. 2, 2013), Tab 3 at 10.
[4] Provider' Model Form A – Individual Appeal Request (Dec. 2, 2013), Tab 3 at 2-4, 8-10.

Regarding Issue No. 4, the Medicaid Eligible Days issue, the Medicare Contractor contends that the Board does not have jurisdiction over the additional days the Provider now seeks because the Medicare Contractor did not make an adjustment to the disputed days, nor did the Provider include a protested amount on its amended cost report for the disputed days as required.

The Provider's Position

The Provider did not file a response to the Medicare Contractor's August 29, 2017 or November 6, 2017 Jurisdictional Challenges. However, the Provider did file a response to the Board's Alert 10. Through this Board Alert, the Board asked Provider's to brief the DSH Medicaid Eligible Days issue, and to supply the following provider-specific information/documentation to the extent it is not already in the appeal record:

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

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

The Provider contends that the State of Texas Medicaid agency typically fails to verify the entire Provider's Medicaid eligible days at the time of the Provider's submission of its cost report. The Provider argues this practical impediment precluded the Provider from identifying all of its Medicaid eligible days as of the date of the filing of the cost report.[5]

[5] Provider's Alert 10 Response (July 18, 2014).

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2013), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination. The jurisdictional issue presented here is whether or not this hospital has preserved its right to claim dissatisfaction with the amount of Medicare payment. "A provider. . . has a right to a Board hearing . . . only if – (1) the provider has preserved its right to claim dissatisfaction . . . by . . . [i]ncluding a claim for specific item(s) on its cost report . . . or . . . self-disallowing the specific item(s) by . . . filing a cost report under protest.[6]

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

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

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

The Board finde that it has jurisdiction over the portion of Issue No. 1 (DSH/SSI Percentage Provider Specific Realignment) challenging the data used to calculate the SSI percentage as there was an adjustment to the SSI percentage (Adj. 40), and the appeal meets the amount in controversy and timely filing requirements. However, the Board also finde that the inaccurate data portion of Issue No. 1 is duplicative of Issue No. 3, the DSH/SSI Systemic Errors issue that was transferred to 14-2895G. The basis of both Issues is that the SSI percentage is improperly calculated, and the Provider does not have the underlying data to determine if the SSI percentage is accurate. The portion of Issue No. 1 challenging the accuracy of the SSI ratio data now resides in Case No. 14-2895G.

Regarding the portion of Issue No. 1 addressing realignment of the DSH calculation to the Provider's fiscal year end, the Board finds that realignment using the Provider's fiscal year end is a Provider

[6] 42 C.F.R. § 405.1835(a) (emphasis added).

election, and there is no evidence in the record that the Medicare Contractor has made a final determination regarding this issue. Therefore, the Board does not have jurisdiction over the DSH/SSI Percentage Provider Specific Realignment issue and it is dismissed from the appeal.

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

The Board finds that Issue No. 2 is duplicative of Issue No. 3. The basis of both issues is that the DSH SSI percentage is improperly calculated, and the Provider does not have the underlying data to determine if the SSI percentage is accurate. Issue No. 2 regarding the DSH/SSI Percentage Provider Specific is dismissed from the appeal as it is duplicative of another issue under appeal.

Issue No. 4 "DSH Medicaid Eligible Days"

The Provider is appealing from a 06/30/2009 cost report, which means that it either had to claim the cost at issue or it is subject to the protest requirement in order for the Board to have jurisdiction.

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

In conclusion, the Board dismisses Issue Nos. 1 (DSH/SSI Percentage Provider Specific Realignment), 2 (DSH/SSI Percentage Provider Specific), and 4 (DSH Medicaid Eligible Days) from this appeal due to lack of jurisdiction.

This appeal is now closed as there are no remaining issues. Review of this decision may be available under 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members

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

FOR THE BOARD

L. Sue Andersen, Esq.
Chairperson

cc: Wilson Leong, Esq., FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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JAN 19 2018

Certified Mail

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

RE: Expedited Judicial Review Request
Hall Render 2009 & 2011 Part C Days Groups
FYE: 2009 & 2011
PRRB Case Nos.: 14-2314GC, 14-3972GC, 15-0508GC and 15-2415GC

Dear Ms. Griffin and Ms. Elias:

On December 28, 2017, the Provider Reimbursement Review Board ("PRRB" or "Board") received a request for expedited judicial review ("EJR"), dated December 27, 2017, for the above-referenced appeals. The Board has reviewed the request and hereby grants EJR of the Medicare Part C day issue in the appeals, as explained below.

The issue in these appeals is:

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

Background

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 disproportionate share hospital ("DSH") adjustment,

[1] December 27, 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).

which requires 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 referred to as the "Medicare" or "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 utilized by the Medicare contractors to compute a hospital's DSH eligibility and payment adjustment.[9]

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

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

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

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[10]

Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary[11] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[12]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[13]

With the creation of Medicare Part C in 1997,[14] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their

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[10] 42 C.F.R. § 412.106(b)(4).
[11] of Health and Human Services
[12] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).
[13] *Id.*
[14] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered

care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.[15]

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the 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 . . .*[16]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[17] In response to a comment regarding this change, the Secretary explained that:

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

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

[15] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).

[16] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003)(emphasis added).

[17] 69 Fed. Reg. at 49,099.

> associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[18] (emphasis added)

Consequently, within her response, 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.[19] In that publication, the Secretary noted that no regulatory change had in fact occurred but that 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, the pertinent regulatory language was "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,*[20] vacated the FFY 2005 IPPS rule. However, the Providers claim that the Secretary has not acquiesced or taken action to implement the decision.[21]

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.[22]

In *Allina*, the Court affirmed the district court's decision "that the Secretary's final rule was not a logical outgrowth of the proposed rule."[23] The Providers claim that because the Secretary has not acquiesced to the decision, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

In these cases, the Providers contend that all Part C days should be excluded from the Part A/SSI fraction and the Medicaid-eligible Part C days should be included in the numerator of the

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[18] *Id.*
[19] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[20] 746 F. 3d 1102 (D.C. Cir. 2014).
[21] December 27, 2017 EJR Request at 7-8.
[22] 69 Fed. Reg. at 49,099.
[23] *Allina* at 1109.

Medicaid fraction. To obtain relief, the Providers seek a ruling on the procedural and substantive validity of the 2004 rule that the Providers claim the Board lacks the authority to grant. The Providers argue that since the Secretary has not acquiesced to the decision in *Allina*, the Board remains bound by the regulation and EJR is appropriate.

Decision of the Board

Board's Authority and Analysis

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 and Determination

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 Board jurisdictional regulations, 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 the notice of the intermediary's determination was mailed to the provider (prior to August 21, 2008) or within 180 days of the date of receipt of the final determination (on or after August 21, 2008).[24]

The Providers included in this EJR request filed appeals based upon original notices of program reimbursement ("NPRs"). The cost reporting periods involved in this EJR request end between December 31, 2009, June 30, 2011, and December 31, 2011.

For appeals of original NPRs for cost reporting time periods ending on or after December 31, 2008, providers preserve their respective rights to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either including a claim for the specific item on their cost reports for the period where the providers seek payment they believe to be in accordance with Medicare policy, or self-disallowing the specific item by following the applicable procedures for filing cost reports under protest.[25]

A jurisdictional review of the appeals in this EJR request shows that all of the Providers have an adjustment to the SSI% on their respective NPRs and/or have properly protested the appealed issue. In addition, the Providers' documentation shows that the appeals were timely filed and that

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[24] 42 C.F.R. §§ 405.1835-405.1841 (2005); 42 C.F.R. §§ 405.1835-405.1840 (2008).
[25] *See* 42 C.F.R. § 405.1835(a)(1) (2008).

the estimated amount in controversy for each group appeal exceeds $50,000. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Authority to Consider the Appealed Issue

The second part of the Board's EJR analysis concerns whether the Board lacks the authority to decide the specific legal question relevant to the 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 appeals involved in this EJR request span fiscal years 2006-2012, thus the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in 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*,[26] 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.

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.

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[26] 863 F.3d 937 (D.C. Cir. July 25, 2017).

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

Board Members Participating:

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

FOR THE BOARD:

Charlotte F Benson for

L. Sue Andersen, Esq.
Chairperson

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

cc: Danene Hartley, National Government Services (Certified Mail w/Schedules of Providers)
Pam VanArsdale, National Government Services (Certified Mail w/Schedules of Providers)
Judith Cummings, CGS Administrators (Certified Mail w/Schedules of Providers)
Wilson Leong, Federal Specialized Services (w/Schedules of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

JAN 19 2018

Certified Mail

Cynthia F. Wisner, Esq.
Associate Counsel
Trinity Health
20555 Victor Parkway
Livonia, MI 48152

RE: **Expedited Judicial Review Determination**
Trinity Health 2009 DSH Medicaid Fraction Medicare Advantage Days Group, PRRB Case No. 13-3905GC
Trinity Health 2009 DSH SSI Fraction Medicare Advantage Days Group, PRRB Case No. 13-3907GC
Trinity Health 2010 DSH Medicaid Fraction Medicare Advantage Days Group, PRRB Case No. 14-2164GC
Trinity Health 2010 DSH SSI Fraction Medicare Advantage Days Group, PRRB Case No.14-2196GC

Dear Ms. Wisner:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' January 3, 2018 request for expedited judicial review (EJR) (received January 5, 2018) for the above-referenced appeals. The decision of the Board is set forth below.

Issue in Dispute

Whether Medicare Advantage Days (Part C Days) should be removed from the disproportionate share hospital adjustment (DSH adjustment) Medicare Fraction and added to the Medicaid Fraction consistent with the decision of the United States Court of Appeals for the District of Columbia in *Allina Health Services v. Selelius*[1]. . . and *Allina Health Services v. Price*[2] . . . (The "Part C Days Issue").[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]

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[1] 746 F. 3d 1102 (D.C. Cir. 2014).
[2] 863 F. 3d 937 (D.C. Cir. 2017).
[3] Providers' January 3, 2018 EJR Request at 1.
[4] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[5] *Id.*

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

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

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

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

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

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the 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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[6] *See* 42 U.S.C. § 1395ww(d)(5).
[7] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[11] 42 C.F.R. § 412.106(b)(2)-(3).
[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 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:

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

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

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. In *Allina Health Services v. Price,* the D.C. Circuit Court concluded that the

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[18] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).
[19] 69 Fed. Reg. at 49,099.
[20] *Id.*
[21] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[22] 746 F. 3d 1102 (D.C. Cir. 2014).

Secretary was required to engage in notice and comment rule making before deciding to include Part C days in the Medicare fraction and, consequently, the Medicare fractions were procedurally invalid.[23]

Providers' Request for EJR

The Providers point out that because the Secretary has not acquiesced to the decision[s] in *Allina*, 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) (the 2004 Rule). The Providers state that the Board has jurisdiction over the appeals and there are no facts in dispute. The Providers note that the Board is bound by the 2004 Rule and does not have the authority to grant the relief sought, and, as a result, the Board should grant EJR.

Decision of the Board

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

Jurisdictional Determination

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2009-2010.

With respect to a participant's appeals filed from a cost reporting period that ends on or after December 31, 2008, in order to demonstrate dissatisfaction with the amount of Medicare payment for the appealed issue, a participant filing an appeal from an original NPR must show that the Medicare contractor adjusted its SSI fraction when it settled the participant's cost report or the participant must have self-disallowed the appealed issue by filing its cost report under protest.[24]

The Board has determined that participants involved with the instant EJR request appealed from original NPRs and have had Part C days excluded from the Medicaid fraction, had a specific adjustment to the SSI fraction, or properly protested the appealed issue such that the Board has jurisdiction to hear their respective appeals. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[25] and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The group appeals in this EJR request span fiscal years2009 and 2010, thus the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and,

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[23] *Allina Health Services v. Price* at 943-44.
[24] *See* 42 C.F.R. § 405.1835 (2008)
[25] *See* 42 C.F.R. § 405.1837.

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. [26]

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

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

Board Members Participating

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

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[26] On January 3, 2018, one of the Medicare contractors, Wisconsin Physicians Service ("WPS"), filed an objection to the EJR request in a number of cases identified in the EJR request. In its filing, WPS argues that the Board should deny the EJR request because the Board has the authority to decide the issue under appeal since it is not bound by the Secretary's regulation that the federal district court vacated in *Allina.* The Board's explanation of its authority regarding this issue addresses the arguments set out in WPS' challenge.

Schedules of Providers[27]

cc: Byron Lamprecht, WPS (Certified Mail w/Schedule of Providers)
Wilson Leong, FSS (w/Schedule of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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JAN 19 2018

Certified Mail

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RE: **Expedited Judicial Review Decision**

CHS NY 2008 SSI Fraction Part C Days Group, PRRB Case No. 13-1638GC
CHS NY 2008 Medicaid Fraction Part C Days Group, PRRB Case No.13-1629GC
McKay 2009 SSI Fraction Part C Days Group, PRRB Case No. 16-3886GC
McKay 2010 Medicaid Fraction Part C Days Group, PRRB Case No. 14-1675G
McKay 2010 SSI Fraction Part C Days Group, PRRB Case No.14-1676G
McKay 2011 Medicaid Fraction Part C Days Group, PRRB Case No. 14-2594G
McKay 2011 SSI Fraction Part C Days Group, PRRB Case No. 14-2625G

Dear Ms. Webster:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' January 5, 2018 request for expedited judicial review (EJR) (received January 8, 2018). The decision of the Board is set forth below.

Issue under Appeal

The issue in these cases 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]

[1] "SSI" is the acronym for "Supplemental Security Income."
[2] "DSH" is the acronym for "disproportionate share hospital."
[3] Providers' January 5, 2018 EJR Request at 4.

Statutory and Regulatory Background

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[4] 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].[5]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[6]

With the creation of Medicare Part C in 1997,[7] 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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[4] of Health and Human Services
[5] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).
[6] *Id.*
[7] 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-

care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the intermediaries to calculate DSH payments for the FY 2001-2004. [8]

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)[9]

The Secretary purportedly changed her position in the 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."[10] 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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173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.

[8] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).

[9] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).

[10] 69 Fed. Reg. at 49,099.

> associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[11] (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 Federal fiscal year (FFY) 2008 final rule was issued.[12] 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* (*Allina I*),[13] 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.[14] More recently in *Allina Health Services v.* Price (*Allina II*),[15] the Court found that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction was vacated by *Allina Health Services* above. The Court found that the Secretary was required to undertake notice and comment ruling-making and the 2012 regulation was invalid. Once again, the Secretary has not acquiesced to this decision.

Providers' Request for EJR

The Providers point out that prior to the 2004 rulemaking, in which the Secretary attempted to adopt a new policy to begin counting Part C days in the Medicare Part A/SSI fraction, the Secretary treated Part C patients as not entitled to benefits under Part A, rather they should be included in the Medicaid fraction of the DSH adjustment.[16] In the May 2003 proposed rule for Federal fiscal year 2004, the Secretary proposed "to clarify" her long held position that "once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage."[17] Further, the Secretary went on, "[t]hese days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patients' days for a [Part C] beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction."[18] The Secretary

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[11] *Id.*
[12] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[13] 746 F. 3d 1102 (D.C. Cir. 2014).
[14] Providers' EJR request at 1.
[15] 2017 WL 3137976 (D.C. Cir. July 25, 2017)
[16] Providers' EJR Request at 4 citing to Allina 746 F.3d at 1105.
[17] 68 Fed Reg. at 27,208. ,
[18] *Id.*

explained that "once a beneficiary has elected to join a Medicare Advantage plan, that beneficiary's benefits are no longer administered under Part A."[19]

However, in the final rule for the Federal fiscal year 2005, the Secretary reversed course and adopted a policy to include Part C days in the Medicare Part A/SSI fraction and exclude the Part C days from the Medicaid fraction effective October 1, 2004.[20] The Secretary's actions were litigated in *Allina I* in which the Court concluded that the Secretary's final rule was not a logical outgrowth of the proposed rule and a vacatur was warranted. The Secretary has continued to issue the DSH fractions as he has for prior years as if the vacatur had never happened, or issuing a new rule without notice-and-comment rulemaking.[21]

The Providers are seeking EJR over the appeal because the Board does not have the authority to adjudicate the continued application of the 2004 rule and its policy change to the applicable portion of the cost years at issue.[22] The Providers point out that the Board continues to be bound by the regulation on Part C days unless the Secretary acquiesces in the *Allina* court rulings, which he has not done.[23]

Decision of the Board

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

Jurisdictional Determination

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2008,[24] 2009, 2010 and 2011.

In these cases the participant's appeals were filed from a cost reporting periods that ended on or after December 31, 2008. In these cost reporting years, in order to demonstrate dissatisfaction with the amount of Medicare payment for the appealed issue, a participant filing an appeal from an original NPR must show that the Medicare contractor adjusted its SSI fraction when it settled

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[19] *Id.*
[20] 69 Fed Reg. 49,099 (Aug. 11, 2004).
[21] *Id. at 7*
[22] *Id. at 10,* citing 42 C.F.R. § 405.1867 ("in exercising its authority to conduct proceedings under this subpart, the Board must comply with all the provisions of Title XVIII of the Act and the regulations thereunder.").
[23] *Id.*
[24] The 2008 fiscal year under appeal is December 31, 2008.

the participant's cost report or the participant must have self-disallowed the appealed issue by filing its cost report under protest.[25]

The Board has determined that participants involved with the instant EJR request filed their appeals from original NPRS and have had Part C days excluded from the Medicaid fraction, had a specific adjustment to the SSI fraction, or properly protested the appealed issue such that the Board has jurisdiction to hear their respective appeals. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[26] and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The group appeals in this EJR request span fiscal years 2008, 2009, 2010 and 2011 thus the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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[25] *See* 42 C.F.R. § 405.1835 (2008).
[26] *See* 42 C.F.R. § 405.1837.

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

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

Board Members Participating

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

FOR THE BOARD:

Charlotte Benson for

L. Sue Andersen, Esq.
Chairperson

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

cc: Pam VanArsdale, NGS (Certified Mail w/Schedules of Providers)
Bruce Snyder, Novitas Solution (Certified Mail w/ Schedules of Providers
Wilson Leong, FSS (w/Schedules of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Certified Mail JAN 19 2018

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

RE: Expedited Judicial Review Request
Alhambra Hospital and Medical Center (Provider No. 05-0281)
FYE: June 30, 2011
PRRB Case No.: 15-1587

Dear Mr. Ravindran:

On December 26, 2017, the Provider Reimbursement Review Board ("PRRB" or "Board") received a request for expedited judicial review ("EJR"), dated December 22, 2017, for Alhambra Hospital and Medical Center's ("Alhambra" or "Provider") Medicare Part C days issue included within this individual appeal. The Board has reviewed the request and hereby grants EJR of the Medicare Part C day issue, as explained below.

Alhambra describes its Medicare Part C days issue in the following manner:

> [W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare Fraction and added to the Medicaid fraction consistent with the decision of the Unites States Court of Appeals for the District of Columbia in *Allina Health Services v. Sebelius*, 746 F.3d 1102 (D.C. Cir 2014).[1]

Background

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 disproportionate share hospital ("DSH") adjustment,

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[1] 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).

which requires 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 referred to as the "Medicare" or "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 utilized by the Medicare contractors to compute a hospital's DSH eligibility and payment adjustment.[9]

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

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

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

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[10]

Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary[11] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[12]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[13]

With the creation of Medicare Part C in 1997,[14] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their

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[10] 42 C.F.R. § 412.106(b)(4).
[11] of Health and Human Services
[12] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).
[13] *Id.*
[14] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in

care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.[15]

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the 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* . . .[16]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[17] In response to a comment regarding this change, the Secretary explained that:

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

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

[15] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).

[16] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003)(emphasis added).

[17] 69 Fed. Reg. at 49,099.

> associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[18] (emphasis added)

Consequently, within her response, 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.[19] In that publication, the Secretary noted that no regulatory change had in fact occurred but that 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, the pertinent regulatory language was "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,*[20] vacated the FFY 2005 IPPS rule. However, Alhambra claims that the Secretary has not acquiesced or taken action to implement the decision.[21]

Provider's 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.[22]

In *Allina*, the Court affirmed the district court's decision "that the Secretary's final rule was not a logical outgrowth of the proposed rule."[23] Alhambra claims that because the Secretary has not acquiesced to the decision, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

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[18] *Id.*
[19] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[20] 746 F. 3d 1102 (D.C. Cir. 2014).
[21] *See* EJR Request at 17.
[22] 69 Fed. Reg. at 49,099.
[23] *Allina* at 1109.

In these cases, Alhambra contends 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, Alhambra seeks a ruling on the procedural and substantive validity of the 2004 rule that Alhambra claims the Board lacks the authority to grant. Alhambra argues 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 and Analysis

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 and Determination

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue. Pursuant to the pertinent Board jurisdictional regulations, 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, and the request for hearing is filed within 180 days of the date of receipt of the final determination.[24]

For appeals of 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 a specific item at issue by either including a claim for the specific item on its cost report for the period where the provider seeks payment it believes to be in accordance with Medicare policy, or self-disallowing the specific item by following the applicable procedures for filing a cost report under protest.[25]

A jurisdictional review of Alhambra's timely filed request for hearing shows that Alhambra filed its appeal from its original notice of program reimbursement that settled the cost reporting period ending on June 30, 2011, and that Alhambra's Audit Adjustment Report shows that the Medicare Contractor adjusted Alhambra's SSI percentage during settlement. In addition, Alhambra claims that the amount in controversy is in excess of $600,000.

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[24] 42 C.F.R. §§ 405.1835-405.1840 (2008).
[25] *See* 42 C.F.R. § 405.1835(a)(1) (2008).

Board's Authority to Consider the Appealed Issue

The second part of the Board's EJR analysis concerns whether the Board lacks the authority to decide the specific legal question relevant to the 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 appeal involved in this EJR request covers the fiscal year 2011, thus the appealed cost reporting period fall squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, Alhambra (and other 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*,[26] 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.

Board's Decision Regarding the EJR Request

The Board finds that:

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

2) based upon the Provider's 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 Alhambra's request for EJR for the Medicare Part C days issue described above.

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[26] 863 F.3d 937 (D.C. Cir. July 25, 2017).

Alhambra has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is not the only issue under dispute in the instant appeal, this case remains open.

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)

cc: Evaline Alcantara, Noridian Healthcare Solutions (Certified Mail)
Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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JAN 23 2018

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RE: Jurisdictional Decision
Alta Bates Medical Center – Summit Campus
Case Number: 13-3709
FYE: 12/31/2009

Dear Mr. Jaeger and Ms. Alcantara:

Alta Bates Summit Medical Center – Summit Campus, or the Provider, is appealing the amount of Medicare Reimbursement as determined by the Medicare contractor. The Provider filed the request for appeal on September 20, 2013 regarding a final determination (Notice of Program Reimbursement) dated March 26, 2013. The Medicare Contractor has challenged jurisdiction over the last two remaining issue in the appeal, and the Board's jurisdictional decision is set forth below.

Background

The Provider stated twenty issues in its Model Form A – Individual Appeal Request. Issue Nos. 1, 2, 3, 4, 5, 6, 19 and 20 have been transferred to group appeals. The Provider has withdrawn Issue Nos. 7, 8, 9, 10, 11, 12, 13, 14, 15 and 16 via letter dated December 26, 2017. The Medicare Contractor, Noridian Healthcare Solutions, has challenged the Board's jurisdiction over the last two remaining issues in the appeal – Issue Nos. 17 and 18. The Provider did not file a response to the Jurisdictional Challenge.

Issue No. 17

Issue No. 17 is titled "Allied Health Program, Adjustment Number: N/A Reimbursement Impact: $218,670." *Model Form A – Individual Appeal Request (Sept. 19, 2013), Tab 3 at 17.* The Provider contends that nursing and allied education program cost is eligible to additional payments and requests it be properly reimbursed for these costs. *Id at 17-18.*

Issue No. 18

Issue No. 18 is titled "A & G [Administration & General] Allocation to the Allied Health Program, Adjustment Number: N/A Reimbursement Impact: $700,000." *Model Form A – Individual Appeal Request, Tab 3 at 19.* The Provider contends that nursing and allied education program cost is eligible for additional payments and requests to be properly reimbursed for these costs. Specifically, the Provider alleges that Administration & General net accumulated cost must be "grossed-up" because otherwise an inadequate amount of these cost would be allocated to the nursing school. *Id. at 19-20.*

Medicare Contractor's Position

The Medicare Contractor states the Provider did not cite any audit adjustments with relation to its dispute for either Issue No. 17 or 18. The Medicare Contractor's position is that it did not render an adverse determination over the Provider's allied health program or the allocation of A&G to the allied health program, and this payment was omitted from the Provider's as-filed cost report (referring to exhibit I-13 in the *Medicare Contractor's Jurisdictional Challenge (Dec. 6, 2017)*). The Medicare Contractor contends that the Provider's dissatisfaction stems from its failure to claim the allied health managed care payment.

The Medicare Contractor argues these two issues should be dismissed as the Provider did not preserve its right to claim dissatisfaction for these issues by including a claim for the specific items on its cost report. Also, it argues the Provider has not properly preserved its right to claim dissatisfaction for this issue as self-disallowed by protesting the item on its cost report.

Board Decision

APPLICABLE STATUTES AND REGULATIONS

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2012), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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

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

42 C.F.R. 405.1835(a)(1)(2012).

The applicable procedures for filing a cost report under protest in CMS Publication 15-2, Section 115.1 state "[w]hen you file a cost report under protest, the disputed item and amount for each issue must be specifically identified in footnotes to the settlement worksheet and the fact that the cost report is filed under protest must be disclosed."

ANALYSIS AND JURISDICTIONAL DETERMINATION

The Provider is appealing from a 12/31/2009 cost report, which means that it either had to claim the cost at issue or it is subject to the protest requirement in order for the Board to have jurisdiction.

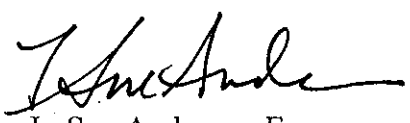
The Board finds it does not have jurisdiction over Issue Nos. 17 and 18 which seek payment for nursing and allied education program costs. The Provider did not include a claim for these costs on its as-filed cost report, and the Medicare Contractor made no adjustment to these costs as they were not claimed. Additionally, the Provider did not protest these costs on its cost report as self-disallowed as required by 42 C.F.R. 405.1835(a)(1)(ii). The Board finds the Provider has not preserved its right to claim dissatisfaction with the amount of Medicare payment for these specific items at issue, and therefore the Board does not have jurisdiction over Issue Nos. 17 and 18 in this appeal which seek nursing and allied health program costs.

This appeal is now closed as the last two remaining Issues are dismissed for lack of jurisdiction. Review of this decision may be available under 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members

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

FOR THE BOARD



L. Sue Andersen, Esq.
Chairperson

cc: Wilson Leong, Esq., FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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JAN 23 2018

CERTIFIED MAIL

Wade H. Jaeger
Reimbursement Manager, Appeals/Litigation
Sutter Health
P.O. Box 619092
Roseville, CA 95661

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

RE: Jurisdictional Decision
Alta Bates Medical Center – Summit Campus
Case Number: 13-1227
FYE: 12/31/2007

Dear Mr. Jaeger and Ms. Alcantara:

Alta Bates Summit Medical Center – Summit Campus, or the Provider, is appealing the amount of Medicare Reimbursement as determined by the Medicare contractor. The Provider filed the request for appeal on March 26, 2013 regarding a final determination (Notice of Program Reimbursement) dated October 9, 2012. . The Medicare Contractor has challenged jurisdiction over the last remaining issue in the appeal, and the Board's jurisdictional decision is set forth below.

Background

The Provider stated five issues in its Model Form A – Individual Appeal Request. Four of the five issues have been transferred, and only Issue No. 1 remains which addresses the Disproportionate Share Hospital Payment/Supplemental Security Income Ratio Issued March 2012, Realignment (hereinafter "DSH SSI Percentage Realignment issue"). The Medicare Contractor has challenged the Board's jurisdiction over this issue.

Medicare Contractor's Position

The Medicare Contractor's position is that Issue No. 1 addressing the DSH SSI Percentage Realignment issue was a part of Case No. 11-0772GC which the Board dismissed on March 2, 2016 on the basis that the Board does not have jurisdiction over the SSI Ratio Realignment issue. The Medicare Contractor claims the Provider has included the DSH SSI Percentage Provider Specific issue which is duplicated by Issue No. 2 which has been transferred, and duplicative issues are prohibited by PRRB Rule 4.5. The Medicare Contractor asserts the Provider is arguing the same thing in both issues - that the SSI

percentage is understated and that it needs the underlying data to determine what records were not included, if any.

The Provider's Position

The Provider did not file a response to the Medicare Contractor's October 25, 2017 Jurisdictional Challenge. The Provider describes the DSH SSI Percentage Realignment issue as "the SSI percentage as generated by the Social Security Administration ('SSA') and put forth by CMS is understated." *Model Form A – Individual Appeal Request (Mar. 25, 2013), Tab 3 – Statement of Appeal Issues at 14.* The Provider further explains that it may choose to use its cost reporting period instead of the Federal fiscal year in the DSH calculation...and that part of this issue may be resolvable with the Medicare Contractor's agreement to realign the SSI percentage from the federal fiscal year to using the Provider's cost reporting period. *Id at 14-15.*

The Provider describes Issue No. 2, the Disproportionate Share Hospital/Supplemental Security Income Ratio Issued March 2012, Accurate Data issue (hereinafter "DSH SSI Percentage Inaccurate Data issue"), as "the SSI percentage as generated by the Social Security Administration ('SSA") and put forth by CMS is understated." *Model Form A – Individual Appeal Request (Mar. 25, 2013), Tab 3 – Statement of Appeal Issues at 15.* The Provider further explains that CMS did not use the best data available at the time of settlement to calculate the SSI fraction because of various reasons. *Id at 15-16.* Issue No. 2 was transferred to Case No. 17-2169GC on September 12, 2017.

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2012), a hospital has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination. Additionally, PRRB Rule 4.5 states that a Provider may not appeal an issue from a final determination in more than one appeal.

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

The Board finds it has jurisdiction over the portion of Issue No. 1 (DSH SSI Percentage Realignment issue) challenging the data used to calculate the SSI percentage as there were adjustments to the DSH SSI percentage (Adj. 21 and 33), and the appeal meets the amount in controversy and timely filing requirements. However, the Board also finds that the inaccurate data portion of Issue No. 1 is duplicative of Issue No. 2, the DSH SSI Percentage Inaccurate Data issue which has been transferred to Case No. 17-2169GC. The basis of both Issues is that the SSI percentage is improperly calculated, and the Provider does not have the underlying data to determine if the SSI percentage is accurate. This part of Issue No. 1 is dismissed from the appeal because is duplicative which is prohibited, and it now resides in Case No. 17-2169GC.

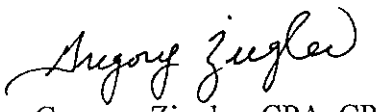
Regarding the portion of Issue No. 1 addressing realignment of the DSH calculation to the Provider's fiscal year end, the Board finds that realignment using the Provider's fiscal year end is a Provider election, and there is no evidence in the record that the Medicare Contractor has made a final determination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

The appeal is now closed as this is the last remaining issue. Review of this decision may be available under 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members

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

FOR THE BOARD



Gregory Ziegler, CPA, CPC-A
Board Member

cc: Wilson Leong, Esq., FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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CERTIFIED MAIL

JAN 23 2018

L. Ryan Hales
Vice President, Revenue Mgmt.
Quorum Health Corp.
1573 Mallory Lane, Suite 100
Brentwood, TN 37027

RE: Watsonville Community Hospital
Provider No: 05-0194
FYE: 07/31/2006
PRRB Case No: 18-0333

Dear Mr. Hales:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's December 8, 2017 request for hearing which was received[1] by the Board on December 14, 2017. The Board's jurisdictional determination is set forth below.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2016), a provider has a right to a hearing before the Board with respect to a cost 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 and the request for hearing is received by the Board within 180 days of the date of receipt of the final determination by the provider.

Decision of the Board

In this case, the Provider's appeal was filed from the Notice of Correction of Program Reimbursement ("RNPR") dated June 9, 2017. The Provider is deemed to have received the final determination 5 days after the issuance of the NPR, which would have been June 14, 2017.[2] Thus, the 180 day filing period expired on December 11, 2017. However, the Board received the Provider's request for hearing on December 14, 2017, which is 183 days after the presumed receipt of the NPR. The Provider did not afford any explanation as to why its appeal request was being filed beyond the deadline for submission of a timely appeal.

[1] *See*, 42 C.F.R. § 405.1835(a)(3) (2015) (a provider has a right to hearing before the Board if, among other things, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the date of receipt of the final contractor determination.) 42 C.F.R. § 405.1801(a)(2) (2016) (the date of receipt means the date stamped "Received" by the reviewing entity.)

[2] 42 C.F.R. § 405.1801(a)(1)(iii) (the presumption, which is otherwise conclusive, may be overcome if it is established by a preponderance of the evidence that the materials were actually received on a later date.)

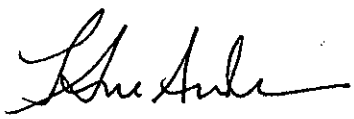
Therefore, the Board finds that the Provider's hearing request was not timely filed within 180 days of the date of receipt of the final determination and hereby dismisses this appeal.

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

Board Members Participating:

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

FOR THE BOARD:



L. Sue Anderson
Chairperson

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

cc: Byron Lamprecht
Cost Report Appeals
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Suite 200
Omaha, NE 68164

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

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JAN 24 2018

CERTIFIED MAIL

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

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

RE: Merit Health River Oaks Hospital
Juris. Challenge DSH – SSI (Provider Specific)
PN: 25-0138
FYE: 12/31/2013
PRRB Case Number: 16-2281

Dear Mr. Summar and Mr. Lamprecht,

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

Merit Health River Oaks Hospital ("River Oaks" or "Provider") filed a timely appeal on August 15, 2016 from its Notice of Program Reimbursement ("NPR") dated February 23, 2016. 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-SSI Part A Dual Eligible Days.
(5) DSH Medicaid Fraction -Dual Eligible Part C Days
(6) DSH Medicaid Fraction -Dual Eligible Part A Days
(7) DSH-Medicaid Eligible Days
(8) DSH-Dual Eligible Part C Days
(9) DSH-Dual Eligible Part A Days

After transfers, abandonment and duplication of issues only DSH-SSI Provider Specific and DSH-Medicaid Eligible Days (Issue # 1 and #7) remain in the case.[1]

[1] *See* Medicare Contractor's Jurisdictional Challenge dated November 9, 2017 and Medicare Contractor Position Paper dated November 21, 2017.

The Medicare Contractor filed a jurisdictional challenges regarding Issue #1, DSH – SSI (Provider Specific) on November 9, 2017. River Oaks did not file a jurisdictional responsive brief.

Medicare Contractor's Position

The Medicare Contractor contends the SSI issue has two components: SSI realignment and SSI data accuracy. The Medicare Contractor states that the issue over realignment should be dismissed since the Provider has not exhausted all available remedies and is premature. The Medicare Contractor contends since the decision to realign a Provider's SSI percentage with its fiscal year end is an election the Provider makes by submitting a formal request through its Medicare Contractor[2]. The Medicare Contractor further contends that the data accuracy component 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.[3] 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.[4]

Provider's Contentions

River Oaks contends that the SSI percentage published by CMS was incorrectly computed since CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End. River Oaks also states it has not yet analyzed the Medicare Part A data since it has not yet received the data.[5]

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 - 405.1840 (2016), 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.

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

River Oaks filed its Final Position paper on October 30, 2017 briefing the SSI% provider specific issue. The provider mentions the recalculation of the SSI% based on its cost reporting period in the paper,

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[2] 42 C.F.R. § 412.106(b)(3).
[3] Case # 16-0677GC.
[4] *See* Jurisdictional challenge dated November 9, 2017 (Received November 13, 2017).
[5] *See* Provider's Position Paper received October 30, 2017 at 8-9.
[6] See Providers Individual Appeal Request dated August 12, 2016.

however goes on to state that when it receives data from CMS it will identify patients that were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year.[7]

The Board finds that it lacks jurisdiction over the Provider Specific issue as it relates to realignment from the FFY to Cost Report Year as the Medicare Contractor did not render a determination of the realignment issue. The Provider has not exhausted its available remedy of requesting CMS to recalculate the SSI ratio using the Provider's fiscal year under 42 C.F.R. § 412.106(b)(3). The Board finds that it has jurisdiction over the portion of 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.19). However, the Board finds that this issue is duplicative of the SSI Systemic Errors issue appealed in Group Case No. Case No. 16-0677GC.

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). Accordingly, the Board dismisses Issue #1 DSH – SSI (Provider Specific), from this appeal and the case will remain open for the remaining issue of DSH-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 the appeal.

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

FOR THE BOARD

Gregory H. Ziegler

Gregory H. Ziegler, CPA, CPC-A

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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13-1308

CERTIFIED MAIL

JAN 26 2018

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

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

RE: Jurisdictional Determination
Bartow Regional Medical Center
Provider No.: 10-0121
FYEs: March 31, 2009 and 2013
PRRB Case Nos.: 13-1308 and 15-2995

Dear Mr. Summar and Mr. Lamprecht:

These cases involves Bartow Regional Medical Center's ("Bartow") appeals of its Medicare reimbursement for the fiscal years ending ("FYEs") on March 31, 2009, and March 31, 2013. In response to the Medicare Contractor's jurisdictional challenges, the Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed Bartow's documentation for both cases. The Board finds that it does not have jurisdiction to hear Bartow's appeals of its Supplemental Security Income ("SSI") percentage "provider-specific" issue, as this issue is already contained within two different group appeals, or its Medicaid eligible days issue, because Bartow did not claim or protest these days on either of the appealed cost reports as required by the applicable regulation. As these two issues are the only issues involved in Bartow's above-referenced appeals, the Board hereby closes these cases, as explained below.

Pertinent Facts

On October 3, 2012, and February 18, 2015, the Medicare Contractor issued Bartow's notices of program reimbursement ("NPRs") for the cost reporting periods ending on March 31, 2009, and March 31, 2013, respectively. On March 28, 2013, the Board received Bartow's request for a Board hearing ("2013 RFH") regarding its October 3, 2012 NPR, in which Bartow seeks Board review of six issues. Shortly after filing its 2013 RFH, Bartow transferred four of its issues to various group appeals, one of which was its SSI "systemic" issue, leaving only its SSI "provider-specific" issue and Medicaid eligible days issue in its individual appeal, PRRB Case No 13-1308. On July 14, 2015, the Board received Bartow's request for a Board hearing ("2015 RFH") regarding its February 18, 2015 NPR. In its 2015 RFH, Bartow seeks Board review of nine

issues, but later transferred all of its issues to various group appeals with the exception of SSI "provider-specific" and Medicaid eligible days.

PRRB Case No. 13-1308

On July 8, 2013, the Board received the Medicare Contractor's jurisdictional challenge dated July 3, 2013, ("July 3, 2013 Jurisdictional Challenge) in which the Contractor argues that Bartow's SSI "provider-specific" issue is not an appealable issue, but a realignment request, as Bartow states that it is preserving "its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period."[1]

The Medicare Contractor filed a second jurisdictional challenge, dated October 30, 2017, in which the Contractor challenges Board jurisdiction over both Bartow's SSI "provider-specific" issue and its Medicaid eligible days issue. In addition to the arguments set out in its July 3, 2013 Jurisdictional Challenge, the Contractor argues that Bartow's SSI "provider-specific" issue is essentially the same as its SSI "systemic" issue that Bartow transferred to a common issue related party ("CIRP") group appeal. Thus, the Medicare Contractor claims that Bartow has the same issue in two separate appeals, in violation of Board Rule 4.5. With respect to the Medicaid eligible days issue, the Medicare Contractor argues that it "did not render a final determination over the disputed days[]"[2] because Bartow did not claim these days on its cost report. The Contractor claims "that the disputed days represent a completely new subset of days not previously presented . . ."[3]

On July 22, 2014, the Board received Bartow's "Alert 10 Response" in which Bartow provides the Board with a description of the process that it used to identify Medicaid eligible days and includes a statement that the additional Medicaid days sought in its appeal could not be verified prior to Bartow's cost report filing deadline.

PRRB Case No. 15-2995

On September 28, 2015, the Board received the Medicare Contractor's jurisdictional challenge in which the Contractor questions, among other things, the Board's jurisdiction to hear Bartow's SSI "provider-specific" issue and its Medicaid eligible days issue. The Contractor argues that Bartow's SSI "provider-specific" issue is not an appealable issue, but a realignment request, and that this issue is duplicative of Bartow's SSI "systemic" issue. The Medicare Contractor also argues that, contrary to the applicable Board jurisdictional regulations, Bartow did not protest or claim the additional Medicaid eligible days it is seeking to add through its Board appeal.

On October 21, 2015, the Board received Bartow's jurisdictional response ("Response"). In its Response, Bartow argues that the fact that its disproportionate share hospital ("DSH") payment was adjusted in its NPR is sufficient to establish Board jurisdiction over its Medicaid eligible

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[1] 2013 RFH TAB 3, at unnumbered page 1.
[2] Medicare Contractor's Final Position Paper Ex I-2, at 4
[3] *Id.* at 5.

days issue. In addition, Bartow responds to the Board's Alert 10 by providing a description of the process that it used to identify Medicaid eligible days and by reporting that the additional Medicaid days sought in the appeal could not be verified prior to the cost report filing deadline. Lastly, Bartow argues that its SSI "provider specific" issue and its SSI "systemic" issue are "separate and distinct" issues, the former involving a reconciliation of MedPar data and a fiscal year realignment, while the latter focuses on "more in-depth aspects of the MedPar data" and includes the treatment of various patient populations (Part C days and days that fall under CMS Ruling 1498-R).[4]

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, 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"

In both the 2013 RFH and the 2015 RFH, Bartow summarizes its SSI "provider-specific" issue in the following manner:

> 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.[5]

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[4] Response at 17-18.
[5] 2013 RFH TAB 3, at unnumbered page 1; 2015 RFH TAB 3, at unnumbered page 1.

With respect to Bartow's SSI "systemic" issue, Bartow describes the issue as follows:

> The Provider contends that the SSI percentage[] calculated by [CMS] was incorrectly computed because of 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 days v. total days[,] . . . non-covered days[,] . . . CMS Ruling 1498-R[,] . . . matching methodology pursuant to CMS Ruling 1498-R [and] failure to adhere to required notice and comment rulemaking procedures in adopting policy on [exhausted benefit], [Medicare as second payor] and [Medicare Advantage] days . . . [6]

In its SSI "systemic" issue statements, Bartow sets out a long list of reasons why it claims that CMS incorrectly computed its SSI percentage. In its SSI "provider-specific" issue statement, Bartow fails to describe any additional reasons or patient populations "entitled to SSI benefits" that would distinguish the two issues from each other or in any way differentiate these issues in a significant manner. The Board concludes, therefore, that Bartow's SSI "systemic" and "provider-specific" issues challenge the same data underlying the SSI percentage calculation and are ultimately the same issue.

In addition, although Bartow's SSI "provider-specific" issue statements include a proclamation that Bartow "preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period[,]" the Board notes that Bartow's right to request realignment of its fiscal year for the SSI percentage calculations is a provider *election*, not an appealable issue before the Board.[7]

As Bartow previously transferred its SSI "systemic" issue into mandatory CIRP group appeals (namely, PRRB Case Nos. 13-2319GC and 16-0677GC), the Board hereby dismisses, pursuant to Board Rule 4.5, Bartow's SSI "provider-specific" issue from its individual appeals, PRRB Case Nos. 13-1308 and 15-2995.

Issue 2—Medicaid eligible days

In its jurisdictional challenges, the Medicare Contractor argues that Bartow did not claim or protest, on its as-filed cost reports, the Medicaid eligible days at issue in the instant appeals. The Contractor claims that since it did not issue a final determination with respect to these days, the Board does not have jurisdiction to consider the additional days in either of Bartow's appeals.

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[6] 2013 RFH TAB 3, at unnumbered pages 1-10 (emphasis omitted). Bartow's 2013 RFH SSI systemic issue statement covers all of the patient populations listed in Bartow's 2015 RFH SSI systemic issue statement. *See* 2015 RFH TAB 3, at unnumbered page 2-3.

[7] *See* 42 C.F.R. § 412.106(b)(3) (2012)

In both PRRB Case Nos. 13-1308 and 15-2995, Bartow filed documents that describe the process that it uses to identify Medicaid eligible days. Bartow argues that the additional Medicaid days it seeks to add in these appeals could not be verified prior to the cost report filing deadlines. In its Final Position Paper for PRRB Case No. 13-1308, the Medicare Contractor points out that Bartow cites to Audit Adjustment 23 as the adjustment pertaining to its Medicaid eligible days issue, but the Contractor argues that "this adjustment does not render a determination over the disputed days."[8] The Medicare Contractor goes on to argue "that the disputed days were omitted from the cost report[,] not claimed by [Bartow], [thus the Medicare Contractor] did not render a final determination over them." The Contractor concludes by asserting that "the disputed days represent a completely new subset of days not previously presented to the [Medicare Contractor]."[9]

In its Final Position Paper for PRRB Case No. 15-2995 ("2015 FPP"), the Medicare Contractor points out that it received Bartow's FYE March 31, 2013 cost report on August 28, 2013, but the Contractor did not begin its review of the cost report until December of 2014, thus Bartow had "more than 20 months to gather Medicaid eligibility data to submit before the desk review."[10] The Medicare Contractor goes on to argue that "[t]he provider is not challenging the [Medicare Contractor's] computations, but merely requesting the inclusion of additional days in these computations. The provider has failed to identify any adjustments to Medicaid days, and failed to protest the issue . . ."[11]

In order for the Board to find that it has jurisdiction to hear Bartow's appeals of this issue, Bartow must have demonstrated its dissatisfaction with the amount of Medicare payment for the Medicaid eligible days it seeks to include through these appeals. Under the jurisdictional regulations governing Board jurisdiction for both PRRB Case No. 13-1308 and PRRB Case No. 15-2995, Bartow has preserved its right to claim dissatisfaction with the amount of Medicare payment of the Medicaid eligible day at issue in these appeals if it either (1) included a claim for these Medicaid eligible days on its cost reports for the periods in question, or (2) self-disallowed these Medicaid eligible days by following the applicable procedures for filing cost reports under protest.[12] Following review of Bartow's jurisdictional documentation, the Board is unable to find that Bartow either claimed or protested these Medicaid eligible days that it now seeks to include in these cost reporting periods. Bartow has not shown that the Audit Adjustment numbers that it cites pertain to the Medicaid eligible days since both adjustments relate to the SSI percentage and DSH generally. In addition, Bartow has not shown that it self-disallowed these contested Medicaid eligible days by filing its applicable cost reports under protest. Accordingly, the Board finds that it lacks jurisdiction over Bartow's Medicaid eligible days issue in both PRRB Case No. 13-1308 and PRRB Case No. 15-2995, thus the Board must dismiss this issue from both of these individual appeals.

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[8] 2013 FPP at 22. The Medicare Contractor states that Audit Adjustment 23 represents a decrease in the percentage of SSI recipient patient days to Medicare Part A patient days and a decrease to the allowable disproportionate share percentage. Id.
[9] *Id.* at 24.
[10] 2015 FPP at 4.
[11] *Id.*
[12] *See* 42 C.F.R. § 405.1835(a)(1) (2012)

Conclusion

The Board finds as follows:

(1) Bartow's SSI "provider-specific" issue and its SSI "systemic" issue are the same issue. Since Bartow has its SSI "systemic" issue as the basis of two mandatory CIRP group appeals (PRRB Case Nos. 13-2319GC and 16-0677GC), the Board hereby dismisses Bartow's SSI "provider-specific" issue from both of Bartow's individual appeals, PRRB Case No. 13-1308 and PRRB Case No. 15-2995;
(2) The Board lacks jurisdiction to hear Bartow's appeals of its Medicaid eligible days issue in both PRRB Case No. 13-1308 and PRRB Case No. 15-2995, thus this issue is hereby dismissed from these two appeals; and
(3) As PRRB Case Nos. 13-1308 and 15-2995 contain no additional issues, the Board hereby closes these 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: John Hamada, Federal Specialized Services
Wilson Leong, Federal Specialized Services

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Refer to: 13-3376G

JAN 26 2018

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RE: King & Spalding 2007 Low Income Pool Sec. 1115 DSH Waiver Days Group
Jurisdictional Review
PRRB Case Number: 13-3376G

Dear Mr. Polston and Mr. Pike,

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

BACKGROUND FACTS –

The Board established a group appeal on August 26, 2013 for King & Spalding 2007 Low-Income Pool Sec. 1115 DSH Waiver Days Group. The group issue statement reads, in part, as follows:

> "The Providers are appealing the Intermediary's exclusion of days associated with the Section 1115 Medicare Florida Low-Income Pool waiver from the numerator of the Medicaid fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs"). ...The Board further has jurisdiction over any adjustment to the Providers' IRF Medicare DSH payment, including those aspects of the DSH calculation that were not specifically considered by the Intermediary in the NPR. ..."[1]

Pertinent Facts:

All of the years in this appeal are 09/30/2007, prior to the requirement to file an "unclaimed cost" under protest.

[1] Provider's appeal request at Tab 2 (August 23, 2013).

All participants are appealing adjustments to DSH in general, and none of the adjustments specifically state Low-Income Pool 1115 Waiver Days.

	Days removed[2]	Days requested[3]
Participant # 1	7,408[4]	26,466
Participant # 2	net increase 2259[5]	12,296[6]
Participant # 3	0	50,927
Participant # 4	net increase 298	1,383
Participant # 5	0	8,654
Participant # 6	95	13,545
Participant # 7	593	3,878

For participants #1, 3, 5, 6 and 7, the days removed are less than the days requested, there is no evidence in the record to show that the days removed were the Low-Income Pool Sec. 1115 waiver days which are the subject of this appeal. For participants #2 and 4, the days adjusted resulted in an increase to DSH days. The adjustments referenced do not identify that Low-Income Pool Sec. 1115 waiver days were adjusted and the reimbursement calculation show the requested days as additional days.

The Medicare Contractor did not file a formal jurisdictional challenge, but did state in its review of the jurisdictional documents that Low-Income Pool is not an "appealable issue" and the Board lacks subject matter jurisdiction. It also stated that provider 4, 10-0028 was appealing from a revised NPR that did not specifically adjust the Low-Income Pool days.

Board Decision:

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

Provider 10-0028

The Board finds that it does not have jurisdiction over participant #4, North Brevard County Hospital, because it has appealed from a revised NPR that did not specifically adjust the Low-Income Pool 1115 waiver days under appeal.

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

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[2] Providers' Preliminary Position Paper and Final Schedule of Providers under tab D.
[3] Providers' Preliminary Position Paper and Final Schedule of Providers under tab E.
[4] Tab 1D (-1045-44-48-71-18-6352+170)
[5] Tab 2D (-3496-542+2706-135-760-56+2412+800+1330)
[6] Providers' Preliminary Position Paper and Final Schedule of Providers under tab 2B.

> (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 revised NPR. Here, the Provider only submitted a copy of the adjustment report, and did not include the supporting workpapers, reopening notice, reopening request, etc., as is required in the Board rules. The Provider's adjustment report shows an "increase in Medicaid days" due to a Medicaid audit. There is no evidence that the Low-Income Pool 1115 days were the subject of the revised NPR, in fact as the Medicaid days increased, the evidence supports the opposite. As the Provider has not documented that Medicaid eligible days were specifically adjusted as part of the revised NPR under appeal, the Board finds that it does not have jurisdiction over participant #4, 10-0028 for 09/30/2007.

Remaining Six Participants

The operation of the jurisdictional gateway established by 42 U.S.C § 1395oo(a) was addressed by the Supreme Court in the seminal Medicare case of *Bethesda Hospital Association v. Bowen.*[7] The narrow facts of the *Bethesda* controversy dealt with the self-disallowed apportionment of malpractice insurance costs.[8] The provider failed to claim the cost because a regulation dictated it would have been disallowed. In that situation, the Supreme Court found § 1395oo(a) permitted jurisdiction over the "self-disallowed" claim. The Court wrote:

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[7] *Bethesda,* 485 U.S. 399 (1988).
[8] *Id.* at 401-402.

> [U]nder subsection (a)(1)(A)(i), a provider's dissatisfaction with the amount of its total reimbursement is a condition to the Board's jurisdiction. It is clear, however, 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.*[9]

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

> Thus, petitioners stand on different ground than do providers who bypass a clearly prescribed exhaustion requirement or *who fail to request from the intermediary reimbursement for all costs to which they are entitled under applicable rules.* While such defaults might well establish that a provider was satisfied with the amounts requested in its cost report and awarded by the fiscal intermediary, those circumstances are not presented here.[10]

The Board concludes that the they have jurisdiction over the Low-Income Pool 1115 Waiver days issue for the remaining six Participants[11] under *Bethesda.* The Board finds that the Providers' were barred by regulation from claiming the specific type of days, and claiming them on the cost report for payment would have been futile.

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

Board Members Participating

L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Gregory H. Zeigler, 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

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[9] *Bethesda.* at 1258, 1259. (Emphasis added).
[10] *Id.* at 1259. (Emphasis added).
[11] Each of which appealed from an original NPR.